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Doctor Bergin gave the following address at the Conference on Bioethics at St. Vincent's Hospital, Melbourne, Australia on Feb. 14, 1983.

Plato said that the ideal king should be a philosopher. I... J. N Santamaria, in proposing this address, implied that the physi...n, too should be a philosopher, although he would also speak as a p...sician What a golden dream, that kings and physicians should b... philos ophers. That the Father of Medicine, Hippocrates, becam... a phil osopher is evident from the ethical testament he gave to th... profes sion. Aristotle, his near contemporary, the greatest of phil...ophers was the son of a physician and had the mark of a physician in some o his writings. The father of the great Galen had a dream in which h foresaw the successful place in medicine his son would gain, and t prepare him for it, sent him first to Pergamos to learn philosophy then to Alexandria to be trained in medicine.

Although the medieval Arabians, Avicenna and Averroes, as well a the latter's Jewish contemporary, Maimomides, were also distin guished for their philosophy as well as for their medicine, the priority given to philosophy has not always been so marked, nor the links with medicine so close. Indeed, the disruption of the bonds or the corruption of the philosophy to which medicine has been bound, is reflected in disastrous deviations from an acceptable norm which will be discussed later in this paper. The need for a sound philosophy to assist the profession and the public to embrace or reject the new technology will also become clear.

It is neither necessary nor possible to picture the whole of medicine before we look at its philosophy, if indeed there is a philosophy specific to it. Nevertheless, we may be helped by a sketch of its development. Leaving aside the special nature and history of Chinese medicine, there are only fragments of real medical information in the deciphered writings of Sumerian and Babylonian times, rather more from the Egyptians who had a large but incomprehensible pharmacopeia, and most of all, from the Greeks, by whom accurate clinical observation and rational management are first recorded. Greek doctors ministered not only to their own, but also across the Mediterranean, particularly in Rome, where they were very much servants rather than honored professionals. Advancement in understanding, in diagnosis, and in associated techniques was limited until Galen clarified anatomy and dogmatized somewhat about therapy.

Survival Need Supersedes Academics

If it is correct that the beloved physician, Luke, studied medicine in Tarsus, he probably did so in a Greek school and prior to his conversion to Christianity. In the Christian world, generally for the first few centuries, there was hardly space for academic studies in medicine in the face of the need to survive against emperors, lions and gladiators. When the pressures lessened, the intellectual considerations were more for theological than medical matters. At the same time, the monasteries preserved many of the medical texts, the hospice prototype of later hospitals arose, and surgery was practiced, some of it in a spectacular manner as judged by the operation reports concerning the canonized brothers, Cosmas and Damian, who were Arabs and Christians. From their Moslem contemporaries and successors came major input to medicine for they, like the monks, had discovered and preserved the knowledge of the Greeks. With the emergence of the scientific method in medieval times came anatomy, pathology and surgery, particularly in Italy. In the mid-16th century, Thomas Linacre, priest and physician, established the Royal College of Physicians in London, for the betterment of medical education, the development of ethical standards and the coherence of the profession. Subsequent to this, England made major contributions like Harvey's discovery of circulation, Jenner's immunization against smallpox and Thomas Willis's

identification of disease patterns. Therapy was as yet limited a id surgery severe.

In the 19th century, Germany contributed greatly in patholo y, England delineated more conditions clinically and France added to them, especially in neurology. France also advanced the study of fu c- tion through the outstanding work of Magendie and his pupil, Cla de Bernard, who introduced biological experimentation on mo le animals and in this, saw himself as the founder of experimental m li- cine. He is of special significance not only because of his major is- coveries, but also as a leading figure in the reaction against extre ne vitalism, who yet did not lose his sense of the philosophical. Ponde ng philosophically, we inevitably reflect on experimental medicine to ay with its ramifications extending in man himself to the newly on- structed gene, the artificially conceived zygote, and the fre ly aborted fetus.

Bernard's contemporary, Pasteur, discovered the effect of mi ro- organisms in fermentation and sepsis. The application of this kn wl- edge, coupled with newly discovered anesthesia, transformed sur ery and obstetrics. Blood transfusion after World War I transformed t em again. Knowledge of the rhesus factor later enabled Liley to intro ce a new form of transfusion. Chemotherapy and antibiotics arrived ith World War II. After the nuclear explosion came the electron m ro- scope and the isotope scan. The knowledge explosion and the t ch- nical explosion swamped medicine. DNA and recombinant D NA kindled anxiety about the genetic explosion. Unicellular biology nd immunology revealed a new world. Transplant surgery beca e a reality.

Improved biochemical mensuration raced alongside radiological and other diagnostic techniques; computerized axial tomography laid are the brain; nuclear magnetic resonance stands to lay bare its l yers white and gray — layers whose individual neurons have long since een punctured by techniques advanced in this country for the purpo e of electrical recording from the center of a single cell. After the bir h of Louise Brown, we returned to this country to note the construc ion, implantation and delivery of her many Australian cousins. Elsew ere, Karen Quinlan lives on after her electric plug has been disconn cted and Barney Clarke lives on with his hydraulic heart linked pe rma- nently to the national grid. (Editor's note: Clarke subsequently d ed.)

As the mystique of medicine has lessened and the potency of its drugs and instruments has increased, there has been, though not neces- sarily for the same reason, a change in attitude adopted by the publi toward doctors. It is unlikely that today the profession would find admirers to write, as Robert Louis Stevenson did, about "men eve generous, discreet and tactful standing above the common herd and sharing little in the defects of their period."

Whether or not doctors commonly seek the power of which Ia Kennedy says they have too much,[1] there is little question that the developments outlined above place in their hands more than average responsibility for the lives and welfare of their fellows. At the same time, more demands are made on them for better communication and greater accountability. It is probably to their benefit, nevertheless, that attitudes have changed from those reported to me by a refugee doctor from Germany, practicing in a small New Zealand town some years ago, whose patients must have absorbed some of Robert Louis Stevenson's ideas. "This is a wonderful country," he said, not only for the food and freedom he was then experiencing, but in addition, "here, the doctor can do no wrong." That the same error can be fostered with more serious effects even today is manifest from the statement made by the judge in the New Zealand high courts when Dr. Melvyn Wall, pediatrician of New Plymouth, applied for an injunction to prevent an abortion which had been authorized, but which he considered unwarranted. The injunction was refused on the grounds that Dr. Wall had no legal standing and that the decisions of certifying consultants were beyond review. "Parliament," Mr. Justice Speight said, "has appointed these men God."[2] What is the attitude of doctors themselves? Are they gods? Can they do no wrong? Do they understand the particular temptations which affect them in the fields of status and power and money?

Prime Minister's Address

When New Zealand's prime minister addressed a large gathering of economists, politicians and senior administrators in Switzerland two weeks ago,[3] he opened his address by saying that he expected such an audience to consist mainly of practical people. He challenged them somewhat by saying that 50 years ago Maynard Keynes had observed that practical men believe themselves to be exempt from any guiding ideas or intellectual influences. One is tempted to ask to what extent such remarks might be transposed to refer to some of our doctors, for despite what history tells us about the tremendous power of the idea in the genesis of revolution and social change, many of us will have heard a lecturer say, or will have read an author who has written, that a particular argument can be left to the philosophers with the undertone that the deliberations of philosophers are unreal and irrelevant. Medical issues at the bedside or in the operating theater are real and practical. What, then, is philosophy and what is the effect for doctors of leaving philosophical discussion to the ivory tower personnel they believe philosophers to be?

Man — be he patient, physician, priest or politician — knows and quests and studies in some degree his own being and that of things about him. He has values and goals and wonders how best to achieve them, knowing at the same time that there are some things which

ought to be done and others which ought not. On the whole, he would prefer to do good and avoid evil, although he may not always find it easy to know what is good, or to do it when he knows. When he studies such matters formally, writes about them, and influences others by his beliefs and writings, he is philosophizing and there are different fields of human activity in which such study may be carried out. One of them is moral philosophy which determines the criteria for proper conduct for the group. For the physician, this corpus of standards and guidelines constitutes his medical ethics. Such ethics guide — or used to guide — the doctor in what he does to and for his patient, and in his relationships with other members of the profession. This latter category tends to be more a matter of etiquette than serious ethics, and there have been such deviations in the first category that the whole question of medical ethics has, for the time being, become a mockery. But let us look at the philosophical background to ethics in general to see if this enlightens us about the ethics of the medical profession.

For Plato, man was dual — his body a prison of the soul. For Aristotle, he was an integrated unity of body and soul, a single person of dignity and merit. The Christians, at first attracted to Plato, eventually built an Aristotelian man, notably through Albert and Aquinas in the 13th century. The scientific developments from the 14th century made no alteration in basic man but the effects of the Enlightenment and the Age of Reason were considerable, for with the scepticism and idealism of Descartes and Kant, man became a less certain, less unified and less significant person. Aided by subsequent philosophers came empiricism and various forms of utilitarianism. Metaphysical man disappeared in materialism. The image of God was replaced by the machinery of man who became another biological category. In the second half of the 19th and early 20th centuries, determinism was readily grated onto the evolutionary hypothesis of Darwin, the dialectic patiently fostered by Marx and the dreams unravelled by Freud.

Collectively the most recent philosophies have been humanist, secular and often atheist. They have also been the weightier influences among scientists, educators, economists and rulers. Along with the newer philosophies has been the ongoing decline in religious belief and practice. Doctors are children of their age, affected more by media environment and custom than by serious study beyond their science and techniques. That much of their thinking has been influenced by the above concepts is reflected in their attitude to the family unit, sexual activity for the adolescent and the unmarried, population control, and abortion. Having said that, it would be a grave error if our special interest in the aberrations of medical men led us to see all the problems of the world which derive from unsound philosophy concentrated in the hospital clinic or the consulting room. The deployment of nuclear tipped missiles, the sale and distribution of lesser armaments, the training of terrorists, the torture of political opponents and oppression of the poor are all matters of grave contemporary anxiety related to differing views of man and his end and the means to achieve it.

Writing on crisis in the modern world, René Guenon refers to unending change and the speed of it, to dispersion of activity not unified by consciousness of higher principles, to veritable disintegration of human activity in all the orders in which this can still be exercised.[4] He goes on to say, "These are the natural and inevitable results of an ever more pronounced materialism, for matter is essentially multiplicity and division; and this be it said is why all that proceeds from matter can beget only strife and all manner of conflicts between people and individuals. The deeper one sinks into matter, the more the elements of divisions and opposition gain force and scope; on the other hand, the more one rises towards pure spirituality, the nearer one approaches to that unity which can only be fully realized by consciousness of the universal principles."

Revelations from History

If we turn to look at the historical event which exemplifies the effect of change in philosophy, in judgment exercised by medical men not so much about purpose and value *in* life as purpose and value *of* life, there are no more telling revelations than those provided by Auschwitz, Dachau and Treblinka in 1945. That year saw the skulls and charred flesh, but it did not show the beginnings. More than 20 years earlier, Binding and Hoche, one a lawyer, one a psychiatrist, published their *Release of the Destruction of Life Devoid of Value*, a title to be remembered by any physician looking at the philosophy of medicine.[5] The inspiration was Hegelian and utilitarian, and although the implementation became National Socialist, the work of Hoche and Binding predated installation of the Nazi government. Subsequent documentation more than adequately details delivery and dispatch of children with acquired or congenital defects, elderly with failing minds and others psychotic, retarded or afflicted with physical disability.[6,7] The later holocaust in which the victims offered were in the main racially — i.e., genetically — selected, has been written about and pictured on the screen often enough for further reference to be superfluous, or it would be so if doctors of today remained sufficiently aware of the part that doctors played in that whole immense tragedy. One of the initial theorists was a doctor. Doctors selected the victims, often in the most perfunctory way, and were party to the secrecy of the operation in its earlier phases. Doctors tessted different methods of terminating life — starvation, from which recently canonized Maximilian Kolbe died, was followed by intra-

venous carbolic acid.[8] As the enterprise developed, doctors conducted on living men and women experiments cruel beyond belief. How could it be? Even the most callous application of a utilitarian philosophy hardly provides a rational answer.

Some of those involved were sadistic; others probably found it difficult to extricate themselves from the mire once they had stepped into it. These men were victims of themselves, then of the totalitarian monster which governed them, but they would have been saved from themselves, and the sick would have been saved from them, if they had adhered to the very simple ethical demands of the Hippocratic Oath. They would have been saved if they had guarded one another in ethical solidarity. I do not mean that one should have guarded the misdemeanor of another, but that each should have promoted the good of all as the Dutch physicians did when, as a group, they refused to participate in labor-oriented health care which the occupying forces endeavored to impose, and which they saw as the first step in elimination of the unfit. After that would have come the elimination of the racially impure. It did come, of course, but not at the hands of the Dutch doctors.[9]

I have indicated that the outcome of the failed ethics — really the failed profession which led to participation in the genocide conducted by an ostensibly civilized nation — is not sufficiently recalled by older medical men, nor sufficiently known to younger doctors. Alexander, American psychiatrist and official United States observer at the Nuremberg trials, summarized the whole sad history in the medical literature in 1949, concluding his account with the reminder that it was the first step away from principle which opened the door to disaster. The avalanche began, he said, with the first decision that someone else's life was not worth living.[10] The same thought was expressed by Christopher Hufeland, himself a doctor, more than 150 years ago, when he said with telling foresight, "If the physician presumes to take into consideration in his work whether a life has value or not, the consequences are boundless and the physician becomes the most dangerous man in the state."[11]

A more detailed account of the medical aspects of the Holocaust has been given by Wertham[12] and another by Brennan[13] What the latter sets out to do is show how readily abortion in the USA today equates with genocide in Germany and her occupied territories 40 years ago. Only the size of the victim has changed and, to some extent, the method of disposal. The Holocaust was tyranny at its worst, but it is the well-argued thesis of Schooyans of Belgium that abortion with social and legal blessing inevitably becomes tyranny also.[14]

Because doctors are now agents in such tyranny, carrying out procedures for which they would previously have been forbidden to practice, and because the numbers of such procedures have increased greatly despite modern advances in medical and obstetrical care, we ask ourselves what has changed. It cannot be the maternal uterus, or the developing child or the skills of the midwife. No, the change has been in the response and performance of the doctor. This is evident in the rewording of the profession's ethical codes, alteration in editorial outlook of prestigious medical journals[15] and the revelations of those who have repented of their massive manipulation of pregnant women.[16]

Spokesman Questioned

When the spokesman for the Medical Association was questioned about the change in attitude and code of doctors on the abortion issue, he quipped, "We are not living in Ancient Greece." Taken seriously, of course, Greece has much to teach us, not the least of which is the legacy which is the Hippocratic Oath. Although the precise genesis of the Oath is not known, its wisdom is clear enough when it requests respect from physician and patient, each for the other, and the same for physician and student, and likewise when it urges that no harm be done and pronounces firmly for the sanctity of life — no abortions, no assisted suicide, no euthanasia. It is, of course, a pre-Christian document without religious or denominational content and fully consonant with natural law. That it should have survived as long as a guide indicates the acceptability to doctors generally and their teachers of the principles enunciated. This can be said despite the fact that medical students graduating in modern times have not ceremoniously recited the oath anywhere near the extent that the general public appears to believe.

The fact that following Nuremberg and the formation of the World Medical Association, representatives of the profession set out the same principles as those of the Oath in more contemporary wording indicated a certain resolution to avoid the hideous errors of the 1930s and 1940s, and indicated also, recognition of the need for ethical criteria. The most potent sentence in the Declaration of 1948, known as the Geneva Declaration,[17] is that which obligates "utmost respect for human life from conception." In the circumstances of its origin, it seems to have come from humble and contrite hearts, but sadly, it is the utterance which has come most to be dishonored.

As if to reassure itself, as well as the public, the World Medical Assocation has made further declarations: Helsinki in 1964, to guide in the conduct of research; Sydney in 1968, regarding the definition of death in those whose organs might be used for transplant; Oslo in 1970, concerning so-called therapeutic abortion, and Tokyo in 1975, warning doctors against participation in torture.[18] Overall, the aims are commendable, but developments in the abortion field have made

them sound hollow. The difference between the 1948 Declarati n o
Geneva, which proclaims utmost respect for human life from co icep
tion and that of Oslo in 1970 which admits abortion accord g t
local custom, says it all. The lack of resolve in the Oslo decla ıtio
illustrates the change in ethical attitude within the professi ı, a
ethical change secondary to what has almost become a cultural ang
across the face of the globe.

At this point, I would like to say that I realize the hazard i
lighting faults of apparent generalization which carries us all alc
leaves the impression that all doctors are bad. I have other th
say which indicate that that is not my belief, but we do
especially in the abortion area, from the silence of those who
of ill will. Martin Luther King reminds us that "we shall have tc
in this generation not so much for the evil deeds of the wicke
the appalling silence of the good."

It has been no surprise to observe the appearance of infan
countries where abortion has been nationally sanctioned for
or more.[19,20] The fact that it has come to our notice th
number of legal actions in the United States [21,22] and in th
Kingdom [23-27] in the past few years does not mean, of cours
had not been heard of before this. Infanticide has been a soc
lem in societies like Imperial Rome where paternal manageme
household could be despotic — a problem in cultures where
a particular sex were and are abandoned; a problem in conc
poverty. Now it has become a problem to beset the physica
fect child. In this new phase, infanticide merits our atten
two main presentations: the one where the full-term child
born physically or mentally defective, and the other, the n
stage abortion wherein the child refused to die and steps w
by the attending physician to see that it did. The Edlin trial
where asphyxiation within the womb was the techniqu
Waddill trial in Los Angeles where strangulation in the bass
described, were both cases of this sort. Doctors were ch
were acquitted, one on appeal, the other on a second trial. [2

In the other form of infanticide, that which relates to t
but defective infant, the child has, on occasion, been left w
or water to die like one dessicating in the desert. This w
with the Down's syndrome child with duodenal atresia at
kins, Baltimore, and the situation was similar to the even
ing which Dr. Arthur, pediatrician, Leeds, was tried and
1982.[30-34] The legal discussion in the court, the corresp
the medical journals, the earlier publication of a report
Haven[35] indicated that the instruction for which Dr.
arraigned was not uncommon practice and personal comment tells
same story. Infanticide is not so much a future horror as a prese
reality. Questions have been asked in the Federal Parliament in t

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country about a child who suffered from Down's syndrome and, on this account, was not treated with vigor and persistence for its respiratory tract infection.[36]

In another English case, the Down's syndrome child would have been left without helpful treatment if there had not been intervention through the court requiring necessary surgery to be carried out.[37-39] A similar positive approach to the care of such infants, but not requiring involvement of the court, is proposed and practiced by C. Everett Koop, pediatric surgeon, pro-life creator and Surgeon General of the current United States administration. Last September, he appeared before a subcommittee of the United States House of Representatives and, standing firmly on his own considerable experience in reparative surgery of defective neonates, he requested the application of maximum skill and knowledge for the Down's syndrome child and children with similar afflictions. He promoted basic nourishment as a minimum measure, no matter how severe the defect. He also stated that in 35 years, no parent had complained to him for helping a child to survive.[40]

A Bizarre Development

An interesting and bizarre development from legal abortion and its logical sequel, infanticide, is the claim that has now reached the court on a few occasions for compensation for wrongful life. A recent English case which went to the House of Lords did not succeed, for the law Lords found it impossible to determine a basis on which life was wrongful and, if one pauses to reflect, there is something contradictory in the concept of wrongful life.[41-43] The claimant saying that no life is preferable to life with handicap is comparing impossible life with no life, instead of one life with another life, one state of life, one quantum of well-being with another. Moreover, the wrongful life concept carries with it the shadow of obligatory abortion which is totalitarian and frightening, as well it might be when we realize that abortion is readily available now not only for the child with a sex-linked hereditary disorder, but for a child simply suffering from the wrong gender. What is wrongful here is surely not the life and not the gender, but the philosophy which destroys one for the reason of the other.

Apart from matters of courtesy and confidentiality, of standards, of financial recompense and its source, of advertising oneself or denigrating a colleague — apart from these, the majority of the ethical problems in medicine are concentrated around the begetting and beginning of life and the management of the end of life. Taken overall, there are more particular problems than can reasonably be dealt with at one time. Those which I have touched upon come from the early

life group and it is clearly the intention of the program organizers that consideration of that field be extended in talks succeeding this. Likewise, the challenge associated with the care of the dying will be presented. No doubt there will be discussion about the prudent application of procedures for resuscitation, the duration of life support measures which are proving to be unhelpful for recovery, the death of the brain, the timing of transplant surgery. In all these circumstances, judgment will relate to the human condition and human dignity, whether we are restoring the one or maintaining the other. Are we assisting recovery or prolonging the exitus? Are we restoring man or producing a grotesque caricature of him?

I do not intend to go further in these topics at present, but medical research is an important area, and in this city, pre-eminent in the world in the successful achievement of extra-uterine conception,[44] it would be inappropriate not to make reference to in vitro fertilization. The fact that I have nothing to say which would deny the biological success of the experiment does not prevent me from reflecting on the anomaly of massive fetal destruction in the womb alongside fetal construction outside the womb. To some, it would seem churlish to decry the procedures or the scientists who have mastered the fertilization and implantation techniques, but the area is one in which physicians and philosophers must surely ask questions.[45, 46]

Problematic Aspects

They must not, however, act as if asking questions is enough. The lists of aspects which are problematic are now well known and include matters relating to storage and delivery of sperm, especially exchange sperm (masturbation AIH — AID sperm bank), the meeting of sperm and ovum on a plate, excluding the embrace of husband and wife, the cleaving to be one flesh, the fertilization of several ova followed by the discarding, holding of or experimentation upon those excess to need; the presence of abortion (excess fertilized ova) at the early stage, or later if gestation seems not entirely normal; the complexities relating to parenting when the sperm is donor and the surrogate womb is donor.[47] The possibility should also be entertained that in some societies, extrauterine conception could become the norm, and licensing for its use a requirement. Once again we face the fundamental philosophical question, whether what can be done should be done. And for many of us, the mechanization without human passion, the dehumanization inherent in the procedure and the importance of the derivative possibilities could outweigh the excellence of the technical achievement.[48]

I am well aware that this topic of the test tube baby which, except perhaps for that of the cloned human being, must be the high point of ethical questioning at this time, has been the subject of much discussion by research groups of lawyers and theological personnel, and the considerations have included concern at the political level.[49] While it is wholly appropriate that government should look very closely at procedures which may affect individual human beings so adversely, it is even more appropriate that the profession should regulate itself. Nor should we forget the political element which has been so prominent in the German Socialist euthanasia program, in abortion in almost every country, and in sterilization. This last may be a subtle imposition as by doctors who, at the puerperium, unwarrantedly extend their surgical brief through social ideas which they have themselves uncritically absorbed; or the imposition may be not so subtle when home or foreign governments bribe or coerce Third World nationals as has happened in Indonesia, Thailand, Taiwan and India.[50, 51] When these objectionable methods are used, the philosophical question ceases to be one of irreverence for the gift, or of contravention of design donation and dignity in the act of union and becomes one of offensive paternalism on the part of doctors or gross totalitarianism on the part of the state. Professional freedom becomes a myth when political pressure or direction supersedes clinical judgment and doctors succumb to social dictation. Manipulation of this sort can end with confinement of political dissidents as psychiatrically disturbed or to torture of political opponents under medical direction.

We have spoken about the human problems which arise when the doctor has no formulated ethics, uncertain ethics or inconstant ethics. Our time would be fruitless if we did not give some of it to a plan which would prevent the development of the unpleasant defections to which I have referred and equip the doctor with guidelines for dealing with new developments as they come.

In the course of an address to an ecumenical gathering of doctors and nurses in Wellington, Dr. John Collins, a young physician speaking on behalf of the Guild of St. Luke, had this to say:

> The ill person is very vulnerable. He needs to accept treatment or suffer further. He needs to trust the physician with his body and at times his mind. This trust is an essential element in the doctor-patient relationship and the doctor must reciprocate with his active concern for the whole person — body, mind and soul. This concern is embodied in all the accepted codes of medical ethics. Because of his commitment to this principle, the doctor must bring to the relationship his own values, not for the religious conversion of the patient, but to guide his diagnostic and therapeutic approach. He must, of course, also bring all the fruits of his study and past experience to the service of the patient.[52]

This statement illustrates the relevance of a doctor's moral stance and points out the need for ethics. He will build ethics as he goes, whether he recognizes it or not. In asking what his ethics should be, we come back to the primary philosophical question: "What is it? What is it for? Who is he? What is *he* for? What does he do?" and the

crucial associated question, "What ought he to do?"

He, the doctor, or she, his modern equivalent, should know ner and women as body, mind and spirit, equipped with powers of kn owl edge and choice, the power to choose good or evil, good or less g od They should know that those who are their patients have the am origin, the same dignity, the same powers, the same obligation . It being required to live out his life in a reasonable way, the sick p son may be obliged — or may desire without a sense of obligation – t obtain the assistance of a physician. The task of the physician i thi relationship is to restore, repair, replace or enhance the functi n o that which is ailing for the sake of the whole. He restores the n ura order with the greatest respect for what nature herself does. H is repairer, not a destroyer or discarder. He is in a relationship ith person of equal dignity whom he advises but does not own, an he concerned with the whole man, not simply the part distort d by injury or disease. In this manner, he adds healing to his curi g and repairing. He brings his gifts in service without pride to a nei hbor exercises charity in so doing, and gives hope. Monetary reward ould be the least of his concerns. Its prominent intrusion into the e and public utterances of doctors in recent times has harmed their r ation ship with the community.

Skills Need Limits, Art

The doctor's skills are scientific and clinical. In the scien fic, h needs excellence, but he also needs limits — limits set by the gnity wholeness and rights of the person whom he treats. In the cl cal, h needs art, the art of ready presence, of listening, of seeing, o emem bering, of reassuring, of waiting, of returning. Specializatio has it place, but never to the detriment of the person. A general fo dation and a wide view are necessary. Skills and primary services s uld b widely distributed, not concentrated in the zones of comfor Shelte and food and water are the first and just elements in he h care Governing powers and administrators will assist in provid g basi structures and in applying priorities. Illich [53] and Kenned 74 hav both verbalized, with unusual clarity, their discontent with e gre machine which they see as abusing human rights, imposi profe sional will, manufacturing sickness and diverting mountains mone from areas of real need. It is better that doctors themselve out the houses in order. They must realize they cannot do all the lanning conquer all the infection, nurse all the sick, feed all the hu y, solv all the social problems. They need the assistance of oth r healt workers, most proximately nurses whose aims they share d who modern academic training and responsibility bring them into a team colleagues rather than servants.

Whether for doctors or nurses, the medical relationship is personal, yet also powerful and responsible, and the whole thrust of our presentation is to emphasize that, on this account, it needs basically the soundest moral philosophy. Multiplied in the clinical sphere or looked at in the preclinical setting of hygiene and preventative health measures, the medical task has a more public aspect. The community has already expressed its legitimate interest in high cost and (literally) high powered medical practice in its midst. To meet community concern in a rational way, a sound political philosophy needs to stand as part of the philosophy of medicine we are examining. That, in turn, requires a sound attitude to family, one which excludes above all those medical activities which diminish or destroy the family. Here we look at the part doctors play in regarding the uncommitted extramarital relationship as equivalent to matrimony, in promoting sterility as much as fertility, in denigrating natural family planning and in accepting abortion as an alternative to normal birth.

Personal and all as the medical task may be, the doctor and nurse must handle them with a sense of mission. Proclamation will usually be by the excellence of their work, but, at times, in spoken witness. To proclaim, they must learn and to learn, they must be constantly alert, humble and receptive. They must use the literature, but the most enduring message comes from life and people, from patients, nurses, colleagues, students. The teachers are at first formal and professional, then senior colleagues, after that one's peers and finally, one begins to learn from one's juniors. One learns, too, from the recorded lives of one's colleagues, and here I do not speak of the great, but of the common man in medicine. Allow for the fact that the obituarists say the best, and note how often we read in newspapers about men and women who have served faithfully for a number of decades in ordinary or remote places, have maintained their skills as well as their courtesy and kindness, have contributed to the local community in various ways, have been concerned for their families and have been nursed by them during long illnesses, faced with courage and hope.

The doctor, like his patient, is moral and for the sake of both, needs a philosophy of suffering and death which will prevent his team hastening away when the metastases appear — a philosophy which enables him to judge the ordinary and the extraordinary, the effective and the ineffective and their interplay. The physician must know that in the end, death will win, that every man has his own Calvary to climb, that he will reach the summit on his own, but that the ultimate tasks of the doctor and the nurse are those of Simon of Cyrene and the holy woman, Veronica.

The Christian physician — and so far we have in no way confined our interest to the Christian — should have no difficulty in accepting some sense of mission as an accompaniment of his ordinary medical calling. Reference has already been made to this, but reference should

also be made to the special role, the special philosophy of the r la-
tively small number of doctors who become missionaries in the ra-
ditional sense of the word, continuing their medical work at the s me
time. Religious workers and missionary societies of different deno in-
ations have contributed greatly to the care of the sick in Asia, Af ica,
Oceania and elsewhere. All have provided their own martyrs. His-
torically, lepers have made a special call and in this field, faith and
persistence have brought high reward.

Leper foundlings and the dying are the special patients of M her
Teresa's group which has so captured world attention. In devel ped
countries, much of the modern hospice movement is in the han s of
highly motivated Christian people, lay and religious. Brothers St.
John of God have treated the sick, not least the mentally sick and
cared for the handicapped for 400 years. Beatification is a rare
accolade, even for medical men and women who join religious o ders,
but one Brother Richard Pampuri, a general practitioner who jo ed a
northern Italian community in the 1920s, was beatified in 198 The
Medical Mission Sisters and the Medical Missionaries of Mary, oung
orders as judged by the history of religious in the Church, both ave a
high component of medical personnel who have espoused healt care
in primitive conditions, often lacking even basic equipmen Lay
people of all denominations have a similar record. We acknowle e the
special dedication and reflect upon the message they provide r the
physician looking at the philosophy of medicine.

Betterment from Ethics, Formation

Not all doctors will be missionaries in underdeveloped c ntrie
operating from an ethic of service at high sacrificial level. All octo
would be better for well-developed ethics and ongoing format n. Ou
question now is how best to achieve this. First, we must ackn wledg
the need and so must politicians and teachers. Fortunately, in ur ow
country — and the literature suggests that the same is c urrin
elsewhere — there is evidence of a return to favor in medical s ools o
an ethics forum, albeit an informal one. The Christian ough o hav
an advantage in motivation and guidance, but will need study discu
sion and reflection on immediate problems like the manag ent o
the defective neonate or perennial problems like contracep on an
cooperation. Access to the personnel and resources of a ioethic
center is an asset and this country is fortunate to have tw center
already established plus authors like Overduin and Fleming w o app
their theology with informed concern to the impact o moder
medical achievement on their fellow men.[55] Mutual support s helpf
for doctors, nurses, students and ethicists, and membership in
group or guild is recommended. Such a group has aims which

beyond problems and include the spiritual welfare of members. The archbishop, patron of our own Guild, recently asked members whether they knew God or merely knew about Him, and commended the priority given to the annual retreat where God can be known.

The archbishop's question about God is basic because we can discuss philosophies and the need for them, but the problems are basically theological and we stop short of the solution if we do not acknowledge this. Writing on man, the Protestant theologian, Brunner, says that the essential being of man is identical with his relationship to God; that the humanity of man exists on the divine word addressed to him and that for this reason, humanism divorced from living religion has more and more tended to emerge as nihilism or subhuman naturalism. Berdyaev said (in *The End of Our Time)* that man without God is no longer man; that humanism, a movement which began with affirmation of man's creative individuality, has ended with its denial. Baillie says (after quoting Brunner and Berdyaev)[56] that the progress of modern thought seems to be making it clearer that between religion and naturalism there is no resting place in humanism, and if naturalism rules, man has no real pre-eminence over beast.

It should be clear, then, that we have no intelligible obligation concerning our own lives or those of patients unless we know our creation and perceive our dependence alongside our power of choice. Creation and its purpose establish the sanctity of life and the obligation to preserve it. Ethical codes hang in mid-air if God is really dead.

Search for Common Ground

We also say that there are still many doctors in our pluralistic society who cannot reach further than man himself as starting point and the fate of the codes and of the unborn child tells us, if nothing else does, that in some areas Christians and humanists have little common ground. Yet, with men of good will, we search for the common ground, hoping that it may exist in part in a certain consensus regarding human values and rights which once would have been called natural law; consensus which concedes right to life on an intuitive basis and hopefully extends it to the unborn; likewise the right to a marriage commitment which expects it to be permanent, exclusive and fruitful and the right to receive competent care, to live in freedom, to die in peace.

Acceptance of such basic agreed criteria is essential to good medicine, though as to use, Father Quay expounds that both code and practice are more vital, more human, when fleshed out with Christian ideal.[57] Pope John Paul says in *Redemptor Hominis* that Christ, the Redeemer of the world, is the One Who penetrates into the mystery of man, fully reveals man to himself, and brings light to his most high calling. When he goes on to say that Christ, through assuming human

nature, raised it to a dignity beyond compare, he is speaking of the flesh which we inspect and palpate, incise and suture.[58] It is also the flesh upon which Claude Bernard began his experiments 120 years ago and his successors continue their observations today.[59]

What Norman Cousins says in his recently published book, *Human Options* is relevant.[60] "The most important thing about science is the scientific method — a way of thinking systematically; a way of assembling evidence and appraising it; a way of conducting experiments so as to predict accurately what will happen under given circumstances; a way of ascertaining and recognizing one's errors; a way of finding the fallacies in long held ideas. Science itself is constantly changing largely as the result of the scientific method. The responsible physician should not be expected to depart from this method no matter how great the compulsion or persuasion." Cousins then says "The good physician is not only a scientist but a philosopher . . . for the moment we accept the importance of values in the study and practice of medicine we also accept an obligation to deal with the philosophical issues." He quotes Claude Bernard who said, I feel convinced that there will come a day when physiologists, physicists and philosophers will all speak the same language." In Cousins's view, that day has not arrived, but he sees a sense of common purpose beginning to emerge. He continues, "Philosophy serves as the great unifier of science and art. Philosophy creates new energies by connecting the human mind to useful questions. Philosophy also provides the means for avoidance of collisions not just between past and present but between people who think systematically and people who are accustomed to great leaps of the imagination. Most of all, however, philosophy enables a physician to be governed by attitudes that supersede and superintend change."

Philosopher, Physician Must Teach

Ideally, the king is a philosopher. Ideally, the physician is a philosopher, but a philosopher teaches and so must the physician. The teaching role of the physician is signified by his courtesy title, Doctor. For some, this will encompass, without formal moralizing, the adoption of an ethical stance which may even be pilloried as reactionary. When, on the other hand, the scientist or physician eschews the question of ethics, claiming that he cannot impose his moral view on another, he leaves serious problems unsolved and invites the imposition of a social view of doubtful moral and therapeutic value on himself. Such a situation is dangerous for both public and profession and is susceptible to correction only by restraint or witness. Restraint is not usually possible until someone is hurt publicly enough as in the thalidomide disaster and witness is always the preferable teacher. Pope Paul VI stressed the virtual impossibility of being an effective teacher without, at the same time, being a faithful witness.[61] The witness role may require, for the sake of principle, the doctor or the nurse to become a genuine martyr — a martyr in medicine, a martyr in metaphysics.

Pope Paul's successor, himself a notable philosopher who came so near to martyrdom, referred at a recent meeting in Rome to "man as a masterpiece of creation renewed in the blood of Christ and called to enter into the family of the Children of God for eternity." On this basis, he reaffirmed the priority of ethics over technology, the primacy of person over things, the superiority of the spirit over matter.[62]

It would be difficult to suggest a more appropriate base from which a physician, acting in the defense and service of life, might look upon the philosophy of medicine.

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