
BIOETHICS OUTLOOK

John Plunkett Centre for Ethics in Health Care

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In this issue

• Our first article is the text of the homily given by Fr Anthony Fisher - a Dominican priest - on the occasion of the funeral mass for Thomas Ryan in Melbourne late last year. Thomas' parents - Clare and Tom Ryan - discovered mid way through Clare's pregnancy that their unborn child was severely handicapped and would die shortly after he was born. We are grateful to Clare and Tom for allowing us to publish this celebration of Thomas' life.

• Next, Bernadette Tobin summarises the recent judgment of the United States Supreme Court which found that "physician-assisted suicide" was unconstitutional.

• In the third article, Myree Harris takes the discussion about the care of people with mental illness a step further by giving a first-hand account of the conditions in which most mentally-ill people who have been de-institutionalised now live.

• Finally, two people respond to the idea, advanced in the last issues of *Bioethics Outlook*, that deliberately cloning human beings violates our sense of the individuality and irreplaceability of other human beings. In the first, Elaine Wallace sets out a variety of issues which the prospect of cloning raises. In the second, Fr Kirahara-Frisch argues that this does not get to the heart of what would be wrong with deliberately cloning human embryos.

Thomas Walter Joseph Ryan - Celebration of a Life

Anthony Fisher

Thomas Walter Joseph Ryan was Advent's child. He was born and died in the week before Christmas, in the season of watching, waiting, expectancy. At this time Mary, the Church, creation is pregnant with child, eagerly longing like a woman in labour. This is the characteristic Advent mood, with all the ambivalence that it implies: a mixture of joy and apprehension, delight and fear, certainty and uncertainty. Christmas, the great season of peace and good will, is around the corner. Yet if there is peace and good will in our world there is war and ill will also. And such a mixture of celebration and grief, of elation and depression, is often in our own hearts too.

Advent and Christmas are times of knowing God is with us. Yet they can be a time of loneliness and of longing too. A child will be born to us, angels will sing "Glory to God on high and peace on earth", and meanwhile Herod will be slaughtering innocent children. The Creator of the universe will become a fragile little baby for us, and there will be no room for him at the inn. The kings of the earth will shower him with gold, frankincense and myrrh, yet he and his parents will have to flee the killing fields of Bethlehem. The first Christmas was marred by unwelcome, anxiety and death. Along with all the celebration of parenthood and childhood, of joy to the world,

there is a darker side to the Christmas story that is often missed by our sentimental carols and cards, but which *we* will all feel *this* Christmas.

Around twenty weeks ago Clare and Tom learnt that their unborn baby was severely handicapped. Ours is a society in which such babies are all too often not welcome at the inn. Despite the pressures of many in our society to abandon, indeed kill, those less fortunate than themselves, Clare and Tom determined to see their pregnancy through and give their little boy every chance. They approached the forthcoming birth with all the excitement and apprehension of new parents, but without the expectation that most have that their child will be healthy and will outlive them. Short of a miracle, Thomas' life would, they knew, be brief like that of the Holy Innocents. But that did not mean it would not be good. 'Pray as if everything depended upon God,' said St Augustine, 'and act as if everything depended upon you.' So heroically they persevered with the pre-natal classes and said their prayers.

They were not alone. I am convinced that God was with them in their hearts and by their side every step along the way. So was his dear Mother, the Mother of Mercy, in whose hospital their son was to be born and die. Mary herself had stood silently, uncomprehending, beside the cross of her boy as he died. Also accompanying them were many dear family and friends. I had the privilege of meeting with Clare and Tom several times over the following months. They, their parents and friends, had many questions. Why would God allow this to happen to their little boy, to them? Should they pray for a miracle? Should they hitch their wanted miracle to Blessed Mary Mackillop's cause? Should they prepare for the possibility of no miracle and a dead baby, or was that a lack of faith? If their baby died before baptism where would he go? How do we make sense of all this? and so on. These questions or ones like them are probably still in all our hearts. Yet Clare and Tom approached them with inspiring faith and hope, with common sense and love.

Last Tuesday Clare and Tom were admitted to the Mercy Hospital to begin the vigil of their labour. Their little boy was born soon after noon the next day. He was immediately baptised 'Thomas Walter' by his father Tom and confirmed Thomas Walter 'Joseph' by me a little while later. Clare's parents were his godparents and sponsors. To the doctors' and nurses' surprise Thomas lived for nearly eighteen hours. He had a beautiful little face and a perfect little boy's body, weighed 4lb 9oz, had dark hair and very soft skin, and was 17 inches long; he had dear little hands and feet and a beautiful face; but his head was incomplete and his fate therefore sealed. His little face had been bruised from the labour, causing one of his little cousins to declare that Aunt Clare had had a 'Diginny' baby, but the rest of his body had good colour and he got warmer and pinker as the day went on. As a token of his being full of love and the Holy Spirit, his heartbeat was strong and he breathed easily. Occasionally he made little sounds and would hold tightly onto someone's finger with his little hands. His parents fed him little drops on the end of a finger.

Before I left on Wednesday night we prayed the prayers for the dying for him with his godparents and uncle. Around dawn Thomas died as he slept between his parents. We gathered again, his parents and godparents, this time to pray the prayers for the dead and to pray for those who grieve them. Everything possible had been done for Thomas by his parents, extended family and friends, by his healthcarers and the Church. But Clare and Tom and so many others of us here this morning had prayed for a miracle. It is a mystery to us why God grants healing to some and not to others. But I firmly believe that Clare and Tom did get their miracles—four in fact—even if they were not quite what they had hoped for.

The first miracle came before his birth, and it was this: that in a society of Herods determined to kill little ones like Thomas, Clare and Tom protected and nurtured him with the devotion of true parents. That was,

of course, a great grace for Thomas himself: it meant he was as safe in his mother's womb as every child should be. But it was also a matter of great merit for his parents and a reflection of their faith and generosity and of their upbringing in fine Christian families who honour the tiny feet of the unborn. "The life and death of each of us has its influence on others," St Paul reminds us this morning. Even while still in the womb Thomas was influencing others, creating opportunities for

others, making space as it were, giving his parents a chance to give testimony to the preciousness of human life and to show courage and true love. That they did so with such natural, unaffected

heroism is surely the action of grace. As the Pastoral Care Worker at the Mercy said to me, she had never seen a couple in such a situation prepare so creatively for the birth of their child.

The second miracle was Thomas' birth itself: quick and easy, allowing him to be born alive, to be baptised (twice!) and confirmed, to be held and photographed and delighted in by his parents. Again unconsciously he made a space for others. This time he made opportunities for his healthcareers, to show their respect and care at a time when their profession is under greater and greater pressures to show less and less care and respect. He made a space for others too, to minister to him and to his parents, as priests and relatives and friends. That, we all know, is a great gift and privilege, one which little Thomas' birth allowed us.

The third miracle was his life: much longer than all had expected, long enough so that every grandparent, uncle and aunt, gathered from various parts of the country, got to visit him, to touch him and be touched by him, to know him a little bit and share in his short life and his parents' joy and tears. Every moment of his life Thomas was held tightly by someone

who loved him. He packed so much into his seventeen or eighteen hours. It was long enough to have his clothes changed several times and to be hugged and kissed and stroked. Long enough for him to leave us many memories, to leave us the many tokens we see around his coffin today. Long enough, too, to give Clare and Tom some time with him, to celebrate little birthdays as he achieved each new hour and especially their private one with him at midnight when against all the odds he saw in a new day. He even gave them a night of disturbed sleep with their child, which is every parent's right.

And the fourth miracle, strangely enough, was his death. For Thomas died free from all pain and discomfort, and free too from all sin. His was a truly holy death, the death of a saint, surrounded by love and prayer. He was met at his death by all the other saints, transported by the angels to Christ's side, to the Father's bosom, granted eternal rest and perpetual light. This is, of course, the hardest miracle of all for us to see. We seem to be giving him back to the God who gave him to us, so soon, too soon. Yet as God did not lose him in giving him to us, we do not lose Thomas by his return. What God gives he never takes away: life is eternal, love is immortal, death is only the limit of our sight. In his very dying Thomas has again miraculously made space for us. His parents were as ready for his death as any parents could be and he left slipping away until they were so ready. But he did not merely slip into history and memory: he has gone into the future and promise. At his baptism and confirmation we prayed that by water and the Holy Spirit he might participate in the mystery of Christ's death *and* resurrection. Thomas has gone before us and he beckons us to follow.

Today we gather once more to pray beside Thomas Walter Joseph. This time we do not really pray *for* him, for we know he was made a saint by God's grace and the Church's sacraments. He lives now with the God who said "let the little children come to me, for to such as these the kingdom of God belongs". We know too that he will be raised on the last
(continued on page 5)

United States Supreme Court rules physician-assisted suicide unconstitutional

A report by Bernadette Tobin

On 26th June the Supreme Court of the United States unanimously decided that the laws which had been passed by two States banning physician-assisted suicide were constitutional. The Court found that the Constitution did not give a patient a "right" to have a doctor give him or her assistance in committing suicide. As the Chief Justice put it, an "asserted" "right" to assistance in committing suicide is not a fundamental liberty interest protected by the due process clause.

Both Washington State and New York State had enacted laws which made it a crime for a doctor to assist a patient to commit suicide. Both states had had their laws challenged all the way to the highest court of appeal in the United States, the Supreme Court. The Supreme Court's judgment reflected the same kinds of reasoning which led the Australian Commonwealth Parliament to override the Northern Territory's Rights of the Terminally Ill Act. The judgment is worth studying in detail. In what follows the key elements in that judgment, as expressed in the words of the Chief Justice, Justice Rehnquist, are set out.¹

Justice Rehnquist began by noting that the states' bans on doctors helping their patients to commit suicide are not innovations. "Rather, they are long-standing expressions of the states' commitment to the protection and preservation of all human life. Indeed, opposition to and condemnation of suicide and, therefore, of assisting suicide are consistent and enduring themes of our philosophical, legal and cultural heritages..." Here Justice Rehnquist noted the unanimous recommendation of what he called a 'blue-ribbon' commission, the New York State Task Force on Life and the Law which concluded that legalising assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable. "...

the potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved."

Many commentators emphasized the tone of Justice Rehnquist's final remark, viz, that the Court's judgment permits the debate (about the morality, legality and practicality of euthanasia and physician-assisted suicide) to continue. In so doing, they often ignored the substantial content of the Court's unanimous judgment. In a powerful summary of the arguments against legalizing euthanasia and assisted-suicide, Justice Rehnquist identified five state interests implicated in the prohibition on physician-assisted suicide:

Five state interests in a prohibition against physician-assisted suicide

1. First the state "has an "unqualified interest in the preservation of human life." The state's prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to this interest."

2. "...all admit that suicide is a serious public health problem, especially among persons in otherwise vulnerable groups. The state has an interest in preventing suicide and in studying, identifying and treating its causes. Those who attempt suicide, terminally ill or not, often suffer from depression or other mental disorders. Research indicates, however, that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated. The New York task force, however, expressed its concern that, because depression is difficult to diagnose, physicians and medical professionals often fail to respond adequately to seriously-ill patients' needs. Thus, legal physician-assisted suicide could make it more difficult for the state to protect depressed or mentally ill persons, or

those who are suffering from untreated pain, from suicidal impulses.'

3 'The state also has an interest in protecting the integrity and ethics of the medical profession. In contrast to (a lower court's conclusion that) the integrity of the medical profession would (not) be threatened in any way by (physician-assisted suicide), the American Medical Association, like many other medical and physician groups, has concluded that physician-assisted suicide is fundamentally incompatible with the physicians' role as healer. And physician-assisted suicide could, it is argued, undermine the trust that is essential to the doctor-patient relationship by blurring the time-honoured line between healing and harming.'

4 'Next, the state has an interest in protecting vulnerable groups including the poor, the elderly, and disabled persons from abuse, neglect and mistakes. The court of appeals dismissed the state's concern that disadvantaged persons might be pressured into physician-assisted suicide as ludicrous on its face. We have recognized, however, the real risk of subtle coercion and undue influence in end-of-life situations. The state's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes and societal indifference. The state's assisted-suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's.'

5 'Finally, the state may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia. The court of appeals struck down Washington's assisted-suicide ban only as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.'

Washington insists, however, that the impact of the court's decision will not and cannot be so limited. If suicide is protected as a matter of constitutional right, it is argued, every man and woman in the United States must enjoy it. The court of appeals' decision, and its expansive reasoning, provide ample support for the state's concerns ...'

Note

1. This report is taken from *The New York Times*, 17 June 1997

Thomas Walter Joseph Ryan - Celebration of a Life

(Continued from page 3)

day, no longer handicapped but with a body glorified like Christ's risen body. Now it is he who prays for us. But we pray today that Thomas Walter's joy may be complete. And that will require that he be joined in heaven by his loving parents, relatives and friends, including, we hope his future brothers and sisters. So we pray for all of them, that God will "wipe away all tears from their eyes", even as we give thanks to Gos for Thomas' short life, trusting that both God and his newest saint are with us now.

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The Abandoned Ones

The plight of the former patients of psychiatric hospitals in New South Wales

Myree Harris RSJ

"I can recommend Oxford Lodge. It's a good place for your brother. The standards may not be what we'd expect but there's a good spirit among the residents."¹ Thus the recommendation of a doctor at one of Sydney's major teaching hospitals. He gave this advice to a prominent public servant whose brother had been a patient in a psychiatric hospital and who now needed somewhere to live. That man's brother, Peter, who has schizophrenia, has now lived in Oxford Lodge for sixteen years.

In March this year, after more than twelve months' monitoring by the Licensing, Support and Development Unit of the Ageing and Disability Department, during which time the rotting floor boards had been replaced, unsanitary facilities had been cleaned up and the food improved, this private 'for profit' boarding house had its licence revoked and its doors closed, amidst allegations of abuse and financial mismanagement, poor nutrition and general neglect of the duty of care.

History

In 1965, 12,421 people were being treated as in-patients in the large psychiatric institutions in NSW: Gladesville, Callan Park (now Rozelle Hospital), Rydalmere, Macquarie, Cumberland, Bloomfield, Morrisset and Kenmore. By 1991, this figure had decreased to 2,294 in-patients yet the population of the State had increased by fifty per cent and the incidence of serious mental illness had not declined.² At present 25,000 adults in NSW suffer from psychotic illnesses such as schizophrenia and bipolar mood disorder.³

At any one time, less than two per cent of those being treated for mental disorder will be

in hospital. Ninety-eight per cent live in the community. Where did all the patients go?

The much-vaunted process of de-institutionalisation took place from the late 1960s through to the late 1980s and the final chapters are being written now. Gladesville Hospital closed recently. Rozelle Hospital will close in a few years. As the large institutions closed, entrepreneurs and medical personnel including psychiatric nurses saw an investment opportunity. Large buildings in the inner western suburbs of Sydney, the Lake Macquarie region of the Hunter Valley and the former guest house area of the Blue Mountains were bought and set up as licensed private "for-profit" boarding houses.

Patients were transported from the hospital to these places. Licences were provided by the State Government, which essentially washed its hands of the former patients and forgot about them. In the words of one boarding house owner, *"When I got my licence back in 1973, they nearly kissed me. I could go away and do as I liked. No one came near me for twenty years. Now they want to set standards."*

How did it ever come to this? The initial promise, that the resources necessary to integrate former patients would follow them into the community, was not kept. The State Government acquired the valuable real estate, the 12,421 people no longer had to be maintained in hospitals. They now received disability pensions, most of which went to boarding house owners. Some unions were all too effective in ensuring that jobs were not lost when the psychiatric hospitals discharged most of their patients. As Brian Burdekin commented:

"One psychiatric institution went from 1,000 patients to 260 patients over a 10 year period. At the same time it went from 650 staff to 650 staff. Ninety eight per cent of resources for this institution, which soaked up \$20 million a year, stayed in the hospital, and only 1 1/2 % went to care for the former patients in the community."

The introduction of standards.

When the Labour Government came into office in 1995, it established up a new Department, called the Ageing and Disability Department, whose Licensing, Support and Development Unit was given the responsibility of overseeing residences for people with psychiatric illness and ensuring that licensees complied with the provisions of the Youth and Community Services Act of 1973. Staff from the Unit now conduct monitoring visits and annual reviews of all licensed residences.

This has opened a Pandora's Box. Currently in New South Wales there are about 150 licensed facilities housing 1,175 residents. Of these, 41% (397 residents) are over 60 years of age and 700 have already been assessed as being in need of aged care. Premature ageing is also an issue for this group as a result of the side-effects of psychotropic medication along

with the poor nutrition and hygiene in boarding houses and general neglect of medical and dental health. The majority of residents, 44% (949 people) have a mental illness, 28% (608 residents) have a developmental disability, 16%

have brain damage, 17% (380 people) have a dual disability, 8% have an age related or a physical disability. Only 3% have no disability.

Premature ageing is also an issue for this group as a result of the side-effects of psychotropic medication along with the poor nutrition and hygiene in the boarding houses and general neglect of medical and dental health.

About two thirds of the population of boarding houses are men."

Over the past two years, several of the owners of licensed boarding houses have chosen to cease operation rather than meet legally-required standards. Others have been prosecuted for failing to meet these standards and their licences have been revoked. For example, when Oxford Lodge closed, the owner contacted friends and arranged for eighteen residents to be moved to their boarding houses. The Central Sydney Boarding House Team placed the remaining twenty two in other Inner Western suburbs facilities. At twelve hours notice, people who had lived together for up to sixteen years were scattered from Katoomba to Kurnell, Campsie to Drummoyne. Six have since ended up in Matthew Talbot Hostel, where four appear set to remain. This was in direct contradiction of a protocol drawn up in September 1996, entitled "Interdepartmental Procedures for the Relocation of Residents prior to the closure of a Private Licensed Accommodation Service for People with a Disability", which states "Relocation to another boarding house is not appropriate".

In the next few months, there will be more closures. Residents of two facilities at Rockdale and Balmain have filled the last remaining spaces in other boarding houses. The Government is faced with a dilemma. Where will it place the people if the facilities under investigation in Marrickville, Katoomba and the three in the Hunter Valley close? Some three hundred people will need to be housed. It must be tempting for the Government to follow the line of least resistance and to prop up the present system. Boarding house owners have formed an association and are lobbying for subsidies. Again, to quote an owner: "If I got \$10,000 a head, or \$20,000, I'd be making so much money."

Altruism appears to be in short supply among many operators of these profit making ventures. There is little indication that subsidies would improve life for the residents

Solutions

The most adequate, and of course the most expensive, solution would be for the Government to establish a *range* of housing options for people with psychiatric illnesses: from Department of Housing units, supported by Mobile Mental Health Teams, through group homes, to cluster housing and larger facilities for up to twenty people. In addition a range of appropriate aged care facilities is also needed (including long-term psychogeriatric hostels and nursing homes and mobile psychogeriatric teams). Provision would also be needed for crisis and respite care, assessment and living skills centres and for clubhouses for communal activities: all this would realise the ideals of 'de-institutionalisation'.

The idea of tackling this is a nightmare for a State Government facing constant challenges in the health area. Besides, the community at large does not care about disabled people. For politicians, responding to the needs of the disabled, in particular those with mental illness, is not a vote-winning issue.

However, there is an ethical dimension to all this. The doctors' recommendation to Peter's brother, together with known practices in boarding houses, indicate that disabled people cannot expect the living conditions ordinary members of the community take for granted. How basic a right is it to be able to make a cup of tea or coffee when one wishes or to take a clean towel when the used one is damp?

Though some facilities are run by caring managers and have reasonable conditions, in general boarding house residents endure poor quality food, locked kitchens, padlocked refrigerators and evening meals before 5pm. They experience overcrowding (up to eight beds to a room), very little personal money, ill-fitting, second-hand clothes and shoes. Does our society really believe that people, already suffering from a disability, deserve no better than this? Many families have simply abandoned these people. They are socially isolated and at the mercy of boarding house owners. And they have no advocates.

Gradually, and usually without fanfare, the large hospitals have closed and the lucrative real estate has been sold. Who checks to see that the people who used to be cared for in these places ever benefit from that sale? Who asks questions about proceeds of the sale of Gladesville Hospital, the looming sale of Rozelle property or about places such as the old Rydalmere Hospital?

It has been very convenient that former patients could be shunted into boarding houses or dumped without support in Department of Housing estates. It is only the neighbours or charities such as the St Vincent de Paul Society who realise the misery these people endure as they struggle to survive in places like the Villawood Estate, the Redfern high-rises, Merewether and Dundas Valley.

No civilised society can ignore the abuse and neglect of its most vulnerable members. Twenty years ago, the patients from our psychiatric institutions vanished. No one cared where they went. Until people with disabilities are finally welcomed and accepted as valued members of our society, our humanity is diminished.

Notes

- 1 The names of all people and institutions in this article are fictitious.
- 2 "Leading the Way" A framework for NSW Mental Health Services, 1991-2001, NSW Health Department, Second Edition, 1994.
- 3 Leading the Way, *ibid*
- 4 Brian Burdellin: Address given at the Anglican Expo, St John's College, Adelaide, 1994
- 5 Data Report. Residents of Private Licensed Accommodation for people with a disability, NSW Licensing Support and Development Unit of the Ageing and Disability Department, 1996

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...disabled people cannot expect the living conditions ordinary members of the community take for granted.

On Deliberately Cloning Human Beings:

A first comment by

Elaine Wallace

If a cloning procedure were available to humans, would people want to use it? If so, what reasons could they have? What would it mean to both the 'original' and the 'clone'? It has been argued that the practice should be proscribed because it violates our understanding and appreciation of the uniqueness and preciousness of each human being. There are, I think, other reasons why it should not be done.

First, a point of clarification. Cloned individuals would be genetically identical to one another, but this does not mean that they would be replicas of the same person, any more than identical twins are the same person. In fact they would be much less alike than identical twins. The question of 'who we are' is meaningless outside of the experiences we have had and our perceptions and memories of those experiences, regardless of our DNA. No two people, even two who are genetically-identical and reared in very similar circumstances, have exactly the same experiences. Even if everything else were equal, one would be fed first and the other second, or if fed simultaneously one would be fed on the left and one on the right, or one by the mother and one by a wet nurse, etc. As they grow older their experiences will diverge even further as they become more physically independent. The occasional story of identical twins meeting after a long separation and finding they have many things in common does not show that they are the same person separated into different bodies. People with identical genes who are reared separately in time as well as place would diverge even further from one another.

It has been said in the popular press that some wealthy people might want to have clones made of themselves so that they can inherit *their own* wealth. This involves a

misshapen and mistaken idea of what makes a person. Clones could not be reproductions of the same person. Human beings share much of their DNA with one another. The fact that human beings on the other side of the world can donate blood, bone marrow, etc. for transplantation into a sick person indicates that in the human family we are sometimes genetically related more closely to people we do not even know than to those in our immediate family who may have incompatible tissue types. In addition we all share 98% of our genes with our near primate relatives. What makes us genetically different from one another and from other primate species genetically is only a fragment of our DNA. What makes humans different from one another in behaviour and achievement the result of a complex inter-relationship between the raw material (the DNA) of intelligence, musical aptitude, physical strength (although even that is related to the circumstances in which people live), etc. and the experiences which different people have and the meaning which they bring to those experiences. Thus, it is not possible to clone a *person*.

However what is now possible is the cloning of human *embryos*, the creation of replicas of the DNA of a living person. What reasons might someone have to do this?

Some argue that intruding on natural reproduction to create species with desired traits has been going on since human beings began to sow crops and domesticate animals, and that cloning human embryos is simply the next step in this process. Even humans exercise some control over the traits of offspring they produce by the choice they or their families make of mates. And people who avail themselves of artificial insemination programs usually want to ensure that the traits of the

donor are compatible with their ideas of the sort of offspring they want to produce.

But is it morally permissible to clone human embryos? To some, the benefits to society of creating a large number of people with special abilities seem compelling. Others fear that the technology could be misused.

However, nobody could have foreseen the achievements of many of the great people in history who have come from humble backgrounds, but who were able to utilise their experiences to accomplish astonishing feats. Similarly we all know people who had recognised potential and were given every opportunity to realise it, yet for various reasons never did. Because the human race does share most of its DNA, there is just as much likelihood of a person with the potential to become another Einstein or Beethoven being born in a village in the Third World as there is of that person being born in Europe, America or Australia. Whether that person has the experiences necessary to develop that potential is dependent on the circumstances of his or her life.

The attempt to clone exceptional people would also require that conditions be created to provide them with the necessary experiences to develop their talents. But those resources could be better used to provide opportunities for talented people who already exist but lack opportunity.

Another argument against cloning human embryos is that special abilities that we have not even dreamed of may be lying dormant, only requiring the right experiences to bring them to fruition. If cloning of embryos with designated special abilities did become widespread, we would in fact be limiting the human race to those abilities, when there may be others that we do not yet know about.

Against this, some might argue that cloned embryos could provide a source of compatible organs and tissue should those ever be needed

for transplantation purposes. But this would involve treating some human beings merely as means to others' ends rather than as ends in themselves. The same criticism might be made of the widely-publicised cases of couples conceiving children with the intention of using those babies' bone marrow to transplant into older siblings. While many people have children for a variety of ignoble reasons, this does not justify those who do it with transplantation as the motive.

If as a society we already tacitly accept the artificial creation of multiple births through assisted reproduction technology, then have we any reason to object to cloning embryos so long as it is intended to raise them as separate human beings and not to use them as organ donors? Ethically, there may be little difference between deliberately creating clones and interfering with reproductive processes to create identical multiple births. (Non-identical multiple births are already commonplace in assisted reproduction programs.) Many people see nothing wrong with this, arguing that non-identical and identical multiple births occur naturally anyway. (What should happen to the unused embryos that result from I.V.F. programs is another issue altogether.) But I think that we *do* have reasons to object to cloning human embryos: apart from any other moral consideration, widespread cloning would involve an imprudent use of resources. The attempt to provide the experiences and circumstances necessary for clones to achieve their hoped-for potential would deny those same resources to people who already exist and are unable to function at the desired level simply due to lack of opportunity. It would thus violate what we owe in justice to people who already exist.

Elaine Wallace has a Master of Arts in Applied Ethics. She was formerly Head of the Social Work Department at St Vincent's Hospital in Sydney.

A second comment by Fr Jean Kitahara-Frisch, S.J.

The recent successful cloning, which started from a somatic cell of an adult sheep has once more evoked the perhaps remote prospect of cloning in humans. Such cloning, it has been claimed by many, would be incompatible with human dignity. I would agree with this claim, but not for the reason apparently given by most.

It is said that reproducing an entirely genetically identical individual would deprive this individual of his right to an absolutely unique individuality. Is not this to attribute too much weight to the genetic component of this individual's personality? The not so rare occurrence of identical twins would seem to provide ample evidence that such is not, and cannot, be the case. As parents well know, such twins often become quite different from one another, depending on the external environment in which they grow up, the persons they happen to meet, and of their own free choice. In fact, nobody has ever claimed identical twins to be deprived of dignity or individuality, and rightly so.

Though one can readily agree that "man-made identical twins" may react to external circumstances in similar ways much more frequently than other genetically non-identical humans, this is far from denying the twins' capacity for free choices, less one becomes guilty of radical genetic determinism.

In a similar way, speaking as if cloning could create a "replacement" for another human being would seem to make the unwarranted assumption that a person's uniqueness is due only, or mainly at least, to his or her genetic make-up. Already biologically this kind of reductionism is highly questionable. Much more so, of course, from a philosophical point of view.

The real reason why human cloning could easily offend against human dignity appears to me to have rather much in common with the reason why human reproduction by *in vitro* fertilisation is condemned by the Church. Every human person has the right to be born from the loving intercourse between a father and a mother and the right (as much as

depends on us) to be raised in a family. To willingly deprive a person of such rights is a grave injustice that ignores in fact the dignity of this person and the rights inherent in that person.

When condemning human cloning it is important that we do so for the right reason, less we be accused of opposing, once more, the progress of science for philosophically and humanly unjustifiable reasons.

Fr Kitahara-Frisch is a Jesuit priest who lives in Tokyo.

Mary Philippa Brazill Foundation Support Scheme for Research and Education in ethics

The Trustees of the Mary Philippa Brazill Foundation invite both individual applicants and applicants who represent institutions, particularly institutions in the fields of education and health care, to apply for financial and other support from the Foundation.

The Mary Philippa Brazill Foundation was established in 1993 for the purpose of providing financial support for research and education in ethics with an emphasis on the ethics of health care and with special regard to the promotion of these activities in Catholic institutions in Australia. The name of the Foundation commemorates Sister Mary Philippa Brazill, the Sister of Mercy who was one of the founders of the Mercy Private Hospital in Melbourne and an inspiring leader in the provision of health care.

Each year, the Foundation will offer financial support to enable applicants to undertake (in Australia or overseas), further educational studies (including attendance at conferences, symposia or seminars) and/or to conduct research in ethics; it will enable institutions in Australia to support scholars (from within Australia or from overseas) to undertake teaching, research or other allied activities in ethics and will support the sponsorship of conferences, symposia or lectures in ethics.

Application forms are available from the Mary Philippa Brazill Foundation Mercy Congregation Centre, 720 Heidelberg Road, Alphington, Victoria 3078. Applications close on 31 August each year.

NOTEBOOK

Master of Arts in Applied Ethics (Health Care)

Ethics in Health Care or Bioethics is increasingly important in society, in health care institutions and in professional practice. The Master of Arts in Applied Ethics (Health Care) is offered by Australian Catholic University in fleximode with seminars and supervision scheduled by negotiation with students. The course will be of value to professionals and other citizens interested in the moral and social significance of ethical issues in health care and, in particular, to members of institutional ethics committees.

Duration of Study

One year full-time ; Two years part-time

Admission Criteria

Professional qualification with experience; or suitable undergraduate degree in Philosophy or Theology

Advantages

- advanced study by coursework, with the opportunity for research
- access to staff, facilities and resources of the John Plunkett Centre for Ethics at St Vincent's Hospital
- Video-conferencing facilities offer regular opportunities to interact with staff and students in other states
- Applications for second semester 1997 and for first semester 1998 are now being considered.

For Further Information Contact:

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