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The Ethical Canary: Science, Society, and the Human Spirit, by Margaret Sommerville

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In her recent work *The Ethical Canary: Science, Society, and the Human Spirit*, Professor Margaret Somerville contends that ethics is being outpaced by scientific innovation. As a result, Professor Sommerville believes that it is necessary to rethink our ethical position and establish ethical imperatives that would eliminate all bias of custom, culture, and religion. Her views and proposals are of global significance and relevance.

On April 5, 2001, the *Indiana Journal of Global Legal Studies* brought together this distinguished panel to discuss Professor Summerville’s arguments and conclusions.

**DEAN ALFRED C. AMAN, JR.**

Good afternoon, and welcome to our Author Meets Readers Panel. A very special welcome to our author and the George P. Smith, II Distinguished Visiting Professor of Law, Margaret Somerville. I will have more to say about Margo and the panel in a moment, but first, just a few words about the chair.

This endowed chair was established by George P. Smith to broaden students exposure to scholars and judges of national and international reputation and to allow distinguished visiting scholars the opportunity to do their research here and to share their ideas with our students and faculty, both inside and outside of the classroom.

On a periodic basis we offer this chair to a prominent scholar who comes to the School to participate in the intellectual life of our community, and the synergy that these opportunities create benefits us all. The chair creates dynamic opportunities for discovery and exchange that otherwise would not exist, and we are very grateful, indeed, to Margo Somerville for being here this year and for being such a wonderful catalyst for all kinds of conversation.

We are especially grateful to Professor George Smith for making Professor Somerville’s visit possible. I am very happy to say that he is with us today and will participate on this panel. Please join me in not only welcoming Professor Smith, but also in thanking him for this opportunity.
Professor Somerville holds appointments in both the Faculty of Law and the Faculty of Medicine at McGill University in Montreal. She is the Gale Professor of Law and, as such, she is the first woman in Canada to hold the name Chair in Law. She is the Founding Director of the McGill Centre for Medicine, Ethics and Law. She plays an active role in the worldwide development of bioethics and the study of the wider legal and ethical aspects of medicine and science. She has a background in science as well as in law, having graduated with distinction in pharmacy from the University of Adelaide and then in law with First Class Honors from the University of Sydney. She was awarded a Doctorate in Civil Law by McGill University. She has received Honorary Doctorates in Law from the University of Windsor, Ontario; Macquarie University in Sydney; and St. Francis Xavier University in Nova Scotia; and she was elected a Fellow of the Royal Society of Canada in 1991. She is the recipient of many honors and awards, including the Distinguished Service Award of the American Society of Law and Medicine; the Pax Orbis ex Jure Gold Medal of the World Jurist Association, for her support of and dedication to the cause of world peace through law; and the Order of Australia, in recognition of her international contribution to law and bioethics.

Professor Somerville has an extensive national and international publishing and speaking record. She has wide experience in communicating with large audiences, especially television and radio audiences, on topics that raise complex legal and ethical problems for society. She is regularly and frequently involved in such work in Canada and abroad. She is a consultant to governmental units and nongovernmental bodies regarding public policy. She was the Founding Chairperson of the National Research Council of the Canada Human Subjects Research Ethics Committee. She has served on many editorial boards, advisory boards and boards of directors, including the Canadian Centre for Ethics in Sport and the American Society of Law, Medicine and Ethics. She has also been an ethics advisor to the Auditor General of Canada. I can tell you, since we share the Dean’s Suite and her office is not far from mine, that since she has been here she has been involved in a variety of things. People from Australia call for interviews and, even today, I thought it was particularly interesting, when she said, “Wow, I’ve never been asked before to give advice to a TV series on their script, but I had a lot of things to say about it.” She is extraordinarily versatile and does so many, many interesting things.

The panelists this evening will be speaking on various chapters of Professor Somerville’s most recent book, *The Ethical Canary: Science, Society and the*
Human Spirit. This was published in hard back by Viking Press and soon will be out in soft cover by Penguin Press. This book is a finalist for the inaugural Shaughnessy Cohen Prize for Political Writing, awarded by the Writers’ Trust of Canada. The Shaughnessy Cohen Prize is awarded to the author of a non-fiction book that is of outstanding literary merit and enlarges understanding of contemporary Canadian political and social issues.

Let me just say a brief word about our panelists. We’ll begin with Professor Somerville, who will make some opening remarks about her book in general. Following her comments, each panelist will speak for about ten minutes. Professor Somerville will respond briefly to each panelist’s remarks, and we will welcome audience participation as well. Some of the conversations may have to be cut off until the very end due to time constraints.

Our first panelist is David Smith. He is the Director of the Poynter Center for the Study of Ethics and American Institutions here at the University, where he is also a Professor of Religious Studies and Adjunct Professor of Medicine and Philanthropic Studies. He is the first author of Early Warning, a set of case studies and recommended guidelines for decisions about testing for the late onset of autosomal dominant genetic diseases, published by I.U. Press in 1998. He is also co-author of The Social Face of Death, the study of experiences with death and bereavement in a small Indiana town. Professor Smith is currently working on a book on religion and the morality of care for the dying. He will discuss Chapter 2 in Margo’s book called “Making and Un-Making Babies: The Ethics of Human Reproduction.”

Roger Dworkin is the Robert A. Lucas Professor of Law here at the Law School and Nelson Poynter Senior Scholar at the University’s Poynter Center. In addition to his numerous writings and articles, he is the author of Limits: The Role of the Law in Bioethical Decision Making, published by Indiana University Press in 1996 and co-author of Early Warning, published by I.U. Press in 1998. He also has a case book in law and medicine. He is currently working on a paper on a study of patient autonomy and the doctor-patient relationship. Professor Dworkin will discuss Chapter 7 of the book, called “Pushing Parents to the Sidelines: The Ethics of Imposing Treatment on Seriously Ill Children.”

Yvonne Cripps is the Harry T. Ice Professor of Law at the Law School and the first scholar to write about the legal implications of genetic engineering. Her first book, Controlling Technology: Genetic Engineering and the Law, established biotechnology as a new and vitally important field of legal inquiry. She has written numerous books and articles and currently has an article
underway on “Patenting Resources: Biotechnology and Sustainable Development. Professor Cripps will discuss Chapter 3, entitled “Immortalizing our Genetic Selves: The Ethics of Human Cloning.”

Finally, Professor George Smith will discuss Chapter 5, “Dealing with Death: The Ethics of Euthanasia.” Professor Smith received his B.S. degree in economics, business, and public policy in 1961 here at Indiana University. And then, I am very proud to say, he also received his J.D. degree here in the School of Law. He has an LL.M. from Columbia and was awarded an honorary Doctor of Laws degree from IU in 1998. He has been a professor of law at the Catholic University of America in Washington, D.C. since 1977. He is the author of many books and publications, including his most recent book, Human Rights and Bio-medicine, published by Kluwer International.

We now begin our Author Meets Readers Panel with an overview of the book by Professor Somerville. Welcome Margo Somerville.

PROFESSOR MARGARET SOMERVILLE

Thank you, Dean Aman, for that kind introduction, and thank you to my longtime friend and colleague, Professor George Smith, for founding the visiting chair which I am honored to hold. I believe there is a little nepotism in my appointment. Thank you, too, to the other panelists for coming here today. It’s wonderful for me to have the opportunity to discuss The Ethical Canary with you—he hasn’t necessarily been having an easy time—not in Indiana, I hasten to add, but elsewhere.

Many people ask me where the title came from, so I thought I would come dressed to show you. About eighteen months ago, I was invited to a conference in Lubeck, in Northern Germany, a beautiful, mediaeval city. My hosts wanted me to give a speech on the ethics of the allocation of healthcare resources. Germany has a socialized health care system, somewhat similar to Canada’s. I had been writing about the ethics of allocation in these kinds of systems and they wanted me to give the opening speech. I agreed, thinking that it would be at 9:00 in the morning, in a conference centre. But when I arrived my hosts said, “Oh, you understand that you are speaking at the opening dinner tonight, don’t you?”

The dinner was held in a magnificent medieval guild hall. There were about two hundred and fifty guests. The evening commenced with a champagne cocktail party, before a formal dinner. Between the champagne and the dinner I was to give a speech on the far-from-amusing topic of the ethics of
the allocation of health care resources. The Dräger Foundation was sponsoring this event. Drägerwerks AG is involved in the health care industry as the largest manufacturer of anesthetic gas machines in the world. The President of the company introduced me in the full German tradition as Frau, Professor, Professor, Doctor, Doctor. My thought was: "How am I ever going to get these people who were in full party mode, to pay attention?" I stood up and, without saying anything, tucked my hands under my armpits and flapped my folded arms as though they were wings. I was wearing a bright yellow jacket over black pants. Authentic canary colors. The people in the audience looked at me and then at each other, in great surprise. They were suddenly silent. I said, "I'm the ethical canary." I went on to explain that issues such as the allocation of health care resources, are ethical canaries in our societal mineshaft. What I meant is that they are testing the ethical air not only of those issues, they are also telling us about the quality of the ethical air in the societal mineshaft as a whole. For instance, what we decide about human cloning is not only relevant to cloning, but those decisions will establish important values for society in general. When I had finished the speech, my Dräger Foundation hosts expressed their great pleasure at the canary metaphor that I had used. I was puzzled by the depth of their appreciation. Finally, one of them realized that I didn't fully understand. He explained that they were the company that had invented the machines that replaced the canaries in the mineshafts and that was why the men who use that equipment are still today called dragermen—as indeed the definition of "dragerman" in the Oxford English Dictionary confirms. It was a complete coincidence that I had come dressed in yellow and black and chosen this image. They thought that I had planned it.

But, why are these ethical canaries so important at the moment? I suggest that in the last twenty-five years of the twentieth century we've had a revolution in consciousness and conscience. Our new consciousness is a recognition that we need to search for shared values at a societal level. In the past, we didn't need to engage in such a search, mainly because we assumed—whether or not we were correct in doing so—that we had such values through reliance on a shared religion, for instance, the Judeo-Christian tradition. Certainly that was true for Canada and I would assume for the United States. But now, our Western societies are multi-cultural, multi-religious, pluralistic, secular, post-modern, individualistic, industrialized or post-industrial, democratic, and globally connected. Any one of these characteristics means that we can no longer assume, in any given situation, that we have the same values as the person next to us, about what we ought and ought not to do. That lack of
consensus in a range of particular situations, leads to a loss of consensus, in
general, at the societal level, about the values that ought to govern, for example,
the extraordinary new powers that science and technology are opening up.

We humans form society—and we can feel that we belong to something
larger than ourselves—through creating a shared story, that is, by telling each
other a story that we all buy into. This shared story constitutes the societal-
cultural paradigm that carries the values that we espouse as a society. In the
past, we found that story mainly through organized religion, even if, as
individuals, we weren’t particularly religious. In fact, the word religion comes
from “re...ligare.” Ligare means to bind together, re ligare, to rebind
together. We can no longer use religion in that way and have had a revolution
in consciousness in becoming aware of the need to search for a new societal
story.

For the same reasons, and because we have been faced with some
momentous and unprecedented decisions by the new science, we have also had
a revolution in conscience—that is, we cannot afford simply to assume that we
or others will necessarily do what is right and not do what is wrong, for
example, in developing and using the new science. Rather, we must bring our
individual and collective consciences to bear to decide on what is right and
wrong.

Our shared story has always focused on the two great events of every
human life—birth and death—and we have created that story by surrounding
those events with ritual, myth, and meaning, and in doing so, created our
communal values, attitudes, principles, and beliefs. The new science is
changing not only how we view birth, but also the transmission of human life
and life itself, and likewise, how we see death. For this reason, the new science
is a particularly important force in creating the new shared story or societal-
cultural paradigm. One consequence of the fact that it is the new science that is
forcing us to re-evaluate birth and death, is that we are adopting an extremely
rational, individualistic, physically-based approach in doing so. One of my
goals in The Ethical Canary is to try to bring into our shared story other
essential components, in particular those we can access only through human
ways of knowing other than reason. While individualistic and rational
considerations are important, alone they are not sufficient. For example, it is
not enough to ask what does passing on human life through cloning mean for a
child who is a clone—important as such an individualistically based inquiry is
in this context—but what would it mean for our concept of the family, or,
because of its impact on values, what would be its effect at the community level
or the societal level? And what would it mean if we looked not only, as we usually do, to physical risks and harms presented by the new science and technology, but also to their metaphysical or intangible risks and harms—risks and harms to our values and beliefs, to the units of deep cultural information that are passed on from generation to generation—what Richard Dawkins calls "memes."

One reason we focus on physical risks and harms in deciding on the ethics of what we may or should not do with the new science, is because they are one of the few matters on which we can all agree—we can agree that it's unethical to subject either individuals or groups of people to high degrees of physical risk or serious harm. The problem is that very often we stop our analysis there, and make our decisions about what it is ethical or unethical to do only on that basis. One example of such an approach can be found in the report on human cloning of the United States National Bioethics Advisory Commission. If you read that report carefully, you'll find that although the commission did take some evidence about the views on human cloning of different religions, the report, itself, focuses almost entirely on the physical risks of cloning as the basis for its conclusions. Two editorials about human cloning in this morning's *USA Today*—one for it and one against—reflect the same narrow focus. The *USA Today* stance is against human cloning and the Raelians (who come from my home city of Montreal) are for it. But the only argument given against it, is that it is not yet safe enough to clone a human child. That could be taken to mean that once cloning is shown to be "safe," there are no objections to carrying it out.

The overall societal situation I've just outlined has also led to another major change. Because we are so diverse and, as a result, we lack the ability to agree about what our fundamental values as a society ought to be, and because we have adopted an approach of intense individualism (that is, I'm entitled to live by my own values and it's politically incorrect, or worse, of you to try to interfere with those), we have shifted to using only situational ethics or a consequentialist or utilitarian ethics basis for ethical analysis at the societal level. Under such an approach nothing is inherently right or wrong. Rather, all that one can say is that it all depends on the situation. You can apply that approach to euthanasia, to cloning, to reproductive technologies, or whatever other situations you wish. In *The Canary* I ask, "Is it possible, in a secular society, without using religion as a basis, to come to a societal consensus that some things are inherently wrong?"—a question that, more than any other, has placed *The Canary* and me in the cross-hairs. Are there any basic values on
which we might all agree? The first of the two values that I propose in *The Canary* is a profound respect for all life—not just human life, but all life—and a special respect for human life. In “The Canary” I speak about the unethical ways in which we treat and view animals, especially those raised as a food source, and I believe that such treatment is a major ethical issue for the immediate future. Indeed, such unethical treatment might actually effect us in physical ways, if we take what is currently happening in England with Mad Cow disease and foot and mouth disease as examples. To the extent that these epidemics have resulted from over-intensive and non-natural animal husbandry, which also deprives animals of a reasonable quality of life, we, not only they, are suffering the harmful fallout. So, to repeat, the first value which we might use as the basis of a test for inherent wrongness, is a profound respect for life, especially human life.

The second value that I propose is that we must not act in any way that would seriously harm what I call the “human spirit.” To accept that we have a human spirit does not require us to be religious or have any supernatural beliefs, although the concept of the human spirit is not antithetical to such beliefs. What I mean by the human spirit is the intangible, invisible, immeasurable reality that we need to feel surrounds us, if we are to find meaning in life and life worth living. Another way to describe it is as the deeply intuitive sense of relatedness to others to our world and to the universe in which we live. I propose that anything that breaches or seriously harms either of those two values is inherently wrong. Moreover, that which is protected by these values can be regarded as what I call “secular sacred,” that is, it must be treated with the utmost respect.

Now my proposing these two basic values as a test for inherent wrongness in a secular society has caused outrage among certain reviewers of *The Canary*. Some of those reviewers characterized these concepts, and here I am quoting, as “vague and woolly”; “a kind of black box ethics machine”; “remarkably imprecise” and “pure hokum.” These reviewers do not accept that these values, as I believe, are self-evident presumptions on which we should base our search for ethics. As one other reviewer puts it: “[Somerville] fails to make a convincing case as to why we should accept such values.” I would have thought, to repeat, that it is a self-evident basic presumption that we ought to have respect for life. We might disagree as to what such respect requires of us, that’s, however, a separate question. But the point on which *The Canary* has suffered the most—and the most acerbic—attacks, is for not showing that there’s any basis for assuming that we should start from a presumption of
respect for life or that such a presumption is necessary. In contrast, however, other reviewers have accepted these concepts as fundamental to our search for meaning in life, describing them “as two litmus tests”; “the attractive and reasonable ideal of the secular sacred that proposes that there is such a thing as the human spirit which undergirds and advances human society”; and “a recognition that the human race now needs to weave a fine line between the scientific and the sacred, and we need to incorporate some of the old religious awe and mystery of life into our world view if we are to prevent a descent into moral blindness.” The powerful discordance between those two groups of opinions provides an important insight which I think is fundamental to understanding what we’re discussing here today, and indeed to many of the arguments, proposals and concepts in The Canary. Some of us believe that we can find our way into an ethical future on the basis of just reason and logic and taking into account only material reality. Others believe that we also need a sense of something beyond ourselves and of the metaphysical (again, I hasten to point out that does not mean that we have to believe in the supernatural) to guide our ethical progress into the future. The Canary sings its song from a perch within the latter group. Thank you.

PROFESSOR DAVID H. SMITH

The Ethical Canary is an ambitious book, covering issues that range from the bedroom (or petri dish) through death, to the question of just allocation of resources in our society. It’s the kind of book that several writers produced at the beginning of the bioethics renaissance thirty years ago but that few have tried recently. The explosion of biotech possibilities and serious writing, the vigorous media coverage of bioethics, and a preoccupation with producing work that is academically kosher have all had the effect of deterring many of us from trying to write such a book. It is to Margo Somerville’s great credit that she was undeterred, for she has produced a provocative and readable book that is sure to stimulate discussion and that says many wise things along the way.

I will defer mentioning the aspect of the book that I find most important until the end, but I want at the outset to stress two aspects of Margo’s argument that I find particularly attractive. One of these is the idea of what she calls “ethics time,” by which she means to suggest that ethical reflection and arriving at sound ethical judgment takes time. Snap judgments either of approval or disapproval are almost always wrong. One needs to live into the situation as an individual and allow oneself time to ponder; in my own life when confronted
with hard decisions I have often found that if I can make myself take a little
time the right decision isn’t something I “make”; rather it is something that
emerges and seems almost inevitable. And the same thing holds true for
communities; abstract and distanced decision making may often be
acrimonious, but there is an important sense in which it is easy because the
actual options haven’t really been lived with. Such decisions can easily become
exercises in what the existentialists used to call bad faith. Somerville is right to
suggest that as a community we should resist rushing to judgment, and invest
serious time in conversation and listening.

Second, and related to this point, Somerville repeatedly speaks of the
importance of living with uncertainty. The new possibilities and difficulties on
our intellectual horizon can be disconcerting and it calls for courage to live with
fewer certainties than earlier generations knew, even if the uncertainty is
precisely about the hope for something that they never would have dreamed of.
Indeed, one of the things I appreciate most about Margo’s book is the fact that
it makes me ask: what is the special difference between the contingency with
which humans have always lived—the contingency of famine, sword or acts of
God—and the new contingency that is a product of greatly increased
knowledge and power?

But it would be boring for me to continue this panegyric, so I will turn to
Margo’s discussion of new technologies for reproduction, leaving attention to
the cloning issue to Professor Cripps.

In Chapter Two of The Ethical Canary, Margo discusses several “hot
button” issues. These include abortion, “selective reduction” of embryos in
multiple pregnancies, the fate of frozen embryos left over from IVF procedures,
and access to fertility services by single persons or gay and lesbian couples. I’ll
attempt a brief summary of her views on these topics.

Margo argues that access to abortion services ought to be legal but
“Because abortion is legal does not mean that it is right . . . in all
circumstances.” Abortion decisions require ethical justification because “a
sense of the secular sacred would require that we treat the passing on of human
life with the utmost respect and that we act with great responsibility in doing
so.” She is therefore ambivalent about the Morgentaler case that struck down a
Canadian abortion law that limited but did not preclude access to abortion. I
believe she would prefer a set of social arrangements in which the presumption
was against abortion, to the current one in which abortion is not presumed to
raise any ethical issues at all. I have a lot of sympathy for Margo’s observations
here, but one fact that she doesn’t give much play is the inequity involved when
the burden of proof is shifted to the need to justify the abortion, for persons with access to effective representation will have a much better shot at making these justifications effectively.

What can we say about the ethics of making pregnancy possible? Margo rejects the use of aborted fetuses as a source of ovarian tissue. "There is something profoundly cynical and dehumanizing about using a fetus, who itself never came to life, as the source of a child. It raises ethical issues about treating the fetus as a commodity, an object or a thing." But on the whole there is a presumption against interfering with women's reproductive rights, although this does not extend to the right of sale of body parts. And other restrictions apply, e.g. use of the sperm of dead males without their consent. Generally speaking, Margo argues that fertilized ova should be treated with respect; she does not rule out their disposal but resists disrespectful or careless disposal.

The chapter builds to a discussion of access to reproductive services. Margo's key claim is that "we must place the child at the center of both the decision-making and the infertility business." That's the child rather than the infertile couple or individual. "My basic presumption is that a child needs both a mother and a father, and for society to participate in deliberately creating a situation in which the child will not have both raises serious ethical concerns." Margo doesn't want to require that parents be married; she imagines situations in which a gay couple and lesbian couple living together might rightly have access to services. Nor does she preclude adoption by single parents, if those adoptions are clearly in the interests of existing children. But she insists that there is a limited but real normative structure to parenting relations, a structure that fertility services should not intentionally subvert.

Probably I have said enough to suggest that Margo has entered controversial territory with courage and conviction. I'll conclude with a general observation, including a little criticism.

The striking thing about Margo Somerville's book, at the end of the day, is her method of work. The contrast with her countryman Peter Singer is overwhelming. Singer is a relentlessly consistent utilitarian. His discussion of the issues I've just briefly canvassed—or of any other question in ethics—is part of a well worked out philosophical system. There are some great advantages of this way of "doing" ethics, for it highly rationalizes the discussion. But the disadvantages are at least as obvious: ethical considerations often thought to be central, classic examples are keeping promises and respect for basic human rights, are subverted to the demands of
the system. Fundamental intuitions, traditional practices, cultural differences come in at a tertiary level, if at all.

Margo's method is self-consciously more eclectic. For example, as I have suggested, she creates a category of the "secular sacred" and a lot of her argument hinges on location of the burden of proof. Her theoretical commitments are more modest; her perspective more nuanced. I certainly prefer her way of doing things. But I think that for her, too, the chosen method has its limits and I will mention two.

First, Margo's vision is so catholic and nuanced that it is hard to predict where she will come down on something. There is some territory in between Singer's mechanistic system and Margo's discussions of individual issues, insightful as those discussions often are. For example, the principle of focusing on the good of the child could be deployed earlier and more consistently within this chapter. It might have some implications for the discussion of abortion.

Second, Margo's judiciousness sometimes means that one can't tell exactly what her conclusion is. For example, although I am clear that she has grave reservations about providing infertility services to gay or lesbian couples, at the end of the day I am unsure whether or not she means to preclude such provision. And if she does not, then what is the "cash value"—or what are the policy implications of—the reservations she has articulated so crisply?

In short, Margo has been just what she said in the Introduction she wanted to be: an ethical canary. It's a beautiful bird, and an honor to get to respond to its song, albeit in monotone.

PROFESSOR MARGARET SOMERVILLE

Thank you for your wonderful comments. They capture so much of the ethical tone I was hoping to communicate in The Canary. To reply briefly: You said that "one needs to live into the situation as an individual" in doing ethics. That is so true. Your comment brings to mind an experience I had when lecturing at a hospital. The case of a very seriously ill baby with a fatal genetic disease was presented at Grand Rounds. I was then asked to comment on the ethical issues raised by the case. I said that I thought that it was ethical, within the parameters I had outlined, to turn off the life-support systems. One of the doctors in the audience, who was caring for the baby, said, "Fine, you come with me right now and you can do it." I faced such a different reality in acting on what I had proposed, as compared with just standing there and talking about what should be done.
David has talked about the approach to ethics that I take in The Canary: I believe in what I call collectively "other ways of human knowing"—moral intuition, creativity and imagination, human memory (history), common sense, "examined emotions"—as well as reason. Reason and logic are enormously important, but often they function as secondary—nevertheless crucial—verification mechanisms of decisions reached primarily on the basis of these other ways of knowing, particularly in the area of ethics where I believe moral intuition plays a very important role. We must take care, however, with definitions in comparing reason and logic with other ways of knowing, because there can be semantic confusion. Some philosophers would include within their definition of reason and logic, some mental processes that I would call intuition or others that I would characterize as "examined emotions." But I believe that in doing ethics this "experienced living" of a situation that raises ethical issues—the experiential ethical knowledge that can result—is at least as important as our logical, cognitive knowledge. Moreover, the relation between these kinds of knowledge is one of the areas where law and ethics play complementary roles, because the law can provide a safeguard in requiring rational and logical analysis when the other kind of knowledge might go in a wrong direction.

As for abortion, the point I make in the book is that although I do not believe there should be a legal prohibition on abortion in the first trimester of pregnancy, that does not mean that such abortions are always—or for some people ever—ethical. The ethics of abortion is a separate question from its legality, and, whether or not abortion is legal, an abortion decision always raises ethical questions for each woman and, indeed, for families, communities and society. What I was writing about in that section of The Canary, is my concern that since the Supreme Court of Canada decision that David mentioned, the Morgentaler case, which struck down the entire Canadian abortion law as unconstitutional; in Canada a woman can have an abortion the day before she gives birth and there is no criminal or other offense at all. At present, there is absolutely no legal limit on abortion at any stage of pregnancy, because Parliament has not, although it could do so, replaced the law that was invalidated by the Supreme Court. Since that time, we have had a major increase in abortion in Canada. The figures I give in The Canary are for the province that I live in, Quebec, where there has been about a twenty-five percent increase in the last year for which we have figures. Moreover, the major increase is in the twenty to twenty-five year old group of women, not in a younger age group, where youthful irresponsibility might be an explanation.
David is right, I think basic presumptions are enormously important, including in relation to abortion, because they determine the basic ethical air—set the basic ethical tone—in society. I believe that we have moved away from a basic presumption that abortion is something to be very concerned about and very serious, even if, in some circumstances, we believe that abortion should be legal and available. I do not have any survey research on this matter, but my impression is that many young women and perhaps young men who are involved in these decisions, basically think that abortion is ethically acceptable and there would have to be some really serious reason for it not to be such. In other words, the basic presumption that governs decision making about abortion may have changed among many younger Canadians from its being ethically unacceptable with some exceptions, to its now being ethically acceptable with some exceptions.

David, I very much like your term “sacriligious disposal” in relation to a breach of the respect that we owe to human embryos. It is the other side of the coin or mirror image of what I’m talking about when I use the term “secular sacred.”

I was very interested to hear your analysis of the differences between Peter Singer’s and my approaches to ethical analysis. We are both Australians and have known each other for a long time and know that we disagree on many things. (But what’s the world coming to that you’ve got to choose between two Aussies?) Your comments brought to mind those of one of the reviewers of the book. He said he could have written *The Ethical Canary*; all he would have needed to do would have been to write the opposite of everything he believes in and he would have had the same text as the one I had written.

“Doing ethics” can be a very uncertain enterprise, and sometimes trying to make ethics certain is the single biggest ethical mistake that we make. That is what I am trying to prevent in arguing that we need to learn to live more comfortably with uncertainty. Sometimes we must do that in order to be as ethical as we can. You rightly comment that you cannot be sure where I will—or even have—come down on some issues, and name access to reproductive technologies by single people or lesbian and gay couples, as one such issue. That section has also confused some other reviewers and, in some ways, I am sorry that such confusion has occurred. But it is for me an area of ethical uncertainty and I wanted to articulate and share that uncertainty and it seems that might be the cause of the confusion. I start by putting the child in the centre of the decision making about adults’ access to reproductive technology. I use the basic presumption that children need and want, if possible, their own
biological mother and father as the parents who will raise them—we know that from the adoption situation. I work through the analysis that flows from that presumption, but I come to the conclusion that we should not prohibit access to single people or lesbian or gay couples, because doing so would do more harm than good. To have a child is not an inherently wrong thing to do. It is a life affirming, positive, hopeful thing to do. And prohibiting the access of certain people to reproductive technologies will not prevent their use, they will just be used less safely, and it is to discriminate against these people on the basis of their marital status or sexual orientation which we must not do unless it can be justified. As a result of weaving a fabric from the various strands of argument that I have just outlined, I come to a somewhat tentative ethical conclusion that is the opposite of my initial presumption. In other words, my conclusion is an exception to that presumption that, in the interests of the child, we should restrict access to reproductive technologies to a man and woman who will be the biological parents of the child and together raise him or her.

PROFESSOR ROGER DWORKIN

I would like to begin by expressing my thanks to Professor Smith for giving us an opportunity to have Margo with us and my thanks to Margo for giving us the opportunity to have all these exciting ideas to discuss.

In Chapter 7 of her book, *The Ethical Canary*, Professor Somerville tackles the excruciatingly difficult question of who ought to decide what medical care is to be provided to children in the tragic circumstances in which disagreement exists between some of the parties to the parent-child-health care provider relationship. She uses the case of Tyrell Dueck, a thirteen year old boy with osteosarcoma, a very rare form of cancer, whose parents refused conventional treatment because of their religious beliefs, as the center piece of her analysis. In twenty-seven pages she discusses how such cases ought to be addressed, what factors ought to be considered, a presumption in favor of parental decision making, maternal-fetal conflict, blood transfusions for children of Jehovah’s Witnesses, decision making competence, the mature minor rule, the role of complementary medicine and the spirit, the importance of mitigating the pain of families into whose lives the state intervenes, and the need to avoid becoming detached and inhumane. Quite an accomplishment! Indeed, one might say, a *tour de force.*

From a legal point of view I think that the most important part of Chapter 7 is Professor Somerville’s assertion that these cases must be handled on an
individual basis. Surely that is correct. These cases are almost infinite in their factual variability—variability with regard to the parents and their relationship to the child; the parents' attitudes and their reasons for refusing recommended treatment; the child's state of mind and competence; the disease the child has; the remedies that are available; and a whole variety of other factors. Professor Somerville clearly has it right when she says that there is no way to decide these cases other than individually. As a matter of legal process, of course, that is fundamentally important because what it means is that these problems cannot be solved legislatively. The only legislation that can possibly be relevant is a sort of general legislation that authorizes the state to intervene when the child is in need or when the parents are neglecting the child, but there cannot be resolution of real cases through statute because no abstract standard could possibly suffice. Professor Somerville is to be applauded, not only for the obvious correctness of the point, but for making the point at all. Far too often process considerations get ignored in discussions of medical ethics and the way in which the law must respond to them. Yet, at least for a lawyer, often lacking certainty as to what is substantively the best thing to do, process values and process concerns are the only thing that we really have to contribute to the debate.1

Having made the point that cases have to be decided one at a time, Professor Somerville seems to assume that the alternative to legislation, or the alternative to any kind of across the board decision making, is judicial resolution of these problems. I think that that is probably right, although it would be interesting to explore a possible role for newer legal or quasi-legal institutions like, for example, hospital ethics committees. Hospital ethics committees are interdisciplinary bodies, which, at least in the United States, are now required features of every accredited hospital. These bodies are typically made up of physicians, hospital administrators, hospital trustees, other health care providers, either clergy members or persons otherwise trained in ethics, one or more lawyers, and, occasionally, community or consumer representatives. These bodies play widely different roles in different hospitals. Sometimes they do nothing but sit around and talk; sometimes they put on education programs for the staff; sometimes they attempt to provide policies that ought to be followed in the hospital for particular situations; and sometimes they actually try to provide advice or even to impose solutions to ethical

dilemmas. It would be interesting to see whether groups like that, made up of multi-disciplinary perspectives, rather than a single perspective as courts are, might not be useful decision makers for problems about medical care for children. The interesting question is whether it would be possible to take advantage of the benefits that such groups offer—multiple viewpoints, consensus decision making, attention to facts, informality, and speed—while overcoming the obvious concerns about such bodies, which primarily have to do with questions of legitimacy, even-handedness from hospital to hospital, and the fairness of their procedures.

In any event, assuming, as is probably correct, that courts will be the ones to decide these cases, Professor Somerville then lists factors the courts should consider in making the decisions. She mentions the child’s age, experience, intelligence, and independence; what the reasons for the refusal are; the nature and the severity of the child’s illness; the likelihood of the treatment being effective; and the suffering that will be caused by the treatment as well as the suffering that is caused by the condition. Surely she is right that all of these factors are relevant. There may be other relevant factors as well. For example, one might be interested in the parents’ willingness to allow conventional medical treatment if their alternative were also allowed. It is relevant, I think, to consider the parents’ intransigence: Are they flexible in the sense that if their approach doesn’t work, they might change their minds? In this regard it is very important to consider the highly difficult question of the extent to which the parents’ objection is religiously based. What is the relevance of religion here? The quick and easy assumption for those of us who always think in terms of freedom of religion, is that if the parents’ objection is religiously based, that strengthens the objection and makes the case for state intervention weaker than it would otherwise be. I do not think it is obvious that that is the right answer, though. One might think that the fact that the parents’ objection is religiously based demonstrates a level of intransigence and inflexibility that suggests that it should be easier, rather than more difficult, to justify the state’s intervention.² After all, we have known in this country for decades now that parents have a right to make themselves religious martyrs but do not have a right to make martyrs of their children in the interest of the parents’ religious beliefs.³ All of these factors, Professor Somerville says, must be weighed against the

presumption that parents have the right to decide. Here she is consistent with her theme of starting with presumptions. The presumption is that the parents have the right to decide, though that right is not absolute. She says that the parents' rights are derived from their obligation to provide medical treatment for the child, plus a presumption (assumption) that they will act in their child's best interests. Both of those I think are correct. I would put it perhaps slightly differently. I would say that the assumption really is a two part assumption. One is that the parents know and understand more than the child, and two is that the parents care more about the child than anyone else. The first part is important because it suggests why we should take decision making away from the child, but it does not suggest why we should not leave decision making with the doctor. The second part, the assumption that the parents care more than anybody else, explains why the presumption should be in their favor.

Professor Somerville then plays this analysis out in the case of Tyrell Duecks with excursions into the areas of maternal-fetal conflict and informed consent. Her conclusion is never made entirely clear. However, her emphasis on compassion for the family, her criticism of the analysis of the court that ordered conventional treatment for Tyrell, and her chapter title, "Pushing Parents to the Sideline," suggest that she disapproves of state intervention.

If I were to offer any suggestions for this chapter of The Ethical Canary, they would simply be a plea for more—especially a plea that in dealing with this question of medical care for children, Professor Somerville provide a fuller discussion of the opposite side of the coin. What should we do when children and parents do consent, indeed, when they ask for a medical intervention, and doctors don't want to do it? This is the other side of the question. A pressing modern example of this dilemma arises in the case of presymptomatic diagnosis of genetic diseases. It is now possible to diagnose an increasingly large number of genetic diseases before there are any symptoms at all. What happens if parents ask for presymptomatic diagnosis of their child, and the doctors simply do not want to do it? This is not a hypothetical question. My observation is that if the diagnosis will lead to treatment, health care providers are usually perfectly happy to do the diagnosis. But if no treatment is available, then most health care providers will oppose the presymptomatic testing of children. The leading example of this attitude is the leading example of presymptomatic diagnosis, the diagnosis of Huntington's Disease.

Huntington's Disease is a serious and particularly insidious disease. It is an autosomal dominant disease, which means that if one parent has it, each child has a fifty percent chance of inheriting the disease. A person with the disease appears to be normal until mid-life, after they have probably already had their children, which is part of the reason the disease is so insidious. Then beginning around age thirty-five or forty, the person begins to have at first subtle symptoms, subtle uncontrollable movements, followed by subtle lapses of judgment. Eventually, over a period of about fifteen years, the person loses all physical control of his or her body, becomes totally demented, and dies. One can do presymptomatic diagnosis of Huntington's Disease, but there is no treatment. Most people, I believe, take the position that we ought not to do such diagnosis for children. Their arguments are, first, that if the child turns out to have the mutation that will surely lead to the disease (unless the child is run over by a bus or something first) the consequence of the diagnosis will be that the child will be labeled and stigmatized. Indeed, it may even be worse than labeled and stigmatized, the child may be badly treated, even by its own parents. Second, since no treatment is available, there is no benefit to the child from the diagnosis, and therefore nothing to compensate for the stigma, labeling and bad treatment. Third, as an empirical matter, most adults who are at risk for Huntington's Disease and are offered diagnosis reject it. This suggests, these people argue, that we ought to let the child become an adult and choose for itself. There is no hurry. Wait until the child becomes an adult, let the child choose, and the child probably won't want to be tested anyway. Further, they argue, there is no harm in this; because there is no treatment, letting the child decide for him or herself when he or she becomes of age costs nothing.

I completely disagree with all of this. In the first place, those who oppose screening assume that the result will be that the child will have the mutation that causes the disease, but with a dominant disease there is a fifty percent chance that the result will be that the child will not have the mutation. In that event, the child will not be labeled, or it will be labeled as a healthy person. It will not be stigmatized. The child will be able to go through life with the glorious knowledge that the child is not at risk for developing this grave disease, and he or she can make life plans, career plans, and family reproductive plans accordingly. Second, the argument that if there is no treatment there is no benefit, seems to me plainly wrong. In the first place, I have already mentioned one gigantic benefit, which is a happy life free from worry. There are all sorts of other potential benefits too. Even if the diagnosis is that the child will develop the disease, there are benefits, or there can be
benefits, as parents might shower extra love, affection, and attention on the child. Special educational arrangements can be made for the child. Special financial arrangements can be made for the child. It is a singularly one dimensional medical view to suggest that the absence of treatment means the absence of benefit. Third, it is simply false to say that one can simply not test and have no effect on the child. There is no way to avoid having an effect on the child. Not testing the child has an effect just like testing the child does. The effect of not testing the child is that the child grows up thinking of himself or herself as “a person at risk for Huntington’s Disease.” Since the child will have seen a parent or grandparent or both suffer and die from this very disturbing disease, the perception of the child as being a person at risk for Huntington’s Disease will probably be the dominant self-perception of the child. It will become the essence of the child. Given that, it is no wonder adults refuse testing. To test an adult who has grown up thinking of himself or herself as a person at risk for Huntington’s Disease is to threaten that person’s entire self image. This is not a problem if you do the testing with children whose self image is still in flux and as to whom we can provide a now quite different outlook on life. Therefore, my own view is that doctors should test children if the parents ask them to do so unless, of course, a reasonably old and reasonably competent child refuses to agree. I would be interested to hear what Professor Somerville thinks about those things.

PROFESSOR MARGARET SOMERVILLE

Your points are very well taken. One saying in ethics is that good facts are essential for good ethics, and so your emphasis on treating each case on the basis of as full an understanding as possible of its facts and nuances, is very important. I was also very interested to hear your conclusion, that a requirement that each case must be treated individually, means that therefore we cannot use legislation to govern such decision making. I must admit that I had not given that possible consequence any thought. Certainly, if used, the legislation should only set up structures or processes for decision making. That leads to your second point: you are right that process is often ignored in ethics and that can, as you say, sometimes have extremely serious consequences. There is a very old saying in law (I still teach it to my law students and the lawyers here will probably know it): Form is no mere formality. That is also true in ethics to a degree that perhaps the ethicists—at least, who are not lawyer-ethicists—have not necessarily recognized.
We have thought about using alternatives to judicial intervention when parents and health care professionals conflict over the treatment of seriously ill children, because we know the trauma that is involved for families—who are already in desperately traumatic situations—when they end up in court. But this kind of decision making is so immensely serious that often it seems to necessitate the use of a court, especially if other approaches have been tried already. We do try to resolve most of these cases without court intervention, for instance through consulting a clinical ethicist or clinical ethics committee. My concern, though, is that often ethics committees consist of a mixture of more and less dominant people and, frequently, the dominant people—to whom a kind of obsequience is paid—are the health care professionals who may have a very singular, medical mind-set, particularly with respect to imposing treatment on seriously ill children. We react, rightly I believe, on the basis that children ought not to die—it is an intuitive response that there is something desperately wrong in a child dying and we should be able to prevent it. Sometimes, however, this response can cause harm. Some of the most horrific cases that one hears about, particularly from nurses, are of last-ditch attempts by desperate parents who consent to treatment with research therapies that cause terrible suffering to dying children. We must be careful to examine our decisions in these cases, and courts in Canada, more often than one might expect, have protected children from those sorts of treatments. For instance, some transplant physicians pursued the parents of a baby to try to force them to submit their baby to a liver transplant. The baby was six weeks old and had biliary atresia, which meant that liver transplantation was only treatment. In the end, the courts upheld the parents’ refusal and said their decision was within the range of what was acceptable.

As to your example about testing children for Huntington’s chorea, Roger, I don’t think that I agree with your conclusion, although you have put a very good argument for it. We all know that we’re going to die, but we do not constantly live with the immediate consciousness of that fact. There seems to be an awareness-of-death switch triggered in our psyche (although sometimes later on we can reverse it, if we do not die—at least not immediately) if we receive a diagnosis of a potentially fatal or fatal illness. I sometimes compare this situation to the difference between knowing that one day a truck is going to hit you, but you don’t know what it looks like or when it will happen, so you don’t worry about it, and knowing that it is a big, blue truck and when, more or less, it’s going to get you. Somehow, the latter is a totally different reality from the former within which to live your life. And that change from one of these
realities to the other is what terminally ill people experience in trying to adjust to their diagnoses. One of my concerns is that we may not be able to live our lives in any sense of joy and hope, if we know far in advance what that final reality is likely to be—for instance, Huntington's chorea—even though we know that the ultimate reality for all of us is death. The part of The Canary that I like best—if authors are allowed such proclivities—is a short paragraph where I write about hope and set out one of the themes of the book—that hope is the oxygen of the human spirit. We should talk about the need for hope when we talk about whether we need to legalize euthanasia, because even dying people need and can have hope. It is the people who have no hope—not those with depression (hopelessness can be differentiated from depression)—who want euthanasia. Hope is a feeling of connection to the future, and the future that we need to sense to find hope can be very close: it can be looking forward to seeing someone you love this afternoon, or the sun coming up tomorrow morning.

**QUESTION AND ANSWERS**

There is a chapter in the book on infant male circumcision and in that chapter, more than in the one on parents' refusals of treatment for seriously ill children that Professor Dworkin talked about, I write about respect for parents' religious beliefs and their claims to pass on those beliefs to their children or act according to those beliefs in ways that affect their children. My own basic presumption is that we should have the utmost respect for people's religious beliefs, however, there are clearly exceptions to that and I agree with Roger that there are cases where you should not respect the parents' beliefs. From an ethical perspective, however, one would try to take what's called the least invasive, least restrictive approach reasonably available and likely to be effective. So if the parents refused all treatment for their child and two treatments were available, either of which would be medically adequate, the treatment given should be the one that least offends the parents' religious beliefs. We are not justified in acting in brutal disregard of others' religious beliefs, unless that is not reasonably avoidable. So I agree with you, that if the parents want to have "prayer treatment" we should facilitate that, as well as use the conventional treatment in those cases where we are justified in imposing the latter. We have ethical obligations to make such accommodations.

May I add, in response to Roger's proposal that I could have addressed further issues, that one of the major criticisms of The Canary has been that it
has raised thousands of questions and has not given all, or even many, of the answers. In fact, the purpose of the book was to raise ethically relevant questions. I do not believe that it is the proper role of an ethicist to give answers. I believe it's the role of an ethicist to structure an ethical analysis of a given situation so that the people who must decide can ask as many as possible of the ethically relevant "right" questions in order to decide what they think is ethical.

Would the parents' consent to testing a child for Huntington's chorea be ethically and legally sufficient? The patient here is the child and probably you can undertake the test as soon as the child is competent to give informed consent to doing so. (My hesitancy is that some guidelines state that this test should never be carried out on minors.) If you accept that a child may consent and use a "mature minor" doctrine as the test of a child's competence, then children as young as twelve years of age may be able to provide consent. The problem in relying on the parents' consent is that you are depriving the child of a chance of living their life without knowing of their condition and I do not believe that it is right to take away that chance. Rather, we should let the child, when he or she can decide, make that decision. At least that is my view.

On another point related to genetic testing, some Canadian physicians took the stance that they would not provide pre-natal genetic tests to women who were morally opposed to abortion and, therefore, would not consider having an abortion as an option, no matter what the test results. They argue that to provide these tests to such women is a waste of health care resources. I do not believe that it is ethical to refuse a genetic test of a fetus on the basis that the woman would not have an abortion. Generally, the woman has the right to decide whether or not to have a test, provided that it is indicated as medically appropriate. The reasoning behind my stance is consistent with what Roger was saying about some of the benefits of having a test, even if it shows that something is wrong. Let's say the test shows that the fetus has Downs syndrome. Knowing that, the family can start to adjust to the fact that they're having a child with that condition, even though the woman would not have an abortion on that basis.

I turn now to Roger's argument that the parents know and understand better than the child, therefore, you are justified in displacing the child's objection to an intervention; and that they care more about the child than anyone else, therefore, you are justified in displacing the physician as the decision maker or in overriding the physician's disagreement with the parents' consent to testing for a condition such as Huntington's chorea. Again, we need to return to basic
presumptions. The basic presumption is that it is both the parents’ right and
duty to make decisions for the child, but that presumption can be displaced.
When you can show that the parents’ perception of what caring for the child
requires is so contrary to the child’s best interests—and again, that is a value
judgment on the part of the court—you may displace them as the decision
makers for the child. In Canada, you have to show that the parents’ conduct is
such that it amounts to child abuse or neglect, because then, under the relevant
statute, the court can replace the parent as decision maker about medical
treatment for the child. It should be noted that, in general, the courts do not
themselves make the treatment decision, mainly because they are not competent
to do so. What they do is choose a medical decision maker—and often it is not
a physician, but an official guardian or somebody who stands in locus
parentis—who is given the information about the treatment and makes the
decision and provides an informed consent as if they were the parent.

PROFESSOR YVONNE CRIPPS

I, too, would like to thank Professor George P. Smith very much for making
this event possible here at the Law School, and Margo for giving us this
wonderful book to comment on. I am speaking about the chapter on cloning.
As someone who is interested in the law in this area, it is refreshing to have an
opportunity to comment on the work of an author who indicates at the outset
that there are at least two different ways of cloning an animal. To cut two very
long stories extremely short, the first of these is cloning by splitting an embryo
into two parts. This method has been used to clone frogs since the 1960s. The
second method is the “Dolly method,” much more recent and much more
dramatic, because the “Dolly method” means that you can clone from
something other than a reproductive cell; this gives rise to interesting and novel
demographic and other considerations. You can clone from an adult person,
from a man, from a woman, from their skin cells, for example, without needing
a fertile egg. But looking at this through an ethical prism, one must ask
whether the technique of embryo splitting, which has been applied since the
early 1960s to non-human animals and actually since 1995 to human beings, is
so different from cloning by the Dolly technique. The outcome is the same in
both cases—cloned beings. It has been greatly overlooked by commentators,
other than Margo, that human cloning by the embryo splitting technique has
been taking place since the mid 1990s in in-vitro fertilization laboratories. I
was very struck by this as I listened to the recent Congressional Hearings in this
country on whether human cloning should be permitted. A similar debate took
place approximately three weeks ago in the United Kingdom. The British
Parliament was asked to approve cloning of human embryos for the purposes of
stem cell research and it decided to do so. Thus, cloning of human embryos for
the purposes of stem cell research is now officially sanctioned by the legislature
in the United Kingdom. But that debate too overlooked the fact that human
cloning had already occurred, even if the resultant embryos had not been
allowed to develop beyond fourteen days, as will also be the case under the new
law in the United Kingdom. I think the media has been very slow to pick this
up, as you will have observed from the recent press coverage of the Italian
professor who is promising a human clone by the end of the year and by the
news that Australia and Canada are competing for the "lead" in this process.

Reference to competition reminds me of Margo’s comments in her chapter
about commodities and the commodification of human life, and I should
perhaps mention in this context that the patent on Dolly the sheep, and I don’t
just mean the patent on the process which led to Dolly’s creation, but the patent
on the sheep, was very broadly drafted and included many claims, indeed
twenty-eight claims to various kinds of creatures that could be produced by that
particular process of cloning. There were even claims to human cell lines
produced by the Dolly technique. Not just ethically, but legally, that raises
Thirteenth Amendment issues in the United States. This also reminds me that
Margo has been under attack by various critics for basing her book, and
certainly her chapter on the cloning of human beings, on a concept of human
dignity for which, it has been said, there is no obvious justification. Here
I would recommend the Orviedo Convention, which is entitled “A Convention to
Protect Human Dignity.”

These are just some of the introductory issues and I suppose I should admit
that I take a somewhat different view from Margo, albeit with hesitation and
reluctance, on the question of therapeutic cloning of human beings. I refer to
the type of cloning that was approved recently by the British Parliament, that is,
cloning for the purpose of extracting stem cells up to a period of fourteen days
of development. I say this because I find the ethical issues in this area so very
difficult. You confess in your chapter, Margo, that you might not know
yourself what position you would take if faced with a relative, who, for
example, needed stem cell therapy to treat Parkinson’s Disease. That is the area
on which I’d now like to focus. I know this will seem a very trite argument in
some ways but it is a very old one. Your belief that therapeutic cloning of
human beings should never be permitted, even up to a maximum of fourteen
days of development, causes one to think of soldiers in wartime and the way in which countries send their citizens into battle, knowing that they will die or that they will kill and be expected to kill opposing soldiers. We say that killing in such a circumstance is justifiable because we are doing it for the greater protection of society as a whole or to save threatened human life. At some level, I find it quite difficult to differentiate between such situations. Consider the potential of human stem cell research, for example, in treating Parkinson’s Disease or various other devastating illnesses. I use the example of soldiers in wartime just to suggest that perhaps it’s a situational ethics approach that one takes here. There are balances, there are competing interests that perhaps we should consider when we make these decisions.

The entire debate assumes that we can define what it means to be a human being. What it is to be human; and even since Margo wrote at the turn of the century, so much has happened in terms of scientific development. I also think of this in terms of her concept of “ethics time.” The suggestion to which Margo refers—that we shall almost certainly be able to take stem cells from adult human beings without needing to destroy human embryos—has already moved a good deal closer to reality. Technologies evolve and as they do so they often affect the way in which we view the ethics. Related to the issue of fast-moving technology, I should perhaps also point out that Dolly, who is, at least for the time being, our most famous clone has a physical problem in terms of her biological age. Dolly is currently the age of her parent plus four—four being the number of years since Dolly was born. In other words, she was born old, and this was originally said to be one of the many physical barriers to the cloning of human beings. Yet within a period of approximately eighteen months from the discovery of that physical problem, scientists had already solved that difficulty of accelerated aging.

So, we live in an era in which science and technology are rapidly evolving and this should cause us to consider, whether, as biotechnology advances, we’ll be able to define clearly what it means to be human. In this context, I mention perhaps my most shocking example, perhaps anyone’s most shocking example—the headless frog and the purpose for which it was “developed.” Headless frogs were invented (and I use that word as a term of art, for they have been patented) to show what can be done in terms of using spare parts for research. The reason these headless, cloned frogs were created was to satisfy over-anxious people with ethical concerns—to reassure them that we can, and perhaps should, clone human beings so as to use their spare parts. That is, if you have ethical concerns, we can convince you otherwise with these headless
frogs. Would you object to using spare parts from a person who has no head and is therefore, according to these scientists, not human? That brings us to the question of how we view anencephalic babies, that is babies born naturally without any kind of higher brain at all, essentially the brain is missing. These babies can live for several days and we have never regarded them for legal or ethical purposes as not being human because they had less or no higher brain. That leads me, and I’ll try to be very brief, to my conclusion and to trans-genic animals—animals that are, for example, partly human and partly porcine. Such animals have already been patented, and they are thought to be very valuable for the purposes of transplantation. There are herds of pigs that have been genetically engineered to carry a human gene so that when their hearts come to be transplanted into humans, they are less likely to be rejected because the human body will accept them as human rather than porcine. You may think that this is an odd connection with my comments about what it means to be human, but there has already been before the U.S. Patent Office, a patent application known as the Newman application. This application relates to the partly human pigs that have, as I mentioned, already been patented with little controversy. In the Newman application, however, a test was effectively administered to the U.S. Patent Office. With regard to the specified inventions, the proportion of human to non-human animal genes was left deliberately vague. The Patent Office’s consideration of this application is truly fascinating. It involves a long discussion of whether this invented being, that it refers to as a chimera, is patentable and it decides to reject the application because it fails to meet the classic, conventional patent standard that requires an invention to be described and specified in a definite manner. An invention has to be set out precisely, in a manner that enables others to reproduce it. Having rejected the application on that very technical ground, the same sort of ground on which, for example, a new form of engine might be rejected, the Patent Office noted another ground on which it could have rejected the application. That is, it was unable to decide whether the claimed creature was human or not because the ratio of human to non-human animal genes was not specified. There was an implication in the Patent Office’s statement that if the creature in question had, for example, been less than fifty percent human, it might have been regarded as patentable. The Patent Office made it clear that it would not patent a human being, at least, as it put it, in the current state of the law. It then engaged in an inconclusive analysis of how many, what proportion of, human genes would make the creature human. So what is it to be human in this age of genetic engineering and cloning?
Thank you, Yvonne. Your last example brings to mind a research grant application that we have just submitted for funding. It started with a story that people would have thought “off the wall” even five years ago. We were applying for funds to research the ethics that should govern genomics. We used as an example of the kinds of ethical issues raised, the possibility of taking the chimpanzee genome, in which about two percent of the genes are different from the human genome, and replacing the differing two percent with the corresponding human genes, so that when the genetically modified embryo was born, it would have a human phenotype—it would look like a human—but it would have a genotype that was ninety-eight percent chimpanzee. We asked how should we characterize this living being—human, chimpanzee, or neither?

To respond to your example of soldiers going into battle and killing for the benefit of society: basically, the law only allows a justification of killing (or, more accurately perhaps, an excuse for it, even in war) when it’s necessary to save other human life. The definition of “just war” is that you are not the aggressor and war is necessary to defend your population—it is, essentially, a collective self-defense justification. The people whose lives are intentionally taken are those who threaten the lives of your citizens that is, members of the armed services of the aggressor or terrorists—although we all know that there are abuses in warfare that do not comply with this restriction on killing. But to justify killing human embryos by analogy with the just war defense, that is, on the basis that it was necessary to do so to use their stem cells to save other human life with the therapies that would be developed, would be a major extension of that justification or excuse. The embryos are not aggressors. If that justification were accepted, it would mean that I could take any one of you and use your tissues and organs to save say ten other humans—your lungs would be good for two people, likewise your kidneys, your heart could go to someone else, we could use your pancreas, liver, bowel, skin, and bones. But that does not justify killing you. So I would query the “just war” analogy as a justification. Rather, if we are to justify taking stem cells from human embryos for research, it must be on some other basis.

This new genetics research raises problems precisely because it promises so many extraordinary benefits. Take, for example, human therapeutic cloning, where you are cloning human embryos to use them as, what an editorial in the British press called, a “human embryo manufacturing plant.” In other words, the basis of this manufacturing plant would be human embryos. What are the
risks and harms of using human embryos in this way, to the "human spirit" component of our lives, that is, to our values, attitudes, beliefs, and norms? What sort of a society might it mean that we would leave to our descendents in terms of its norms and values, say in the year 2050? Would we become so inured to using human embryos, that doing so would not seem to us to matter any more? For instance, recently I debated Professor Lee Silver from Princeton about the ethics of using human embryos as a source of stem cells. Lee said that if somebody would give him a glass of water, he would happily throw a thousand human embryos in it and drink it. He wanted to make the point that he didn’t think they were any different from any other cell, that they had no moral status. But, whether we like it or not and whatever we may decide to do with it, the human embryo is the earliest form of human life. Sometimes the human embryo is characterized as being only potential human life. But all human life is potential in the sense that we all change throughout life, and in doing so humans are always realizing their potential. The human embryo is simply the earliest form with such potential.

Moreover, with cloning we’re talking about a move from human, sexual reproduction to asexual replication. So it is a-sexual, no sex is involved, and it’s replication, not reproduction. In any other generation of humans than ours, when they have talked about the necessity of respect for life, what they meant was respect for the life of any person who was currently living. With the genetic advances of the last five years, we now have to work out what three kinds of respect for human life require. The old concept of respect for each human life is still on the agenda. The second kind of respect relates to the transmission of human life. What does it require? Is cloning a fundamentally disrespectful way to transmit human life? And the third kind of respect for human life, is that for the essence of human life, that is, for the human germ cell line that is passed on from generation to generation. What must we not do in terms of intervening in that? What does holding the human germ cell line on trust—as the common heritage of human kind—for future generations require of us? We are the first humans who have ever had to decide what that requires, because nobody before us has ever been able to intentionally intervene to alter the human germ cell line—that is, to design future humans.

Finally, as Yvonne points out stem cells can be recovered from consenting adults, which would mean we could avoid using embryos. Certainly, from an ethical perspective, we would be better off as a society doing that. This possibility also opens up another insight: not all advances in science create yet more ethical problems, some such advances actually solve very important
ethical problems. And stem cell research might well prove to be an example of an area where the most recent scientific advances can solve some of the present ethical problems.

QUESTIONS AND ANSWERS

Your question raises the issue of a reaction based on an ethical intuition. We ignore our moral or ethical intuitions at our moral and ethical peril. Sometimes such a reaction is called the ethical "yuck" factor and you must listen to that. There is a wonderful article by a sociologist called Howard Kaye, in the journal *Perspectives in Biology and Medicine*, where he writes that scientists are wrong when they brush aside the public's anxiety about the new science. He argues that this anxiety is the expression of a deep moral intuition about the metaphysical risks of some aspects of the new science, that we must explore. I agree with him.

Yvonne's headless frogs bring to mind a presentation I heard by one of my colleagues in Canada. He said that he would like to create bags of spare human parts that you could hang up in a metaphorical laboratory wardrobe, and when you needed a new heart or whatever, you'd go there. I can't imagine that we would do that, but on the other hand, I have no problems, personally, in cloning a liver or heart or whatever organ or tissue somebody needs, if we are able to do so ethically. My ethical restriction would be, however, that we did not do that through making and destroying human life, so we would have to learn how to do it without creating an embryo and using it as the source of tissues or organs.

PROFESSOR GEORGE P. SMITH, II

First off, let me thank Dean Aman for his kindness in inviting me to participate in this afternoon's most fascinating program. Your creativity, Fred, never ceases to amaze me. I wish to thank Professor Somerville—most sincerely—for her visit to the Law School. Your presence, Margo, honors not only the University and the Law School, but especially me; and I take a particular pride and satisfaction with the wonderful friendship we have shared over the years.

The Bible admonishes us to remember that death comes as a thief in the night. Sadly, today, with multiple (and often exotic) life extending technologies, death all too often lingers and takes hostages for extended periods of time—thereby subjecting them to cruel and unusual punishment in pain and
loss of personal dignity. As Margo observes, correctly, today—more than in
the past—one is more likely to die of chronic degenerative disease than of acute
illness.

I agree, further, with Margo when she calls for a "euthanasia debate"—one
free of obfuscation, grounded in common sense and guided by a goal to
enhance human dignity. I fear, however, contemporary society cannot separate
emotionalism from objectivity just as Margo does herself in Chapter Five of
The Ethical Canary.

There are, to be sure, glimpses of rationality within this Chapter; especially
at page 149 where Margo acknowledges that most agree that competent
individuals should be able to refuse treatment through—for example—advance
directives, living wills or durable powers of attorney. She acknowledges,
further, there is neither a legal nor moral responsibility to administer medical
treatment determined to be futile and, thus, of no positive physiological value
for the patient. Similarly, she recognizes that, again, most agree that there is a
fundamental human right to have adequate pain relief treatment which may
very well have the effect of shortening life. Where we disagree is on the issue
of whether physician-assisted suicide and euthanasia should be legalized. And,
very definitely, we do disagree on this point.

While, for the present, the state of Oregon is the only state enacting
legislation allowing for physician-assisted suicide (e.g., the administration of
lethal doses of drugs for terminal illness), Dr. Edmund Pellegrino of
Georgetown University has lamented that within ten to fifteen years, more and
more states will adopt the Oregon legislative approach. I, however, will
applaud such a movement if it develops for I would see this as a codification of
the right of humane, medical self-determination and view it further as
consistent with the states' responsibility to nurture and enhance human dignity
from the beginning of life to its conclusion

Margo chooses to recognize there is a legal difference between assisted
suicide and euthanasia but also chooses to include physician assisted suicide
within euthanasia. I, however, see both terms as complementary in that both
are but expressions of self-determination or autonomy.

While some argue that palliative care is the principal alternative to
euthanasia, others content palliation and euthanasia are but a continuum of
medical treatment. Indeed, some physicians maintain that providing final
assistance for the hopelessly ill upon request is a professional responsibility and
sound medical practice as such. Still others suggest that in specific contexts
terminal sedation is covert physician assisted suicide or euthanasia.
The very integrity of acceptance and use of sedating pharmacotherapy is tied inextricably to two principles: informed consent and double effect. Before sedation is prescribed and initiated for control of refractory symptoms or those that include a terminal disease with impending death, all other types of palliative treatment should be exhausted. Additionally, there should be mutual agreement by the patient and his or her family of the need for terminal sedation and a full knowledge of the double and ultimate effect of the actions together with the execution of a valid do-not-resuscitate order.

More and more, as palliative care management develops a national—if not, indeed, international—praxis, it can be hoped that terminal sedation will in time be understood as but a continuum of proper treatment. Efforts must be undertaken to assure that terminal sedation does not fall into a quagmire of taxonomical confusion. If viewed as an action that validates personal autonomy or self-determination, this type of palliative care will no longer be seen incorrectly as either euthanasia or physician-assisted suicide. Rather, with this reclassification or clarification in terminology will come an understanding of a medically proper way to assure a modicum of dignity at death.

When discussing medical futility, it is necessary to discuss what medical futility is not. Medical futility is not an act that is impossible to perform; it is entirely possible that the physician has both the technology and skill to perform CPR yet rightly refuses to do so on the ground that such treatment is futile. A given treatment is also not futile merely because it would subject the patient to extreme pain and a lengthy recovery. Nor is a treatment futile if it leaves the patient with a severe mental or physical handicap, because the patient or family, rather than the physician, should have the right to balance the possible harm and good. Allowing a physician to withhold treatment if it is possible or even probable that the patient will be mentally or physically handicapped as a result of such treatment empowers the physician to make quality of life determinations that too greatly infringe on the patient’s autonomy. Quality of life decisions made by the physician should be limited to those when there is no chance that the patient can regain consciousness or when there is no chance that the treatment can free the patient from total dependence on intensive medical care.

Futility must not be used to mask prejudice, such as a refusal to treat an HIV-positive patient for fear of contracting AIDS. Similarly, futility is not hopelessness. Hopelessness is a subjective determination that the patient will not recover, while futility is an objective determination that there is a low probability of recovery.
Futility must also be distinguished from medical experimentation. Under normal circumstances, if a treatment is deemed futile, a physician is under a duty not to administer it. If the physician nonetheless wants to administer the treatment for experimental reasons, he must obtain informed consent from the patient to administer therapy of no proven benefit to the patient with the hope of possibly benefiting the patient, while serving to advance knowledge in a systematic way. While experimentation should be encouraged to determine which treatments actually benefit patients, a physician must exercise extreme caution when choosing this path and when informing the patient should place particular emphasis on the minimal likelihood that such treatment will be of direct benefit. To do otherwise would jeopardize the patient’s autonomy. Even though definitional problems exist, it is recognized that when a medical treatment or intervention is deemed futile, the physician is freed from the moral and the legal duty to provide it.

The four recognized clinical uses of futility are as follows: when a cure is physiologically impossible; when the treatment is non-beneficial; when the treatment is unlikely to produce a desired benefit; when the treatment is plausible but not yet validated.

There is both a moral imperative and a political mandate for national health policies to provide more humane end-of-life care for the dying. In particular, the extent to which palliative medicine can and should provide a type of quality care insurance for those who are dying appears at last to be within public acceptability. Palliative medicine can, in many cases, fill the void of hopelessness in the lives of the hopelessly ill and thereby lift the veil of despair that has forced a demand for assisted suicide because of the very real fear that there is not quality in end-of-life care.

To those disposed to tendentiousness, the suggestion of a taxonomical change of assisted suicide terminology in order to recognize the right of competent, terminally ill individuals to exercise autonomy or self-determination through use of terminal sedation in palliative management would be viewed as but a shallow ruse. The process of public education needed to effect a significant change here is admittedly complex. Indeed, society may not be equipped to grasp the full consequences of such an educative dialogue on this topic. It therefore remains the primary responsibility of the medical profession—supported by law—to provide the leadership needed to rethink the standards of humane care for treatment at the end of life.

By accepting and applying standards of medical futility to come to grips with a more uniform approach to and understanding of terminal illness, a ready
willingness in turn will be seen to accept the use of terminal sedation as a part of palliative treatment and, thus, part of a more comprehensive right to die with dignity and without intractable pain and suffering. Indeed, as has been argued, this form of care can be viewed truly as part of a continuum of healthcare to which every individual should be entitled.

I conclude by suggesting individualistic—not communitarian—concerns and values be in the forefront of the euthanasia debate. Margo, however, disagrees with me. She would consider this present issue within a macro focus of analysis. She is more concerned with the negative impact on the social values and fabric of society if—under whatever guise or label—“euthanasia” is validated. Protecting communitarian values should never trump an exercise of self-determination by a competent person who is suffering a terminal illness. As John Stuart Mill stressed in his essay, “On Liberty,” the only purpose for which power should be exercised over any member of society is to prevent harm to others. I see no long-lasting harm, of any nature, befalling others if competent individuals wish to end pain-filled, medically futile, existences.

DISCUSSION

George: Do you ever agree that there could be a state of medical hopelessness (i.e., medical futility) which would allow a doctor to act in the patient’s best interests, and alleviate that life?

Margo: No, George.

George: So, you want people to suffer through to the very end because there’s hope?

Margo: No, I don’t want that. I believe in fully effective pain relief treatment even if that treatment could shorten life, provided it is necessary to relieve the pain. It is true that not all suffering can be relieved, especially existential suffering. When I speak in The Canary, of giving hope to dying people I am not saying that they can be given medical hope—that is, I am not denying that there is medical hopelessness—I am talking about a psychic dimension of hope. I describe the type of hope to which I am referring as “the oxygen of the human spirit.” It is a feeling of connection to others, to the world and our universe. It is generated by a feeling of connection to the future, even if that future is very soon and will be very short.

George: But could you see a situation where one is gone and can’t have the spirit of hope?
Margo: Well, some people can't, but first we have to separate the issue of pain from other harms such as suffering and loss of hope. I very much believe in killing the pain, but not killing the person with the pain, and I believe in providing pain relief treatment even if it can shorten life, as long as its necessary to relieve the pain—I have no ethical or legal problem with doing that. Moreover, if you have no reasonable option to relieve pain but to use total sedation, so be it, you use it. But I think there is a huge difference between acting with a primary intention to relieve pain, as compared with one of killing the patient with the pain.

George: You would allow terminal sedation then?

Margo: Yes, if you needed it. Provided it was reasonably necessary. Yes.

George: I was taken by your use of the word euthanasia. I think one of the problems with this debate is the word euthanasia and I would use the taxonomy to use self-determination to sell the idea of autonomy at the life end stage

Margo: But you see, George, one of the most important themes of The Canary is that we're not just individuals. We are also members of families, communities and societies. That means that what we do is not simply a matter of concern at the individual level. It is also of concern at these other levels. My fundamental objection to legalizing euthanasia, is not so much with respect to the individual person who wants to be killed or the person who is willing to kill them, it is what approving of that, and even more so legalizing and institutionalizing it, would mean at the level of society.

George: I know, and that's why I think you're small-minded if you'll allow me in that regard. You're going at the macro level and you're sacrificing the micro level and I read your article that you published in our little health journal on this very idea that you're worried about the societal precedent if we allow this to happen, individual euthanasia, to use your words...

Margo: Just let me respond to your comment by going back to a point I made at the beginning of this symposium. In a society that has a religious base, then the religion carries the value of respect for life for the society. In a secular society—which is what we are in Canada and what I imagine you are in the United States with the separation of church and state—then religion cannot carry that value for society. It can carry it for the people in that society who belong to a religion, but not for society, as such, as a whole. So what are the two most important institutions that can carry the value of a profound respect for life in a secular society? They are: the law, which prohibits killing and punishes it—murder is the most serious offense you can commit; and medicine which is committed to the preservation of life—“first do no harm”, do not kill,
give no lethal potion, the oath of Hippocrates. So what are we talking about in euthanasia? We are talking about changing the two most fundamental institutions—the main ones in a secular society that carry the value of respect for life—to have the law say that in general you must not kill, except in some circumstances we will let you do it; and to have our physicians, the other group of carriers of respect for human life, doing the killing. I believe that it would cause enormous harm, because in a secular society we cannot maintain a value of deep respect for human life if we do that—it is only our secular symbols and conduct that establish and maintain that value in such a society. Ironically, legalizing killing is probably less dangerous to maintenance of a value of deep respect for human life in a religious society than a secular one, because in the latter the value can still be upheld by religion, even if people do not live up to it.

George: At page 150 in your book, you say that euthanasia fails to recognize the great mystery that allowing death to occur when its time has come is an act of life. Well, who determines when the time has come for death? The patient? The attending physician who says it’s in the best interests of old George. . . .

Margo: You’re misinterpreting. Recognizing the mystery of death—and of life—requires that no one “determines when the time has come.” I mean when death occurs naturally.

George: Naturally? All right. You are critical of the idea that euthanasia could lead to classifications of uselessness. What about Dan Callahan, are you disdainful of Callahan? You said there comes a point in time . . .

Margo: Oh, Dan doesn’t want to kill people, Dan just wants to let them die. That’s all right, I don’t mind that. Except that I think that his theory is unworkable. Many of us thought up examples to show that when he first proposed it. Dan Callahan, formerly the President of The Hastings Center, wrote a book called “Setting Limits,” and he used the game of cricket as a metaphor. In cricket, if you’re a very good player, after you have made lots and lots of runs, you deliberately allow yourself to be bowled out, because otherwise you could be at the wicket for the whole five days of the match and nobody else would have a chance to score—so you act like a gentleman and do not go beyond what is seen as your “fair innings.” So Dan proposed that after you have had a fair innings in life, you should let “the bowler” get you out. But he means chance or Mother Nature to be the bowler, not a physician with a lethal injection. So Dan proposed that at eighty years old, we have all had our fair innings in life and we should all just bow out gracefully. But he did not
want anybody killed, he was not promoting active euthanasia. Rather, he proposed that the only medical treatment that you should be allowed to have after reaching that age, would be pain relief treatment. So let’s say you eat a whole bag of peanuts and you’ve got an old sluggish bowel and some surgical adhesions, and as a result you get a bowel obstruction. Dan would give you morphine while you die, instead of undertaking surgery to unblock your bowel. I was at a conference shortly after he made this proposal and strong feelings were expressed. I don’t know whether Dan still believes in the position he advocated at the time.

George: Let me just close with one other concern I had. You’re not a situationalist, you’re an apriorist, I take it? But you agree that the situation has some validity—correct?

Margo: George, the situational ethics approach can be necessary, but in my view it is never sufficient. My approach is to ask, first, is the planned course of conduct inherently wrong? If it is, then you must not engage in it and a situational ethics approach or analysis becomes irrelevant. It is only if you can say that the planned course of conduct is not inherently wrong, that you may move on to a situational ethics approach. In other words, a situational ethics analysis is relevant only at a secondary level, after a deontological ethical analysis that concludes that the proposed conduct is not inherently wrong. The predominant approach to ethical analysis in our kind of society is, however, to leave out a deontological or principle-based or “a priori” analysis.

George: In the situation ethic, you do the cost benefit. What would you have at the fulcrum of the balancing test? Would you have love, humaneness, kindness, which would allow one to alleviate the suffering of another?

Margo: But I think killing somebody else, as occurs in euthanasia, is inherently wrong, so I wouldn’t get into that balancing, which is a situational ethics analysis, because that is irrelevant when what is proposed is inherently wrong. Such conduct cannot be justified on the basis of the good that would result from it.


Margo: The content of your objection brings to mind an incident that happened when I was giving a speech on euthanasia at a conference in Australia. I was arguing that as a society we could not afford to have doctors killing people and, therefore, we must not legalize euthanasia. Dr. Roger Hunt, a well-known physician in Australia, who is pro-euthanasia and supported the doctors who carried it out (euthanasia was legalized in the Northern Territory of Australia for a year in 1997, but subsequently the Australian Commonwealth
Parliament overruled the legislation), stood up and said, “I wish you’d stop using that word killing, you’re biasing the debate. Why can’t you call it voluntary active euthanasia (VAE) or an act of self-determination.” Later in this debate, I referred to an article on legislothanatry—the use of legislation to facilitate death. The authors of this article proposed that, if we are going to have euthanasia and legalize it, we should not have doctors undertaking it because people would become fearful of doctors. Indeed this fear proved to be well-founded in the Northern Territory. Many members of the Aboriginal population refused to go to a doctor and would not have their children immunized. Some even expressed the view that it was not merely chance that the legalization of euthanasia had taken place in the Northern Territory, rather, they argued that it was because ninety percent of the Australia’s Aboriginal population lived there. (I am sure, however, they were mistaken in this belief.) As well, people going into hospitals were refusing pain medication, because they were terrified that they were going to be given lethal injections. Anyway, because of such concerns, this article proposes that we should have a group of people other than physicians, who would carry out euthanasia. The authors argued what we would need, if we wanted to avoid abuses of legalized euthanasia, would be people who know how to interpret rules and apply them strictly. They proposed using a group of well-trained lawyers, who, after ensuring that all the requirements were fulfilled, would give lethal injections. With that, Dr. Hunt, who had objected vociferously to my using the word killing, leapt to his feet and said, “What? You’d have lawyers killing people?” It was a very interesting reaction, because what we can see there, is that by switching from physicians to lawyers as the people who would carry out euthanasia, we are taking the medical cloak off euthanasia. That change also makes you more aware that euthanasia is a societal act, not just an individual one. Those changes in turn can make you view euthanasia very differently, as we saw in Dr. Hunt’s case. Euthanasia is an act of killing, and if you’re going to justify it, you have to admit that is what you are justifying.

Yvonne: Your comment that killing is inherently wrong is what caused me to produce my military example because you don’t think that killing is always inherently wrong.

Margo: Self-defense is the exception.

Yvonne: But that’s an exception then . . .

Margo: Yes, it is, but we must carefully examine the forms of killing that the law has excused or justified. They are, as I mentioned before, “just war,” and capital punishment, abortion and self-defense. In all of those, the original
justification was that it was necessary to take human life in order to save human life. For “just war”, you had to be attacked and the lives or safety of your population placed in danger. In capital punishment, an important element of the original justification was that executing this person was necessary to prevent the person killing again. Killing in self-defense is only justified if that is reasonably necessary to protect life. And abortion was originally justified on the grounds that it was necessary to protect the mother’s life or avoid a serious harm to her health.

Yvonne: Those exceptions mean that we cannot really make an unqualified statement.

Margo: Before responding, may I just place euthanasia in the context I’ve sketched above. In euthanasia you’re not killing in order to protect life, you’re killing in order to kill—that’s what’s different about euthanasia.

Yvonne: I’m opposed to euthanasia, but I’m not opposed to therapeutic cloning, and that’s where I would say that on the analogy with the military, it could be argued that it is being done to save or protect another human life. We are not saying that all killing is inherently wrong, and that brings us to the question of what ethics means.

Margo: Why haven’t we got the statement that killing is inherently wrong?

Yvonne: You’ve admitted exceptions: self-defense, to save life...

Margo: But it’s only where the exception is related to abating a direct threat to human life presented by the person who is killed, that the killing is justified. You are choosing between one person being killed and another person being killed, and killing the person who presents the threat is the only reasonable way to avoid it. It is only the avoidance of being killed that justifies killing.

Yvonne: Well that’s taking a very broad view of war but even if I take that view, I could argue that I am choosing between the use of the embryo up to fourteen days development and saving this person’s life. Remember too that these embryos “left over” from in vitro fertilization treatments are commonly destroyed, and not used for any purpose, on the instructions of the person who sought in vitro fertilization treatment and in many countries they are automatically destroyed after five years because it is believed that they deteriorate after prolonged periods of low temperature storage. The choice is between wanton destruction and experimentation aimed at saving human lives.

Margo: No, you cannot argue that, because, it would mean that you could also justify killing somebody in the audience—or perhaps a dying person or a
permanently comatose one—to do the same thing, and we do not recognize such killing as ethically or legally justified. The only way you can justify killing the embryo in order to develop treatments to save other people's lives is to say the embryo has no claim to have its life protected, and that requires saying that it has insufficient moral status to claim to have its life protected.

Yvonne: Because we take a situational ethics point of view, once you've got past the statement that killing is inherently wrong. In the situation where one murders a member of the audience to obtain their parts and then distribute them, we would all say that situationally, that was wrong, it lacked ethical justification in the circumstances.