

HOW THEOLOGY COULD CONTRIBUTE TO THE REDEMPTION OF BIOETHICS FROM AN INDIVIDUALIST APPROACH TO AN ANTHROPOLOGICAL SENSITIVITY

In proposing my topic, my intention was twofold: to show that bioethics, especially American bioethics, will be unable to fulfil the dream of its origins unless it regains an anthropological consciousness that had nourished its founders; to propose parameters which, under certain conditions, would allow theology to help bioethics to refocus on its original hopes. As you see, I would like to find orientations which would allow bioethics to rediscover the richness of its roots.

This explains the outline of my presentation. In the first part, I will discuss the origins and development of American bioethics. I would like to show that the search for anthropological meaning explains why individuals from different disciplinary horizons and various philosophical perspectives met together at the end of the 1960s to set up the basis of what would later be called bioethics. I will show the loss of anthropological meaning that has occurred since its beginning, highlight the obsessive focus on the individual without concern for his/her environment and his/her roots, refer to the situation of irrelevance in which theology has since been placed, and finally mention the limits the phenomenon has put on our ability to discuss basic human issues. In the second part, the individualist approach of the American bioethics will be compared to other approaches, especially French and Latin American. I will attempt to show how other cultural and "national" sensitivities invite us to address ethical challenges raised by scientific and technological developments. Their concern is not "Does the competent individual agree with the procedure?" but "What kind of humanity do we want to become?" The third part will focus on the task of theology. It will be devoted to the contribution theology could make to strengthen our public debates concerning the present and future of our life together.

THE ORIGINS AND DEVELOPMENT OF BIOETHICS

Bioethics came to existence in the mid-sixties when Americans became aware that biomedicine had rapidly developed an impressive array of means to intervene in human life. There were two majors concerns. The first one: medicine had become an enterprise which contradicted its own objectives. American bioscientists had conducted, and were still conducting, experiments on children, blacks, and handicapped individuals, which blatantly violated the ideals of medicine, the guidelines for research on human beings established at Helsinki in 1964, and the Code proclaimed at Nuremberg by the tribunal presided over by

Americans. In a way, bioethics expressed the indignation of a society about the sufferings imposed by researchers on those upon whom they experimented. These people who were indignant about the situation were not so much concerned about the rights which were not respected, but about the inhuman cruelty imposed on vulnerable people by other people who made a profession of beneficence.¹

The second concern was related to the dramatic development of scientific knowledge and technology. It raised new questions which traditional ethical doctrines were not equipped to face. Human societies were being reshaped in radical ways. How were the new challenges to be met? This question obviously suggests a critique of the methods and use of science, but it was not the product of an antiscientific attitude. It led to the first organized efforts to have a better understanding of the dynamics of science and a clearer conception of how scientific advances might be integrated into the total fabric of social life in a responsible manner.² At the outset of what would be called bioethics, respect for the person meant not only autonomy, but solicitude for the vulnerable individual, and social solidarity with those who were excluded from society.³ The question of how these new challenges were to be faced was made more difficult by the lack of interest shown by the various philosophical systems in such issues. As mentioned by Stephen Toulmin: "For those who sought some 'rational' way of settling ethical disagreements, there developed a period of frustration and perplexity. . . . They turned in vain to philosophers for guidance."⁴

Theological systems were no better off, according to Leroy Walters.⁵ It was obvious that the only way to undertake the urgently needed transformation of ethics was to involve individuals and institutions with different competencies and diverse horizons in a regular dialogue. In fact this dialogue started in the mid-sixties and, as LeRoy Walters has shown, "People who either had strong religious interests or were theologically trained played a principal role in the flowering of the field."⁶ In the first years the community of inquiry was composed of a few

¹Jay Katz, "Reflections on Unethical Experiments and the Beginnings of Bioethics in the United States," *Kennedy Institute of Ethics Journal* 4 (1994): 85-92, at 89-90; Jay Katz, "'Ethics and Clinical Research' Revisited: A Tribute to Henry K. Beecher," *Hastings Center Report* 23 (September-October 1993): 31-39, at 32-33.

²The series *The Foundations of Ethics and Its Relationship to Science*, published by the Hastings Center in the 1970s, is a good example of such an approach.

³Mark E. Meany, "Freedom and Democracy in Health Care Ethics: Is the Cart before the Horse?" *Theoretical Medicine* 17 (1996): 399-414, at 399.

⁴Stephen Toulmin, "How Medicine Saved the Life of Ethics," *Perspectives in Biology and Medicine* 25 (1982): 736-50, at 736.

⁵Leroy Walters, "Religion and the Renaissance of Medical Ethics in the United States: 1965-1975," *Theology and Bioethics*, ed. Earl E. Shelp (Dordrecht: D. Reidel, 1985) 3-16, at 7.

⁶Walters, "Religion and the Renaissance of Medical Ethics," *Theology and Bioethics*, 12.

theologians, physicians and scientists who came together, in a nonecclesiastical forum, to give serious thought to problems that were at the interface of biology, medicine and moral theology. Many commentators think that the role of religious ethics remained dominant until 1975.⁷

The concerns of the first participants in the dialogue were of an anthropological nature. Human societies were being reshaped in radical ways. Science and technology could no longer be interpreted as simply a means to better serve human needs. They had become an integral part of the human fabric. Extending traditional insights to the new problems raised by technological medicine was considered an illusion, and protecting individual rights against pressure exercised by the scientific enterprise was only a partial component of the reflection to be undertaken. The key issue for these first participants was finding ways for the whole community to be responsible for the process of facilitating the emergence of a modern medicine which would be humane. I do not think that these people were clearly aware of the Baconian dimension of modern medicine, which makes human nature instrumental "in order to fulfil its moral project."⁸

In the beginning of the 1970s, the dialogue was called bioethics and attracted the attention of the public. The nature of American bioethics is better understood when interpreted from a historical and sociological perspective, rather than a disciplinary one. The sociologist Renée Fox captured well the real nature of the beast when she wrote in 1990: "'Bioethics' is a social and cultural, as well as an intellectual happening."⁹ The image borrowed from the cultural life of the 70s is well taken. As a matter of fact, bioethics took up a lot of room in the political, legal, administrative and public arena, as well as in the university, not to mention the print and electronic media.¹⁰ In 1986, *The Economist* spoke of bioethics as the fastest growing industry.¹¹ Bioethics is a social phenomenon, with its intellectual structure, its language, its players, and so on. This helps to understand why it would early on become a power struggle.

Among factors explaining this popularity was the very rapid movement of the bioethical issues "from the realm of theory and speculation into the real

⁷Walters, "Religion and the Renaissance of Medical Ethics," *Theology and Bioethics*, 8-14; Charles E. Curran, "Moral Theology and Dialogue with Biomedicine and Bioethics," *Studia Moralia* 23 (1985): 57-59, at 58; Daniel Callahan, "Beyond Individualism: Bioethics and the Common Good," an interview in *Second Opinion* 9 (1988): 53-69, at 55.

⁸Gerald P. McKenny, *To Relieve the Human Condition* (Albany: State University of New York, 1997) 18.

⁹Renée C. Fox, "The Evolution of American Bioethics: A Sociological Perspective," in *Social Science Perspectives in Medical Ethics*, ed. George Weisz (Dordrecht: Kluwer Academic, 1990) 201-17, at 201.

¹⁰Samuel Gorovitz, "Baiting Bioethics," *Ethics* 96/1 (1986): 356-74, at 356.

¹¹H. A. Shenkin, *Medical Ethics: Evolution, Rights, and the Physician* (Dordrecht: Kluwer Academic, 1991) 13.

world, particularly into the world of court rooms and legislatures."¹² Indeed, lawyers began paying attention to the ethics of medicine and their presence played a major role in determining the orientation of the new field. This corresponds with a major aspect of modernity: "When it is assumed that under the aegis of liberty, moral judgment cannot be passed on private life, then the only general norms become those supplied by the law."¹³ It helps us understand why ethics is seen as a procedure.¹⁴ It also explains a major role that has been attributed to the different types of ethics committees: to elaborate guidelines and regulations which are a mix of law and moral statement.

At the same moment, philosophers also began paying attention to the ethics of medicine. They became major figures in the elaboration of ethical methodologies needed to resolve dilemmas arising from modern medicine. These methodologies were based on objective and deductive thought¹⁵ and were in line with analytical philosophy. One orientation was privileged and was later called "principlism." "Principlism" is made of four principles (autonomy, beneficence, nonmaleficence and justice). Between these principles a hierarchical order exists; autonomy is first. Indeed, "individualism is the primary value-complex on which the intellectual and moral edifice of bioethics rests."¹⁶

Although the bioethical dialogue was started by people with strong religious concerns, by the mid-seventies bioethics had become a secular enterprise and had a strong legal component. From this time on, humanization of medicine was seen to be achieved, on the one hand, when patients' autonomy was respected and, on the other hand, when the physician's right to use all resources which were needed to answer her or his patient's wishes was recognised. This approach is neither Kantian nor utilitarian as most American textbooks on bioethics suggest. The meaning of autonomy in bioethics derives from legal sources. The philosophy of John Locke is probably more determinative than that of Immanuel Kant in delineating the meaning and use of autonomy in bioethics. Autonomy is then identical with the negative freedom of classical liberalism which consists in protecting the individual from the interference of others. This is shown, for example, in the fact that beneficence has become synonymous with paternalism.

¹²Callahan, "Beyond Individualism," *Second Opinion* 9 (1988): 56.

¹³Daniel Callahan, "Minimalist Ethics," *Hastings Center Report* 11/5 (1981): 24.

¹⁴Tristram, H. Engelhardt, *The Foundations of Bioethics* (New York: Oxford University Press, 1986) 45; Anne Fagot-Fargeault, "La réflexion philosophique en bioéthique," *Les fondements de la bioéthique*, ed. Marie-Hélène Parizeau (Bruxelles: De Boeck Université, 1992) 17-25.

¹⁵Fox, "The Evolution of American Bioethics," *Social Science Perspectives on Medical Ethics*, 207.

¹⁶Renée C. Fox and Judith P. Swazey, "Medical Morality is not Bioethics—Medical Ethics in China and in the United States," *Perspectives in Biology and Medicine* 27/3 (1984): 336-60, at 352.

What could be the role of theology in this new context? Theology was present at the birth of bioethics because religious traditions "[had] reflected over a long period of time on basic human problems and their reflection [was] rooted in some ultimate view of human life and human destiny."¹⁷ In the context where individual rights acquired an almost absolute precedence, other elements which are integral components of human experience were excluded. Time and space were eliminated, community and family were ignored, otherness and transcendence were made meaningless. From the mid-seventies to the early years of the nineties, I have not seen, in bioethical literature, many texts discussing health issues faced by local communities, rural areas or proletarian districts in major cities. It is only recently that bioethical discussions have shown some interest in health care issues related to ethnic and cultural groups. Bioethics made theology keep silent; there was no role for it. James Gustafson and Richard McCormick have summarized the situation well:

In response to a query from a friend (who was a distinguished philosopher) about how the term "ethicist" has come about, I responded in a pejorative way "An ethicist is a former theologian who does not have the professional credentials of a moral philosopher."¹⁸

As we enter neighborhood homes, many of us have been quickened with the peculiar hospitality of a sign that reads: "Beware of dog". There are doubtless many people around who believe that an analogous sign is in place when a theologian is present to discuss the ethical dimensions of biomedicine. Theologians just may bite. Or perhaps worse they may not. At their worst they are seen as extremely dangerous. At their best they are harmless, that is useless.¹⁹

In fact, one may wonder why there would be a role for theology when the basic philosophy of bioethics can be summarized as follows: "Does the competent individual agree with the procedure?" By the end of the 1980s theology had become irrelevant, as well as discussions about basic human issues. Human being was defined by his or her right to self-determination. In spite of major critiques that are addressed to the standard bioethics by Americans themselves, and in spite of other ways of thinking which have emerged in America, I do not think that this basic philosophy has been really challenged.

¹⁷Callahan, "Beyond Individualism," *Second Opinion* 9 (1988): 55.

¹⁸James F. Gustafson, "Theology Confronts Technology and the Life Sciences," *On Moral Medicine*, ed. Stephen E. Lammers and Allen Vervey (Grand Rapids MI: Eerdmans, 1987) 35-40, at 35.

¹⁹Richard A. McCormick, "Theology and Bioethics," *Hastings Center Report*, 19/2 (1989): 5-10, at 5.

OTHER CULTURAL AND NATIONAL ORIENTATIONS IN BIOETHICS

I will now turn to the second part of my presentation. I will compare American bioethics with other approaches. By so doing, I do not intend to show that other national bioethics are better than the American model. By presenting other perspectives, I implicitly recognize that American bioethics is not unique. It is important to underline this element in the present context of globalization, where many people from different countries fear an American bioethical imperialism. Moreover, American bioethics could take advantage of what is going on elsewhere to enrich its own corpus without losing its strength, which consists in its respect for the individual.

In order to disengage the nature of bioethics, Gilbert Hottois, a Belgian philosopher, has undertaken an empirical description of the themes and problems which are discussed in different countries. The list is the same from one country to the next. There are not differences in the procedures used to discuss these themes and problems: commissions, committees, experts, professionals, reports, sessions, seminars, or colloquia.²⁰ Contents however are different. Due to the short time at my disposal, I will restrict my scope to comparing the United States with France and South America.

Issues related to human experimentation were present at the outset of bioethics in America. At the origin of bioethics in France, there was an obsession with new reproductive technologies. For years, I did not understand this perspective. Were not other issues more pressing? It is only recently that I came to understand why. In order to understand the reason I found, let me first compare three themes: prenatal diagnosis, severely defective newborns, and death and dying. In both countries these three themes have aroused a lot of discussion.

With regard to prenatal diagnosis, the cross-cultural study conducted by Dorothy Wertz and John Fletcher shows a diversity of ethical sensitivity between French and American physicians.²¹ In case of moral disagreement, the latter tend to leave the decision to the mother. They wonder whether they are entitled to encroach on a mother's rights, even though she has requested a test they consider futile.²² The former maintain that a physician has a special responsibility toward

²⁰Gilbert Hottois, "La Bioéthique: définitions, problèmes et méthodologie," *Réseaux* nos. 53-54 (1987-1988) 11-25, at 11-12.

²¹Dorothee C. Wertz and John C. Fletcher, *Ethics and Human Genetics: A Cross-Cultural Perspective* (Berlin: Springer-Verlag, 1989).

²²John C. Fletcher, "Prenatal Diagnosis: Ethical Issues," *Encyclopedia of Bioethics*, ed. Warren Reich (New York: Macmillan, 1978) 1336-46; David M. Goodner, "Antenatal Diagnosis of Genetic Defects," *The Journal of Reproductive Medicine*, 10/6 (1973): 261-68; Tabitha M. Powledge and Sharmon Sollitto, "Prenatal Diagnosis—The Past and the Future," *Hastings Center Report* 4/5 (1974): 11-13.

the fetus who has a right, at times, to be protected from parental desires to have a child who perfectly suits them.²³

I come now to the issue of severely defective newborns. In France, the debate has not been as heated as it has been in the United States. In America, the discussion has revolved around the parental responsibility in the decision making. Are they absolute decision makers? French neonatologists have another perspective. After having informed and consulted the parents, they consider themselves to be in the best position to make the appropriate decision. To entrust parents with such an emotional decision would be too much for them.

The discussions around death and dying are the third example I will mention. Brain death, cessation of treatment, death with dignity, and pain control are issues discussed in both countries. They have, however, distinctive features. In France the debate could be summed up in the expression *acharnement thérapeutique*, which could be translated in English by therapeutic harassment. According to *Harrap's Dictionary*, it means "use of intensive medication to keep a person alive." Such a neutral description has lost the meaning of the word *acharnement*; it means relentlessness. The most descriptive image would be: to set the pack on the track of a quarry. *L'acharnement thérapeutique* expresses the popular indignation about the type of death a large number of patients have to go through. Palliative care has been seen as the answer to the indignity of the medicalization of death. The expression "futility of treatment," which is used more and more in America, is unknown in French and cannot be translated by *acharnement thérapeutique* as some Quebeckers have proposed. "Futility of treatment" is an expression coined by physicians to express their opposition to requests coming from patients or their families who require, in the name of their autonomy, treatments which physicians consider useless.

These issues indicate different cultural sensitivities. A first level of interpretation would attribute these differences to the social structure. In France, the hierarchical dimension is more pronounced, and in America relations are more democratic. French medicine would be regarded as paternalistic. There is a second level of interpretation which goes beyond the description and reveals the foundations. No doubt, both worlds express a common anthropological concern. The first principle of the Belmont Report and the basic text of the *Comité Consultatif National d'Éthique*²⁴ are focused on the same ethical ideal: to respect the human person. The diversity which I have highlighted is explained by the interpretation of the moral responsibility of biomedicine in the present context.

²³André Boué, "Maladies héréditaires et diagnostic prénatal," *La recherche* no. 115 (Octobre 1980): 1158-66; François Fougeroux, "Prévention anténatale des malformations et les dilemmes moraux des médecins," *L'année sociologique* 30 (1979-1980): 241-63; Philippe Maroteaux et al, "Réflexions sur les problèmes éthiques du diagnostic anténatal," *Archives françaises de pédiatrie* 41 (1984): 445-48.

²⁴Comité Consultatif National d'éthique, *Recherche biomédicale et respect de la personne humaine* (Paris: Documentation française, 1987) 78 pp.

American bioethics had its origins in a protest, that is, medical researchers were using human beings as means for the benefit of scientific progress and their own promotion. Nature was destroyed and freedom of choice or autonomy was lost. A substantial ethical dialogue was needed so that individuals, in line with the foundational American philosophy, could be in control of their own life. This explains why the main focus of American bioethics has been: "does such and such technological or scientific advance respect the rights of the individual?" French bioethics is based on another conviction. Ethical problems of modern medicine and biology find their unity in the fact that "man is his own creator (in the sense of producer)." This control is shown not only in areas such as artificial procreation, neurosciences, or genetics, but also in more classical issues like death and dying, abortion or confidentiality.²⁵ Bruno Cadoré, physician and theologian, has summed up well this perspective. Bioethics consists "in inventing the way man will 'control' the control of himself and his fellow creature" which is made possible by "the rational project of medicine."²⁶ In biomedicine, our human identity is at stake.²⁷ So the basic bioethical question is: "What humanity do we want to become?"

I will now say a few words about Latin America. The continent has a strong desire to make up for lost time by building high quality university hospitals and research centers of international standard. As a consequence, bioethical problems and dilemmas arise. It is amazing to see how well-structured bioethical organizations are put in place. In return a number of theologians, philosophers and specialists in social sciences in these countries question the relevance of such a bioethics in their context: "The very existence of high tech tertiary care medical centers poses major questions about discrimination and injustice in health care delivery. The more pressing problems in this region are not about how one uses medical technology humanely but about who gets access to modern medicines and how society fairly delivers health care to different groups of people."²⁸

What is the meaning of bioethics in such a context? Some answer that biomedical ethics is independent from economic and social conditions; since Hippocrates, it is defined by the doctor-patient relationship. On the contrary, others say that good ethics "is fundamentally based on anthropological outlooks of the meaning of human life and relations"²⁹ and is denied when large sectors

²⁵Susanne Rameix, *Fondements philosophiques de l'éthique médicale* (Paris: Ellipses, 1996) 17.

²⁶Bruno Cadoré, *L'expérience bioéthique de la responsabilité* (Louvain-la-Neuve/Montréal: Artel-Fides, 1994) 64.

²⁷Comité National d'éthique, *Recherche biomédicale et respect de la personne humaine*, 9.

²⁸James F. Drane, "Bioethical Perspectives from Ibero-America," *The Journal of Medicine and Philosophy* 21/4 (1996): 559.

²⁹Marcio Fabri dos Anjos, "Medical Ethics in the Developing World: A Liberation Theology Perspective," *The Journal of Medicine and Philosophy* 21/4 (1996): 635.

of the population are victims of discrimination. How is it possible to be critical of biomedical practice if ethics does not contribute to fill the gap between medicine and society? In this context: "The ethical challenge is to surmount oppressive and isolating individualism and discrimination, and recast medical ethics into the context of the demand for an integral social justice."³⁰

French and Latin American bioethics differ in their anthropological concerns. But both of them invite us to have another look at what it means to respect the person.

THE TASK OF THEOLOGY

In the final part of my presentation I will focus on the task of theology in bioethics. Theology, as I have already mentioned, played a major role in the setting up of bioethics, but soon after became silent. Different reasons could explain the situation. Pluralism and secularization are among reasons given. There are not only external factors. Others are related to the difficulty of discerning the place ethics should take within theology. Even though I cannot expand on these reasons, I want to make an allusion to them just to highlight different types of challenges theology has to take up.

In the present context of bioethics, the involvement of theology in the bioethical dialogue could bring a positive contribution as much for theology as for bioethics. I will, of course, within the limits of my topic, focus on the contribution of theology to bioethics. The first level of contribution is related to the nature of ethics. Here, I want to highlight two elements. Mainstream and neo-liberal bioethics reduces religious concern to a private affair; this is the first element. At the clinical level, this has a contradictory consequence: for developing a rational ethics, the profound identity of the sick persons has to be excluded from a dialogue which proclaims its high respect for the person. "Le monde vécu," as we say in French, an expression which could be translated by "the lived world" is eliminated from the discussion. This weakens the ethical analysis itself. In order to help bioethics focus on the person as a whole and not only as a rational being, theologians have a first task to be undertaken with others: to show that there does not exist "some independent realm of secular or philosophical discourse, privileged as more reasonable, neutral, or objective, and less tradition-bound, than religious discourse."³¹ When bioethics proclaims itself "reasonable, neutral, or objective," it excludes from the common reflection a wealth of meaning and wisdom. The human person has been impoverished. This has major consequences for clinical ethics and healthcare professional-patient relationships.

³⁰Fabri dos Anjos, "Medical Ethics in the Developing World," *The Journal of Medicine and Philosophy*, 636.

³¹Lisa S. Cahill, "Can Theology Have a Role in 'Public' Bioethical Discourse?" *Hastings Center Report. A Special Supplement* 20/4 (1990) S10-S14, at S11.

A second element is related to the foundational meaning of ethics. Pluralism in ethics has become a central theme. It plays a major role in expressing our respect for the human person. Paradoxically we run the risk of losing sight of what allows us to call all these different visions "ethics." By its concern for the others, theology is particularly well suited to remind us of the basic meaning of ethics which is, at the same time, expressed through these various visions and hidden by them. Ethics is fundamentally about the quality of our relationship with the other and others. It is probably the reason why philosophers like Paul Ricœur and Emmanuel Lévinas have become so inspiring for many theologians and philosophers. They have refocused ethics on its main point.

According to Ricœur, ethics takes root in the desire of human persons to be and in their wish to live well with and for others in just institutions.³² To do ethics is to consider the *imaginative* and *emotional* part of the moral act in society. This aim of ethics fundamentally inspires moral norms which are the historical and rational foundation of the ethical experience of individuals and societies. These norms ensure the recognition of the other, and the timelessness of the social values of cooperation without which there would be no society. At the same time these norms have to be constantly criticized.

This interpretation shows how artificial the opposition between procedural ethics and communitarian ethics is. We have to link together rational procedures of argumentative discussion, and the taking into account of the ethical convictions molded through education in a community tradition. Rational argumentation does not have to exclude "le monde vécu." For example, Christianity promotes selflessness. In this context, charity is neither an alternative to justice nor extrinsic to it. On the contrary, love encourages justice to follow its project through.

Emmanuel Lévinas, the French philosopher, attaches the greatest importance to the responsibility I have toward the other. Paradoxical words like "hostage" and "vulnerable," "elected" and "obsession" are joined to that of "responsibility." In Hebrew, responsibility and the idea of the other are etymologically close: I am born responsible for the other. I owe everything to the other. All the particular choices I may or must do come after the responsibility I have for the other. In saying that the other requires that I be totally responsible for him or her and, in saying at the same time, in a paradoxical way, that the other makes me come to existence, Emmanuel Lévinas forces us to radically rethink our relationship with the other and also our involvement with justice. Indeed, there is not only one other, there are all the others.

Lévinas subverts the whole ethical thinking which has asserted itself in the Western world. With Lévinas, dilemmas and value conflicts which have become the trademark of bioethics take on another facet. What used to appear as a dilemma or a conflict becomes an occasion of creation and development. Indeed justice that we usually practice in our institutions runs the risk of exploiting

³²Paul Ricœur, *Soi-même comme un autre* (Paris: Seuil, 1990).

people under the cloak of a real or illusory common good. In leveling differences, politics is concerned, against its better judgement, only with universality and carries the tyranny of an impersonal justice. In letting itself be moved by the poverty of the foreigner, the widow and the orphan, Lévinas' justice is the recognition of the singularity of the other. "The proximity of the neighbor—the peace of proximity—is my responsibility for an other, the impossibility of leaving him alone when facing the mystery of death."³³

These thinkers offer to theologians a vehicle for stressing in public debate what is the very meaning of ethics. In a context where ethics has become the "in thing" to do and runs the risk of losing its soul, theologians have, on this issue, an important social role. It is a matter of our life together.

In line with the first contribution I have mentioned I want to add a second one. It concerns the recognition of what it means to be a sick person. Bioethics has ranked autonomy at the top. More information is given to the patient. Informed consent is required. Patient self-determination has become law. But this has not resulted in a more humane relationship between doctor and patient. If bioethics had paid greater attention to what it means to be sick, it could well be that the restructuring of our healthcare services—through managed care or HMO in the United States and downsizing our social system in Canada—would have taken another direction.

When I consult a doctor, I do it because I suffer from somatic dysfunction or from a rupture of equilibrium in my functioning. For the physician this dysfunction can be explained. A diagnosis and a prognosis can be issued; the doctor acts objectively. It is not the same thing for the patient. A patient who is or feels sick is challenged in his or her integrity. The patient and those closest to him or her are confronted with the limits of a being whose identity is, in a way, broken. To be sick is to face a major existential crisis. It is the reason why the function of medicine is so central in our societies. It is "to help persons maintain or regain autonomy, which is inevitably damaged by serious illness, and which cannot be maintained without the help of a physician (or other caregiver)."³⁴

Theology should play a major role in increasing our common awareness about what it means to be sick and the response which should follow. Indeed, this is a key point of Christian ethics. This concern for the individual person must, we read in the Parable of the Good Samaritan, underlie any neighborly action on behalf of those "tormented by limiting situations, socially stripped, reduced to the distress of the mere human condition." And, as Paul Ricœur mentions in "The Socius and the Neighbor," "the compassion of the Samaritan has a profound, transcendent meaning. But this meaning and this history are *hidden*."

³³Simone Plourde, *Emmanuel Lévinas. Altérité et responsabilité* (Paris: Cerf, 1996) 153.

³⁴Eric J. Cassel, "Life as a Work of Art," *Hastings Center Report* 14/5 (1984): 35-37, at 35.

Indeed, the "least" are representative of Christ, but neither the just nor the unjust realize it now. Only on the last day, when their question "Lord, when have we seen you hungry and thirsty?" is answered, will they understand.

If the theologian does not address the issue of what it means to be sick for the person who is sick, bioethics will be poorer in tackling themes like suffering, chronic illness, being born handicapped, women's health problems or the use of technology in prolonging life. Bioethics will also be unable to play a positive role in a debate Western societies cannot avoid, the one about organization of health care services.

This last remark leads me to the third contribution I want to mention. To tackle this issue, I will focus my discussion on the social dimension of health. Studies have clearly established that health and illness do not only result from individual factors but are related to social conditions. Those with better health and who live longer have better living conditions. When I look at the history of bioethics, it is obvious that the social context of health and illness did not play a major role in its concern for justice. Justice has been discussed about organ distribution, allocation of hemodialysis machines, distribution of blood products. Justice is confined to distributive justice. In the debates about severely defective and extremely premature babies which occurred in the 1980s, during the Reagan period, there have not been in the bioethical literature many articles discussing the living conditions of the pregnant mothers. High tech was high on the agenda and social dimensions rather low. To develop a sense of solidarity with those who are weakened by illness has not yet come very high in the standard bioethics agenda.

Theology has a richer perspective. Many moral theologians who have written on justice and health care have highlighted its social dimension. The most notable example is *Health and Medicine in the Catholic Tradition* written by Richard McCormick in 1984.³⁵ Feminist theologians have also drawn our attention to social justice in health care, since the starting point of their theology is the concern for people who have no power.³⁶ In spite of these concerns, we could wonder if theologians involved in bioethics have done enough work on the meaning and objectives of a health care system and services which should be put in place. Economists are very vocal on the issue. Some philosophers, for example, Daniel Callahan, have provided some food for thought. What about theologians? Their participation in the public debate is particularly needed in a context where all health care systems are radically challenged. From the perspective of an

³⁵Richard A. McCormick, *Health and Medicine in the Catholic Tradition* (New York: Crossroad, 1985) 75-85; see also Richard A. McCormick, "Moral Theology 1940-1989: An Overview," *Theological Studies* 50/1 (1989): 3-24, at 13-15; for the Anglican tradition, see David H. Smith, *Health and Medicine in the Anglican Tradition* (New York: Crossroad, 1986) 21-34.

³⁶Margaret A. Farley, "Love, Justice, and Discernment: An Interview with Margaret A. Farley," *Second Opinion* 17 (October 1991): 80-91.

outsider, HMO and managed care challenge what has been the basic doctrine of American bioethics: autonomy, beneficence and justice. In Canada, the restructuring of some provincial health care systems, in fact, abandons what has been the foundation of the system, social solidarity in situations of illness.

The requirements of medical high tech have created a situation or a feeling which made cost-containment unavoidable. The system, whatever be the system, had to be restructured. Economists, politicians, planners have transformed services. But the social dimension of illness and the importance of social solidarity in situations of illness have been put aside. Moreover the prevailing role of technology in the whole context has not been discussed. Christian charity has a long experience in developing means for helping the weak and the sick. This long experience with its ups and downs should enable theologians to focus their participation in the bioethical dialogue on a concern for justice which takes into account the concrete reality of suffering human beings.

The fourth and last task that theology could play for strengthening bioethical debates concerns the role we attribute to technology in biomedicine. Francis Bacon is the philosopher who first expressed what has become the modern mentality. Health is an end in itself, and can be achieved by technological control which can prevent the harms and eliminate the limitations that threaten bodily life. According to Gerald McKenny, standard bioethics has not "provided solutions to the moral dilemmas raised by technology," it "has inscribed us deeper into the Baconian project." And he adds: As a result it leaves us at the mercy of the power of medicine (or of society through science) to control us, determine our "preferences," and subject our dying and our provisions for our descendants to its ruthless demands of expediency.³⁷

In fact, in what concerns death and dying, bioethics has developed all types of means to allow us to control our death: living will, advance directives, PSDA, informed consent, truth telling, the principle of double effect action to control pain and so on. We control death, but we do not know any more what it means to die, to suffer, to experience the decay of the body, to live with those who suffer and will die. Modern medicine in order to succeed in its project has made the body a means that can be controlled. Christian tradition has another vision of the body. This vision integrates suffering, enhancement, and death within a larger perspective. Bioethics has to rediscover the body if it wants to regain contact with the whole person. Theology could play a major role at this level.

CONCLUSION

Working with health care professionals and speaking with patients and their families, I have developed a strong conviction. Standard bioethics, if it empowers patients and families in some situations and facilitates professional decision

³⁷McKenny, *To Relieve the Human Condition*, 37.

making in others, falls short of a larger vision, an anthropological concern for what it means to be human and live with others.

I have mentioned four areas where the contribution of theology could be of major importance for society and bioethics: (1) the nature of ethics in bioethics; (2) the focus on the experience of being sick; (3) the social dimension of health and illness; and (4) the rediscovering of the body reduced to a status of means within modern medicine. Bioethics has to regain contact with anthropological concerns. Other bioethical reflections coming from other horizons than America could be, at this level, quite useful.

HUBERT DOUCET
Université de Montréal
Montréal