An Analysis of Health

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In September Sr. Neale will begin an Office of Human Values at the National Conference of Catholic Bishops.

This paper will examine some prevailing definitions of health, a concept central to medicine. There is in fact no concept more crucial to a medical system than that of health. It informs its theory, directs its activities and generally shapes its contours. As Aristotle noted, health is the end of medicine.

Three concepts of health from the history of medicine will be analyzed: those of René Descartes, the World Health Organization (WHO) and René Dubos. An explication of these concepts illustrates their strengths, weaknesses and the different worldviews and methodologies which inform them.

Descartes' view of man and of the scope of science is different from that of WHO and Dubos. His concept of health was a reflection of his dualism and his analytic approach. It is an ideal type of the narrow concept against which WHO and Dubos are reacting.

There is special reason for a careful scrutiny of the World Health Organization's and Dubos' comprehensive concepts. Their views have far-reaching ramifications and are representative of prevailing concepts of health.

The WHO definition is significant in that it is the working concept of the most influential international health organization. It is a paradigm of a broad, positive concept of health. Dubos is consciously reacting to what he considers to be Descartes' misguided scientific aspirations. For Descartes and WHO health is a condition; for Dubos it is a process. Dubos' concept of health rejects the idea of the priority of man in nature and the notion of health as some optimal state.
Descartes was in search of a knowledge, a science of all of nature which would unlock its secrets. His metaphysical position was dualistic—all of reality consisted of either mind or matter. His method, based on a universal mathematics, was, he thought, adequate to achieve knowledge of everything in the physical world. The human organism was part of the material world, subject to the same mechanistic laws of nature as all the rest of physical reality. Health, therefore, referred to the well working of the component parts of the body-machine. In the Cartesian system, health extended only to bodily conditions.

It is interesting to note that this doctrine was found to be inadequate by Descartes himself, who was too perceptive not to realize the psychosomatic character of Princess Elizabeth's ills. In bringing his attention to bear on the union of soul and body, Descartes was forced to modify his mechanistic medical theory and to admit, 

*I don’t even know how to cure a fever because I only know the animal in general which is not the subject and still do not know the man in particular who is the subject.*

World Health Organization

Seventeenth century medicine proceeded on a physical model. History proved this exclusively mechanistic model to be greatly deficient. Once the greatest health threat of the late 19th and early 20th centuries—infec
tious disease—was under control, health professionals found themselves facing a different kind of health problem with inadequate concepts and techniques. The logic and conceptual apparatus of medicine was being forced to shift with the changing disease pattern. It was beginning to be recognized that clinical medicine should treat the individual, not merely his disease. It was acknowledged that other than strictly medical activity had something to contribute to man's health and well being.

There was a discernible shift in the course of the public health movement that developed in response to the challenge of infectious disease and was kept alive by the socio-economic conditions of the Industrial Revolution. Governmental concern for and participation in the health of its citizens increased. Health departments were established with responsibilities for housing, poor law administration and health insurance, i.e., functions whose scope exceeded the concept of health in a narrow sense.

Recognition of the fact that disease etiology is not only biological resulted in medicine's task being expanded to include investigation and elimination of the economic, psychic and social conditions contributing to ill health. Public health in the early nineteenth century sense of dealing with infectious disease was yielding to a more comprehensive approach to medicine.

A former director of the New York Academy of Medicine claimed that the interest in man's health, happiness and welfare adds up to total medicine.
Total medicine implies the application to man of what is known concerning him in the fields of physiology, pathology, diagnosis and therapeutics, and it requires the education of man in hygiene, preventive medicine and industrial medicine. But total medicine connotes more than all this. To satisfactorily fulfill its function it must know the social relationships of man—his way of living, his family, his work, and his reactions to people and things about him. Emotional stress, anxieties, fatsuus, pleasures, an inherent emotional constitution—all go to make up the total individual; and for this individual moulded by his inheritance and by the world about him, medicine must provide.

It stands to reason that the physician's task would expand as did the scope of medicine. In the words of Henry Sigerist, formerly president of the American Association of the History of Medicine, The doctor who once was the individual adviser of an individual patient or family is confronted today with an infinity of new tasks. He has become adviser to the educator to whom he lends his psychological and psychiatric knowledge in order to keep children adjusted to their social environment. He is the scientific adviser to the court who has to ascertain the cause of death and the circumstances under which death has occurred. He is also consulted by the court to determine who has become asocial and the efficacy of a sentence that tends to rehabilitate rather than to punish a criminal.

The medical profession was being called upon to explore and cure not only specific organic disease, but also other forms of human miseries, psychic and social. The future of mankind was being pinned on the future of medicine and the brunt of the responsibility was being placed on the physician.

It was no less prominent a spokesman for this expanded view of medicine than Henry Sigerist who cited the preamble of the Constitution of the WHO as indicative of the changed attitude in the relation between society and medicine. The first aim and objective of the World Health Organization, to achieve the highest possible state of health for all people, is informed by the view that health is a positive state to which every human being has a right. WHO defines health as "a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity."

From a recognition of psychic and social considerations as etiological factors influencing health, it was a short step to the incorporation of "mental and social well being as fundamentals of health."

From a realization that health problems were best approached within a broad framework of social and economic assistance (misleadingly called comprehensive, social or total medicine), all aspects of man's well being came to be regarded as essentially constitutive of health.

René Dubos

René Dubos, too, espouses a comprehensive concept of health, but from a somewhat different perspective than WHO. According to Dubos, the history of science reveals that, as man succeeded in penetrating the secrets of nature, as his discovery of causal laws and the composition of matter progressed, scientific knowledge became more refined and its methodology more analytical. Dubos recognizes the limitations of this tendency, aware as he is of the interrelatedness and interdependence of all of nature. Dubos adopts what might be termed an ecological perspective in reaction to what he considers the lopsided scientific enterprise spawned by
Descartes. Dubos acknowledges that science was advanced by an analytic approach. He is, however, disconcerted that Descartes' dualism fractured man's unity and that his motivation was to conquer and control nature. Dubos disparages the idea that the end of knowledge is control of the external world. Rather, he contends that until now science has failed to apply its methods to the most important aspects of human life—those problems man encounters in the course of daily life. Dubos calls for a new science with laboratory techniques and models to study scientifically man's responses to the total environment. He is convinced that objective knowledge of the highest manifestations of man, of the humanness of man, is achievable. Although he acknowledges that, in their present state, the exact sciences do not account for the phenomena most pertinent to the human condition, he claims in the preface to his Pulitzer Prize winning book that, "I have written this book in the faith that it is possible to deal scientifically with the living experience of man."

Dubos considers the matter of health to be a human phenomenon, something to be viewed not only in the context of the whole man, but also in relation to the total environment. He asserts that "problems of health . . . deal with phenomena that occur at the highest levels of complexity." He thinks that man is not content with a health which only entails physical vigor and a sense of well being, but also regards health as including that condition in which he is most likely to reach the goals he has set for himself. Health is defined as that state which expresses the success of the organism's efforts to respond adaptively to environmental change. Dubos' concept of health goes beyond Descartes', for in Dubos' estimation, health includes more than bodily well being. It is the ability of the person to adapt on all levels that determines health. Descartes' understanding of health, according to Dubos, ignores the most important human characteristics and shows no appreciation of the fact that health is the ability to function within a given environment.

Dubos' emphasis is on adaptation, not on a state achieved. In his view, the WHO concept fails to acknowledge the process character and environmental conditioning of health. It misses the point that moderate stress and tension are necessary conditions of health. Dubos ranks the WHO definition of health with other utopian creations of the human mind. Perfect health can never be reached because man will never be perfectly adjusted to his environment.

Health Is Vague
The concepts just detailed indicate that there is no univocal concept of health, indeed, that the concept is vague on several counts, but especially in two important respects. There is disagreement as to:

1) whether health is total well being (bodily, psychic and social) or whether it refers only to some aspect of total well being;

2) how the individual figures in the concept—whether he should be approached from an analytic, organismic or ecological perspective.

I have called the first of these two issues the range of application and the second the focus of application of the concept health. Different positions with regard to these two major dimensions account for the major discrepancies in competing concepts of health.

Range of Application
We speak of the mind-body complex because of an experience of rationality and animality, but we hasten to add that we are embodied selves, that human phenomena and behavior are psychosomatic. Whatever ontological and epistemological questions continue to intrigue philosophers, whatever phenomena presently remain beyond scientific methodology, there is undeniable interaction within whatever constitutes the complex reality that is man.
At the same time, however, for purposes of clarification and classification of the concept health, it seems helpful to distinguish levels of existence in man which, of course, are not found as so many superimposed layers or components.

Let us first consider an understanding of health which extends only to the bodily realm of human existence. Concepts with this range of application consider a person healthy if his anatomical structure, organs and bodily processes are intact and properly functioning. An indication of ill health would be a disturbance or malfunction in these components. (It ought to be noted in passing that some somatic disturbances can have primarily psychic causes, as in the case of juvenile diabetes or ulcers, and that other somatic disturbances can have primarily psychic manifestations, as with brain tumors.)

Another level of human existence can be designated as psychic. The concept of health extends, in some usages, to psychic disturbances which do not involve bodily malfunctioning as either cause or symptom. That is, a distortion of behavior which is a purely psychological phenomenon is regarded by some as illness. This understanding of health would consider a person with an inferiority complex to be unhealthy. His psychological problem is acknowledged as a health condition even though there is no component involving somatic deviation.

(Some persons refer to psychological or mental health problems, but attribute them to some physicochemical or genetic cause. Proponents of this extension of health, e.g., many mental health professionals, suggest, instead, that there are psychological illnesses with purely psychic causes and manifestations. If this view is held, the concept of health applies to the bodily rather than the psychic category according to this writer’s classification, as would the state of a brain diseased person who was exhibiting irrational behavior because of his brain disease.)

Finally, another level of human existence, the social, can be identified. It is closely related to man’s bodily, and especially his psychic, well-being. Ability to relate to others and success in personal relationships are the criteria applied when health includes this realm of human existence. Failure in personal relationships (e.g., three failed marriages) is a sufficient condition for being labelled ill. Henry Sigerist, for instance, labels as sick and in need of a physician, a criminal who is deviant from social norms.

Proponents of health as social well being are likely to consider someone healthy only if his capacities are fully realized, his living conditions optimal, and his role performance well integrated into his various social relations.

Focus of Application

Closely related to what is called range of application is the dimension of health called focus of application which pertains to the frame of reference or perspective of the concept.

Though it might seem that the term health is always used in reference to the entire living organism, if we approach the matter from the perspective of disease we see that the focus is, in some instances, considerably more narrow. Think of the view of disease, a highly specific and localized view (as in a mechanistic approach) that proceeds on the basis of discrete elements. The corresponding focus or frame of reference with regard to health will be analytical, i.e., concern and awareness will be localized only in the body or its parts. Such was the focus of the bacteriological era when the medical gaze narrowed and the patient, at least in some respects, receded into the background while the knowledge of the well functioning and pathology of his organs and vital processes assumed primary importance.

A second approach focuses on the dynamic, living, coordinated whole. It is the whole organism, the person, who is healthy or ill. From this point of view the individual is not merely an accident of his illness, rather it is the person who is ill. The frame of reference, or focus, in this understanding of health is organismic. The
Greek humoral view approached health from such a perspective, this being precisely the point of Plato's *Charmides*. According to this view one's focus must include the whole person, for it is the person, not just his ailment, which should be treated. A third frame of reference, broader yet in its focus, is the ecological perspective which transcends individual biological organisms and views health entirely from the perspective of systems in articulation. Groups, or populations, or the ecosystem, not anatomical elements or even whole organisms, are the units involved in this focus of the concept of health. The fundamental law of ecology is said to be that everything is relevant to everything else. In this light one historian and philosopher of medicine has expressed his conviction that the individual and his surroundings form an integrated system which is only arbitrarily divided into two parts.

The ecological perspective, then, does more than cite an interdependence of man and the environment. It is, in effect, unable to distinguish them for purposes of designation as healthy or not so.

It is helpful to chart range of application and focus of application on vertical and horizontal axes (see chart). By so doing one could plot, for instance, the three paradigms explained earlier to show that:

1) for Descartes the range of application was bodily and the focus analytical;
2) the WHO range of application was bodily, psychic and social while its focus was organismic;
3) Dubos' concept also had the most extensive range of application, while his focus was ecological.

Why Health Is Vague

In my view the discrepancies in concepts of health reflect differences in the nature and intelligibility of reality.

Descartes' dualism had a purpose. That purpose was to separate theology from philosophy and to ground the latter in a valid method. His method applied to, and could explain, physical reality including the human body.

In Descartes' framework psychic and social activities were in a distinctly separate domain. The body had an independent, logical status explicable by physical laws. Although Descartes had a vision of the unity of all scientific knowledge, he did not believe all of reality could be scientifically known.

The concepts of WHO and Dubos are explicit rejections of anything like a Cartesian dualism. These comprehensive concepts reflect a vision of an all-embracing, indivisible well being termed health. Since these concepts incorporate physical, psychic and social well being, those areas of human well being must, in the final analysis, amount to the same thing. In other words, according to these concepts, psychic well being should not be fundamentally other than physical or social well being. If health and ill health manifest themselves somewhat differently in these areas, they are only diverse manifestations of essentially the same thing.

Dubos speaks of a science of human nature which will unravel the nature of the cohesive forces that maintain man in an integrated state, physically, psychologically, and socially, and enable him to relate successfully to his surroundings.10

Whereas Descartes excluded from the scope of natural philosophy, and therefore of scientific knowledge, that aspect of man which set him apart from the rest of material reality, Dubos speaks as if, in addition to the science of things, there can be a science of humanity which will illuminate the human experience in its totality. In fact, he explicitly chastises Descartes for placing operations of the mind outside the realm encompassed by his method and holds out hope that this realm of human behavior may yet be described in terms of molecular events.
An important point about the scope of science—whether it can make all of reality intelligible—is at issue here. For WHO's and Dubos' concepts to be credible science must be a sufficient method for understanding and coping with all of reality. The present situation of degrees of explanation and prediction (ranging from the ideal deductive-nomological type of the physical sciences, through the historical and functional types more common in biology, to the nontheoretical and statistical generalizations of the social sciences) must be seen as a temporary phase in the gradual development of a unified life science. If such a science could be developed, the case would be strengthened for health's ultimately being something which does, indeed, pertain to bodily, psychic and social realms.

Reduction
Discussion of this matter belongs in part to the controversy over explanation and prediction in the biological and social sciences. Organismic biologists resist attempts of the molecular biologists to reduce biology to physics and chemistry. The problem of reductionism is also an issue in the social sciences. Peter Winch, for instance, claims that it is "absurdity to consider social facts as things, as experimental data on a par with any other kinds of such data. Events of consciousness, according to Winch, do not just happen to differ empirically from other kinds of events. Rather, the events imply a context of humanly followed rules which cannot be causally explained like physical events. Scientific prediction, he asserts, is also precluded in matters concerning social life, since human decisions, by definition, may lead to any one of a set of different outcomes. Paul Weiss also maintains that only observations of overt behavior are within the scope of science, introspective experiences are not."

Health's Primary Meaning
The thesis of this paper is that health's primary referent was and should continue to be a condition of the body. An attempt will now be made to show that reference to psychological or social health is, at most, an analogous use of the term. No one has any difficulty understanding such statements as, "He is in good health, but mentally disturbed," or, "Only someone as mentally stable as John could cope with such poor health." Health, in those contexts, refers to physical well being. If the same term is used in one sentence, e.g., "I enjoy good mental health, but poor physical health," the distinguishing adjectives 'mental' and 'physical' are used and it is seen that reference is made to two things, not one. Although one comprehensive concept has been appropriated to refer to total well being and to justify medicine's intervention in ever wider spheres of human existence, actual usage shows up this concept's total inability to specify the very real differences between health's primary reference to bodily phenomena, and its analogous reference to psychic and social phenomena. Indeed, the phenomenon of qualifying health with the adjectives 'mental' and 'physical' occurs because, although the comprehensive definitional concepts would make it seem otherwise, health does not apply in the same fashion to the different spheres of human existence.

There is in those spheres a condition or range of conditions of harmony, or equilibrium, or successful adaptation, which may analogously be referred to as health. That is, a 'healthy' condition in the psychic and social realms is understood to be one in which things are as they ought to be for the ends of the organism on that level to be best served. When psychological and social functions are unimpaired and prognosis for continuous well functioning is favorable, then 'health' is attributed to the organism in those realms. Those analogous uses of health are frequently elided with its primary meaning so that 'health' now is often used to
I propose that we simply acknowledge that we lack a comprehensive set of general laws which includes the biological, psychological and social models.

Adherence to a broad concept of health has disturbing implications: a diminution of the centrality and responsibility of the individual for his own actions as more and more of his behavior becomes subject to the categorization of pathology; an expansion of the task of medicine in general and of physicians in particular; and the potential for political manipulation of the individual under the guise of health care. A concept of health restricted to bodily well being avoids the medicalizing of all human experience. Furthermore, a narrow concept recognizes human goods other than health. To identify health as total well being and to imply that medical science can achieve it is to sadly delimit human good. It is to be mistaken about the nature of health as well as the means of achieving it.

Health is not the only human good. There are, in fact, numerous other human goods such as friendship and truth, that are open ended and freely pursued by man. These should not, in any way, be construed as aspects of the good of health.

In addition, as Germain Grisez points out, the only kind of goal that one can act for in an efficient way is a definitely defined goal that can be achieved by limited and definite means.13 When comprehensive concepts of health are unpacked and seen to include, for instance, happiness, or interpersonal harmony, or achievement of one's goals, it should be understood that these things are not those well defined goals which certain specifiable techniques can achieve without fail. For instance, action directed at a moon landing, complex as it may be, is of a different sort than action directed at overcoming hostility between races. There are definite and limited means for reaching the moon; but racial division is the sort of problem for which there are no specifiable means necessarily resulting in the desired good.

The point of this discussion about action and goals is to illustrate that there are goals or goods which cannot be fully articulated or efficiently achieved. Comprehensive definitions of health carelessly obscure the...
fact that there are different human goods. Those definitions imply as well that there are techniques which can either fully achieve or closely approximate health so construed. A concept of health with a bodily range of application does not conflate health with happiness or total well being, a glorification of health about which Greek philosophers cautioned long ago. Instead, it regards health as only one human good, not the sum and substance of human goods.

An organismic focus complements a concept with a bodily range of application. It recognizes that the behavior of the organism is not merely the sum of its parts and that the parts cannot be adequately understood apart from the whole. This focus is not unique to physicians and other health professionals. It is the focus that should be adopted by all caring professions—clergy, lawyers, teachers and social workers.

To restrict health to the bodily realm and an organismic focus is hardly to refine the concept to such an extent that it is entirely clarified. For one thing, the norm or standard of bodily health is not precisely determined since there is always more to learn about organs, organic processes, structures and function. The more knowledge we have of such things, the more we take hold of the concept of health.

**Summary**

A restricted concept of health distinguishes between bodily, psychic and social well being. It considers bodily well being to be easily determined in view of the end of man as a living organism and amenable, in great part, to the investigation of the natural sciences. It leaves the determination of the well being of man in other respects to competing ideologies. Such a concept of health regards health as only one human good among several. The determination of this good is contingent upon the end of the living organism qua living and well-functioning organism. His good in other respects depends on the nature of man qua man, i.e., on his purpose or place in the universe—matters on which there is an abundance of views and whose determination hinges ultimately on philosophical commitments.

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4. Ibid. p.51.
In 1974 Congress established the National Commission for the Protection of Human Subjects to report directly to the Secretary of Health, Education and Welfare. Its mandate was to create guidelines governing the use of federal money for research on humans.

Of the ten leading ethicists called upon to advise the Commission, three are fellows at the Kennedy Institute. LeRoy Walters, Leon Kass and Richard McCormick, along with seven others, pinpointed the ethical issues and made individual recommendations on public policy toward fetal research.

In the following article, first published in America (June 21, 1975), Dr. Walters and Father McCormick discuss the work of the Commission and evaluate its final recommendations to HEW.

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The establishment of a National Commission for the Protection of Human Subjects was mandated by law in July of 1974. In the months following, the eleven Commissioners were chosen by the Secretary of Health, Education and Welfare. They include three physicians, three lawyers, two biomedical researchers, two ethicists (a Catholic and a Protestant) and one representative of the public. The eleven Commissioners met for the first time in December of last year.

The very existence of the Commission can be traced to increasing public awareness of biomedical and behavioral research. The volume of research involving human subjects has increased dramatically in the past 25 years. This increase alone would have been sufficient to justify a careful examination of policies and practices in human experimentation. In addition, however, there have been several widely publicized cases—like the Tuskegee Syphilis Study—in which the rights of experimental subjects have been violated. These periodic excesses have raised the question whether more adequate mechanisms for monitoring research are required.

The mandate and membership of the National Commission represent a new approach to the formulation of public policy in a highly complex field. The Commission is a study commission, but also possesses sig-
The review of past fetal research indicated that most studies performed to date have been designed to benefit the fetuses involved in the studies.

During the early months of 1975, evidence on these questions was presented to the Commission in written reports and public testimony. We cannot, of course, provide extensive summaries of the evidence. (Rather detailed summaries will appear in the final report of the Commission, to be published later this year.) We will, however, try to convey at least the flavor of the evidence received by the Commission, with special attention to viewpoints presented by the ethicists.

The review of past fetal research indicated that most studies performed to date have been therapeutic in intent, that is, they have been designed to benefit the fetuses involved in the studies. In addition, some types of nontherapeutic research procedures that involve only minimal risk have been applied without distinction to fetuses prior to birth and prior to abortion. Other more risky or invasive nontherapeutic studies have also been performed, however, in cases involving abortion. Most of these studies have been done prior to, or during, the abortion procedure. For example, the passage of potentially hazardous drugs from the maternal bloodstream to the about-to-be-aborted fetus has been tested. A few studies have also involved living fetuses following abortion.

A great deal of controversy surrounded the questions whether fetal research has in fact contributed to medical progress and whether alter-
native means—for example, animal experimentation—could have been employed to achieve the same goal. It seems safe to conclude that several of the most dramatic advances in fetal medicine have emerged from therapeutic experimentation on fetuses with some risk. At the same time, however, there is some evidence to suggest that, consequentially speaking, high-risk nontherapeutic research on live fetuses has accelerated the pace of medical progress in certain areas. What moral weight one ascribes to this historical probability is, of course, a separate question.

The Commission's consultants agreed that the criteria for fetal death should be identical, insofar as technically possible, with the criteria for the death of an adult organism. The issue of fetal viability, however, was hotly contested. Part of the controversy rested on empirical grounds: precise statistics are seldom recorded if a newborn infant weighs less than one and a half pounds. Equally important, however, was a normative question—whether a fetus with a very low probability of survival ought to be regarded as nonviable or viable. Differing opinions on this point seemed to reflect divergent views on the relative importance of medical progress and fetal protection.

The law's approach to the fetus, as reported to the Commission, is characterized by considerable confusion. The Wade and Bolton decisions on abortion draw a sharp line at the point of fetal viability, but their relevance to the issues of fetal experimentation is a matter of debate. On the other hand, the law of torts and property ascribes certain rights to the previable fetus in utero, provided that the fetus is later born alive. In addition, during 1973 and 1974 twelve states passed laws which either prohibit or restrict live-fetus research.

At a series of public hearings, the Commission received testimony from a variety of groups. Three major positions seemed to crystallize in this public debate. Biomedical researchers, generally speaking, cited past benefits of fetal research and urged the Commissioners not to impede future progress by promulgating inflexible restrictions. Many researchers were, however, willing to accept the prohibition of certain procedures, for example, extending the life of a nonviable delivered fetus for research purposes alone. A second position was presented by women's rights groups, who argued that the Commission should not recommend policies that would in any way interfere with the right of women to secure abortions. A third and rather different view was presented by advocates of the pro-life position, who generally urged that only therapeutic fetal research should be permitted. The major exception to this generalization was a pro-life spokeswoman who was willing to accept diagnostic procedures that do not "substantially jeopardize" the fetus, even if the fetus is a candidate for planned abortion.

The remaining source of input to the Commission was a group of philosophical and theological ethicists. During January and early February the Commission staff contacted numerous scholars in ethics, requesting them to submit twenty-page papers on ethical issues in fetal research and to appear at a round-table discussion with the Commission in March. The ten ethicists who accepted the Commission's invitation represented several venerable ethical traditions—Catholic, Protestant, Jewish and philosophical. Their views also covered virtually the entire spectrum of opinion on the fetal research question.

As direct participants in this aspect of the Commission's work, we may not be in the best position to comment on the contribution of the ethicists. It seems to us, however, that five distinct positions emerged from the ethicists' papers and from the round-table discussions.
A first position, articulated by Prof. Joseph Fletcher, was that the moment of birth is the decisive watershed in fetal development. According to Prof. Fletcher, all types of research are permissible on the fetus in utero so long as there is no intention to allow the fetus to come to term and to be born.

A somewhat more restrictive position was advocated by Dr. Sissela Bok, a moral philosopher at the Radcliffe Institute, and Professor Richard Wasserstrom, a legal philosopher at UCLA. Both agreed with Mr. Fletcher that at certain stages of fetal development, research should be allowed to proceed without restriction. For Dr. Bok, the fetus in the early states of gestation (until approximately eighteen weeks of age) is not a subject requiring protection. Prof. Wasserstrom, on the other hand, accorded protection to the fetus in utero but argued that research on live, previable fetuses following abortion ought to be allowed, since such fetuses have no possibility of surviving to become members of the human community.

A third position was most clearly represented by Dr. Marc Lappé of the Institute of Society, Ethics and the Life Sciences (the Hastings Center). Dr. Lappé clearly wished to respect the fetus at every stage of development. He argued, however, that some fetuses which might have to bear the stigma of prenatal damage throughout an entire lifetime.

We (the present authors) independently concluded that a fourth position provides the most satisfactory alternative. In our opinion, nontherapeutic research that entails "no discernible risk" or "minimal risk" is morally permissible in the case of children. This view is based on the general notion that all members of a society owe certain minimal debts to that society, among them the duty to take part in relatively safe biomedical research projects. This obligation also extends to children, even though they are not aware of it yet. Since children are incapable of giving informed consent, we would argue that their parents should be authorized to provide proxy consent on their behalf. This position can without difficulty be applied to fetuses whose parents intend to bear responsibility for the case of the children-to-be-born. Such fetuses, are in effect, very young children. In cases involving abortion, on the other hand, only research procedures which would be permitted by future parents should be allowed.

A fifth and final position was represented by Prof. Paul Ramsey of Princeton University and Prof. Seymour Siegel of Jewish Theological Seminary in New York. While agreeing with the fourth position on equal protection for all fetuses and children, these scholars argued that only therapeutic research should be performed on subjects who are themselves incapable of giving informed consent. They therefore recommended, as the morally safer course, a proscription of all types of nontherapeutic fetal research.

What, then, did the Commission say in the light of such evidence and testimony? The Commission did not restrict itself to experimentation on the fetus. For instance, it issued recommendations on research (both therapeutic and nontherapeutic) on the pregnant woman. With regard to nontherapeutic research on the pregnant woman, it insisted that the research be evaluated for possible impact on the fetus and required that it "impose minimal or no risk to the well-being of the fetus."

The burning issue confronting the Commission, however, was nontherapeutic research on the fetus itself. A total ban on such research had been in effect since July, 1974. This the Commission removed. In doing so, it distinguished five different situations: the fetus in utero; the situation of anticipated abortion; the fetus during abortion (and the nonviable fetus outside the uterus—which the Commissioners infelicitously designated as the "fetus ex utero"); the possibly viable infant; and the dead fetus.
As for the fetus in utero, the recommendations allow nontherapeutic research provided that "the purpose of such research is the development of important biomedical knowledge that cannot be obtained by alternative means; investigation on pertinent animal models and nonpregnant humans has preceded such research; minimal or no risk to the well-being of the fetus will be imposed by the research"; and proper consent procedures are observed. The key provision here is, of course, "minimal or no risk to the well-being of the fetus."

The Commission insisted on the same conditions for nontherapeutic research on the fetus in anticipation of abortion. If any research presents special problems with regard to the interpretation or application of these guidelines, it could be supported by the Department of Health, Education and Welfare, provided it had been approved by a national ethical review body. It was this latter escape clause that produced the dissent of Prof. David W. Louisell, Professor of Law at the University of California, on this guideline.

The guideline likely to prove most controversial is that dealing with the fetus during abortion and the nonviable fetus outside the uterus. In this situation, research is allowed if "the fetus is less than 20 weeks' gestational age; no significant procedural changes are introduced into the abortion procedure in the interest of research alone; no intrusion into the fetus is made which alters the duration of life." All of this means that the certainly nonviable fetus outside the uterus or during abortion (less than 20 weeks is on the safe side) is extended a single protection: its life may not be either shortened or extended by the proposed research. Once again Prof. Louisell dissented, and, we believe, correctly. The mere fact that a fetus is dying is no ground for withdrawing the protections extended to all other fetuses. The Commissioners argued that the notion of "minimal or no risk" becomes less relevant in the circumstances, for a dying fetus cannot be "harmed" in the sense of "injured for life." Even in this case, however, the Commissioners stated that "considerations of respect for the dignity of the fetus continue to be of paramount importance, and require that the fetus be treated with the respect due to dying subjects." The "respect due to dying subjects" led the Commission to conclude only that "no nontherapeutic interventions are permissible which would alter the duration of life of the nonviable fetus ex utero." On the very premises accepted by the Commission, we believe that the conclusion should have been that no interventions are permissible here that are not permissible on all other dying subjects.

The guidelines fully protect the possibly viable infant, allowing non-therapeutic research only when "no additional risk to the well-being of the infant will be imposed by the research." As for dead fetuses and fetal material, their use in research was recommended within the boundaries of commonly held convictions about respect for the dead.

What can be said of the work of this Commission? Much good news and a little bad. The Commission was working under an almost unreal time restriction (four months), given the complexity and implications of its mandate. Furthermore, it was tackling a subject closely related to but not identical with a highly divisive issue, the question of abortion. Because this nation is divided on the evaluation of fetal life and the moral legitimacy of abortion, it is almost bound to be divided on fetal experimentation. In such circumstances, the Commission could hardly have pleased everyone, or even anyone, completely. A total ban on fetal research would have made fetuses even less approachable than many feel is the case with infants and minor children. On the other hand, a highly permissive policy would have been totally unacceptable to the large segment of the nation that views the fetus as a human subject with rights and claims. Finally, the Commission knew that its attempt to find a middle ground would be eyed carefully by those rightly fearful of a sliding cost-benefits compromise.
On July 29 then Secretary of HEW Caspar W. Weinberger signed new rules governing the use of federal funds for fetal research, following in the main, the advice of the Commission. He lifted the year-old ban on fetal research while prohibiting experiments that would intentionally terminate or artificially prolong the life of an aborted fetus.

The guiding principles in the new rules are that the research must pose only "minimal risk" beyond that which the fetus would already face, and that the same facts could not be known by any other means. (See Washington Post, July 30, 1975.)

With this as background, we believe the Commission's recommendations are in general quite constructive. They not only acknowledge fetal dignity but, except in the single instance noted above, provide protections to the fetus that are consistent with the protections afforded to infants and children. In the vast majority of instances, then, "minimal or no risk to the fetus" is the key restrictive condition on research. Furthermore, there is monitoring checks and reviews calculated to see that the guidelines are observed. The underlying evaluation of fetal life is at some point sharply inconsistent with that of the Supreme Court in Wade and Bolton. But such inconsistency is, from our viewpoint, far more desirable than a consistency that would erode the dignity of fetal life.

First, proposed research that creates problems with regard to the interpretation or implementation of the guidelines must be reviewed by a national ethical review board. Well and good. Whatever the source of the problems, however, no criteria or principles are offered to a review board for use in adjudicating these problem instances. This omission represents a glaring weakness of the recommendations.

Second, there is no explicit provision made for review of the Commission's own guidelines. In an era of rapid medical advance and technological change, such review is a constant necessity.

Third, there are several inconsistencies in the deliberations which undergird the guidelines. For instance, the Commission states that it "has not yet studied the issues surrounding ... the validity of proxy consent for non-therapeutic research." It then goes on to accept, however, the validity of this consent where risks to the fetus are minimal. Similarly, as we noted above, the Commission accepts the equality principle (that all fetuses are in fact to be evaluated equally). It states that "there is disagreement as to its application to individual fetuses and classes of fetuses." Thus, some members of the Commission argued that risks to the fetus to be aborted may be considered "minimal" even if they would not be considered minimal for a fetus going to term. This is scarcely a disagreement about the application of the equality principle. It is a qualification of the principle itself.

Finally, at the eleventh hour the Commission introduced a recommendation that "research on abortion techniques continue." In our judgment this is research on abortion, not precisely fetal research. It is, therefore, at best only marginally related to the mandate of the Commission.

When all is said and done, then, there will be those who think the proposed restrictions on fetal research are too rigid. Others will contend they are too permissive. We believe that the overall protective thrust of the recommendations is a major step in the right direction. What is perhaps more important than the individual conclusions themselves is the way in which this problem was faced, not by legislation or political tradeoffs, or judicial fiat, but by a representative public commission that elicited the views of persons from differing backgrounds, competences and convictions, conducted public discussions, and deliberated openly and candidly on the problem and its implications. Not all problems can be resolved in this way, and even in those instances where they apparently can be, the resolution must probably be tentative and subject to revision. But on the basis of the Commission's work so far, we believe the beginning is a good one, even if not perfect. And because the bioethical problems to face us in the next few decades are complex and staggering in their implications, a good beginning must be welcomed for what it is.
Seymour Perlin, M.D., Senior Research Scholar at the Kennedy Institute, brought together prominent voices from a variety of disciplines to address the issue of suicide in a *Handbook for the Study of Suicide*. (New York: Oxford University Press, 1975, 240 pages.) A work involving several years of active dialogue and collaboration, it consists of eleven highly original essays covering history, literature, anthropology, psychology, sociology, biology, medical sociology, community psychiatry, morality, epidemiology and, finally, a discussion of psychiatric case registers.

In 1967 Dr. Perlin was awarded a grant from the National Institute of Mental Health to establish the first formal postgraduate fellowship program in Suicidology at Johns Hopkins University, School of Medicine. As the program progressed it became apparent that a multidisciplinary textbook of suicide was needed. In response Dr. Perlin began work on the *Handbook* while Professor of Psychiatry at Johns Hopkins and Director of Clinical Care and Training at Hopkins’ Henry Phipps Clinic. Successive fellowships at Princeton University, Oxford University and an award of the Joseph P. Kennedy, Jr. Fellowship in Medicine, Law and Ethics gave him the freedom to complete the work.

The journal *Perspectives in Biology and Medicine* comments on the book: “From a historical, literary and philosophical background it proceeds to the social sciences and to a balanced psychiatric discussion of suicidal behavior. The volume offers a modern view of rational motivation to commit suicide that differs from the traditional psychiatric position that all suicides represent psychopathology.”

The *Handbook* includes contributions from A. Alvarez, critic and author of *The Savage God*; Mary A. Monk, Ph.D., Professor of Community and Preventive Medicine, New York Medical College; George Rosen, M.D., Ph.D., M.P.H., Professor of the History of Medicine, Yale University; Chester W. Schmidt, Jr., M.D., Chief, Department of Psychiatry, Baltimore City Hospital; Richard Brandt, Ph.D., Professor and Chairman of Philosophy, University of Michigan, Ann Arbor; and Peter Sainsbury, M.D., Director of Research, Medical Research Council, Clinical Psychiatry Unit, Graylingwell Hospital, Chichester, England.

George Rose’s essay on “History” examines suicide from classical times to the present, and describes past and present perceptions of suicide.

A. Alvarez’ “Literature in the 19th and 20th Centuries” discusses a possible suicidal element in the artistic creation. He also traces Western European literature’s treatment of the subject from the Romantics to the Existentialists.

R. B. Brandt looks at the morality and rationality of suicide from the point of view of contemporary philosophy. He presents the major ethical and logical arguments for and against suicide.

Jean de la Fontaine discusses the anthropological perceptions of suicide in terms both of theories of suicide and of actual studies on suicide in various cultures.

In the essay on sociology, Ronald Maris examines the impact of suicide on society. How do societal factors contribute to suicide? Does knowledge of rate and motivation for suicide contribute to our understanding of a given society?

Solomon H. Snyder, M.D., provides a provocative study of the “biochemistry” of pleasure in the brain, depression being a major underlying factor in many suicides.

George J. Vlasak’s essay on medical sociology identifies the varied and often prejudicial responses of social systems and individuals within those systems (e.g., in medical centers) to the suicidal patient and to known suicides.

Drs. Perlin and Schmidt in the section on psychiatry consider suicide from the viewpoints of psychodynamic theory; discuss recognition of the suicidal individual; look at attempted and completed suicide cases; and present a unique method for assessing completed suicides.
Recent Arrivals:

Kenneth Casebeer, J.D., will study the rights of children.

Fr. Bernard Häring: "B.F. Skinner never found out what is distinctly human about man."

Mr. Kenneth M. Casebeer, J.D., begins a one-year appointment this fall, the Kennedy Institute's first resident legal scholar. A 1974 honors graduate of Harvard Law School, Mr. Casebeer will undertake a major research project on the rights of children. Mr. Casebeer will investigate the degree to which children are granted control over their own development. The project will proceed in two steps. First Casebeer will examine the legal structure and accompanying literature as it relates to children, including a review of judicial and legislative history to see if a common philosophy underlies our treatment of children. Second, based on those findings, he intends to produce an analytical framework, a research base from which further research and public policy can develop. Keeping in mind the broad question of whether the legal system is justified in treating children differently than adults, Mr. Casebeer will focus specifically on a number of proxy issues relating to medical and other professional relations of and with children. This will include discussion of questions such as: the need for patient consent in biomedical experimentation, variable ages of majority in sanctioning public acts of children (cohabitation, procreation, educational attainment), authorization of third party intervention in the child's development (and conversely whether there exists a right of refusal of such protection).

Mr. Casebeer comes to the Institute from the University of Miami where he was an Instructor of Law. He hopes to teach a course next spring at the Georgetown University Law Center entitled "Issues in the Philosophy of Law," primarily concerned with the development of constitutionalism. In addition to his work on children's rights, Mr. Casebeer expects to work informally with the Institute's scholars by providing them with a legal perspective on their projects.

Father Bernard Häring, C.S.S.R., S.T.D., Kennedy Institute's perennial Visiting Scholar, returns from Rome, Italy for his annual semester in residence at the Center for Bioethics. Father Häring has just completed one and a half years of research and writing on his latest book tentatively entitled Manipulation of Man: Ethical Questions in Medical Practice, Behavior Control and Genetics. It is currently being published in English and Italian with French, Spanish and German versions expected to follow. A spring 1976 publication date is anticipated. (In the United States Seabury Press of New York is producing the book.)
Throughout Father Häring’s works runs the same premise: freedom and dignity of the human person are the highest goods. How to preserve that freedom is explored in his latest book. He seeks to establish criteria for judging acceptable versus unacceptable forms of manipulation.

“Manipulation,” Father Häring said, “is never beneficial if it is a threat to human dignity and freedom.”

In *Manipulation of Man* Father Häring examines major areas of manipulation, e.g., in education, advertising, medicine and politics. The primary focus, however, is on bioethical problems.

“It seems to me,” Father Häring writes in his Preface, “that we have to seek, above all, the ethical boundaries of manipulation, and to do this in the spirit of an appassionate theology of liberation.”

Father Häring’s present subject of study is eugenic sterilization. He plans to produce a series of articles discussing peoples’ responsibility to avoid a disproportionate risk of transmitting congenital diseases. He intends to treat both voluntary and involuntary eugenic sterilization. And, of course, one of the main criteria will be respect for every person’s liberty and dignity together with social responsibility. He will also study sterilization for therapeutic and birth control purposes, since eugenic sterilization frequently coincides with these concerns.

In addition to his research Father Häring will teach an undergraduate course entitled “Manipulation: Threat to Liberty.” The first six weeks of that course will be open for attendance by the general public (see “Events”).

Robert A. Licht, Ph.D., recently completed his doctoral studies in political philosophy at the Pennsylvania State University. His dissertation is entitled “The Teachings of Nature and Soul in Aristotle’s *Nicomachean Ethics*.”

Dr. Licht views the growing ethical dilemmas in biology and medicine as a vivid expression of a deepening crisis in the West. The roots of this crisis, he believes, lie in the twin revolutions in science and politics that form the intellectual foundations of modernity. Dr. Licht is interested in exploring the connections between those foundations and current bioethical concerns.

Robert A. Licht, who taught at Bucknell University and St. John’s College, joins the growing faculty of scholars at the Kennedy Institute.

James Jones, Ph.D., Visiting Scholar, returned in September to the Division of Fellowships at the National Endowment for the Humanities. He has completed six chapters of his ten chapter book, *Bad Blood: The Story of the Tuskegee Syphilis Experiment*. It is being published by Free Press, a division of the Macmillan Company. Dr. Jones anticipates a fall 1976 release.

Dr. Leon Kass, Joseph P. Kennedy Senior, Professor of Bioethics, was selected by the National Endowment for the Humanities to direct one of its five month-long seminars for physicians this summer. The seminars give practicing physicians the opportunity to view their profession through the humanities.

In Dr. Kass’ seminar the participants studied the concept of the human being as expressed in the works of the early Greeks. The participants alternately discussed the writings of Sophocles and Plato and contemporary writings on such topics as death with dignity. They were thus able to assess traditional concepts in the context of today’s reality.
The following is a partially annotated listing of publications by Long-Term and Visiting Scholars during the first half of 1975. Publications released after the departure of a Visiting Scholar are listed herein only if based on work done at the Institute.


Gendell, Murray, Ph.D., "A Review of James A. Sweet's Women in the Labor Force," *Demography* 12(1):27-45, February 1975. The essay criticizes the author for not using a theoretical model as a basis for his analysis of the 1960 census data and for neglecting the major issue of accounting for the long-run increase in the labor force participation of wives and mothers. However, some of the author's findings have potential theoretical significance.


The *Bibliography of Bioethics*, Vol. I is now available for purchase through its publisher Gale Research Company. (Book Tower, Detroit, Michigan, 48226, $24.) Volume One includes 800 English language materials (print and nonprint) published during 1973 on bioethical topics. Volume Two (1974 materials) will be available next summer.

Producing an annual bibliography involves the monitoring of more than fifty journals and over forty indexes and data banks. Each document judged to be within the scope of bioethics is acquired and reviewed by the Project staff.

In addition to the standard bibliographic citation, each document is indexed and assigned one or more subject headings indicating the major bioethical issues addressed by the article.

The Information Retrieval Project is currently developing a software package capable of computer-producing future volumes of the *Bibliography*. This same software package is making possible another valuable tool new to the field of bioethics, an automated information retrieval system. By 1977 the Kennedy Institute will be able to respond to on-demand searches of bioethical literature published in the English language from 1973 forward.

[Note: All material listed in the *Bibliography of Bioethics* is available for use in the Center's Library.]

The *Encyclopedia of Bioethics*, a five-year project scheduled for 1977 publication, now has more than sixty manuscripts moving through the various stages of its review and editing process. The two-volume collection will have a total of 305 articles covering all significant viewpoints in the ethics of the life sciences.

Dr. Warren T. Reich, Editor-in-Chief and a Senior Research Scholar at the Center for Bioethics, described the process: The manuscript is reviewed by at least five editors and scholars before set into print. Quality, suitability (Is it in harmony with the comprehensive scope of the *Encyclopedia*?), bibliographic accuracy and style are all thoroughly reviewed. The average processing time required per manuscript is three months.

Dr. Reich commented: "While the authors are the leading people in their fields, we feel that an added degree of excellence is being assured by the many experts in biomedicine, health, philosophy and the social sciences who are generously serving as reviewers."

The *Encyclopedia of Bioethics*, sponsored by the Center for Bioethics, is supported by grants from the National Endowment for the Humanities, the Joseph P. Kennedy, Jr. Foundation, the Raskob Foundation and the Commonwealth Fund. It is being published by The Free Press, a division of the Macmillan Company of New York.
The Library of the Center for Bioethics, the largest library of its kind in the world, has instituted a new book selection service for librarians and individual scholars. Subscribers to the service, *New Titles in Bioethics*, receives a monthly listing by subject of books, government documents, pamphlets, serial titles and audiovisual aids acquired during the previous four weeks.

*The Bioethics Library, in cooperation with the Information Retrieval Project currently in progress at the Institute, seeks to secure a copy of every new document published in the field of bioethics.*

*New Titles in Bioethics* provides a regular, up-to-date survey of that part of the literature which is most difficult to control bibliographically—books and other separate publications.

The cost is $6 per year, which includes postage and duplicating charges. For further information contact Doris Goldstein. Checks are payable to the Kennedy Institute.

In the interest of internal education and for the opportunity to meet with others involved in the study of bioethics, the Kennedy Institute invites speakers to luncheon seminars or monthly colloquia with its faculty and staff members.

April’s guest was **Ms. Karen Metzler** who spoke from personal experience on the topic “Ethical Issues in the Treatment of the Handicapped.” Ms. Metzler, a twenty-four-year old magna cum laude graduate of Baldwin-Wallace College, was born with spina bifida and suffers severe physical disabilities. She had undergone fifty-eight operations to date. She discussed what life is like on the receiving end of care for the handicapped and challenged members of the audience to examine their own attitudes toward handicapped persons.

May’s colloquium speaker was **Dr. David Blumenthal** of Brown University who is, in his own words, “an ordained rabbi, a university professor of religious studies and a committed Jew.” Dr. Blumenthal’s lecture, “Explorations in the Jewish Perspective on Bioethics” was an examination of how ethical dilemmas are solved within Jewish Tradition. He suggested that the Jewish perspective on ethics might be profitably applied to the study of bioethics, illustrating his thesis by exegeting a text from Maimonides’ *Code*.

A special report was also delivered in May by **Mr. R. Sargent Shriver**, Chairman of the Kennedy Institute Advisory Board. Mr. Shriver discussed his recent three-week visit to Russia as a guest of the Soviet government. He had been invited to present a series of lectures in nine cities throughout the U.S.S.R. The subjects of his addresses to the Soviet audiences centered primarily on international relations and on the development of a code of ethics for the sciences.

**Hans Jonas,** Alvin Johnson Professor of Philosophy at the New School for Social Research in New York, visited the Institute in June for a luncheon seminar. Professor Jonas commented on the lack of a corresponding moral code capable of meeting the demands of scientific advances. At the New School he is striving to develop a new code of ethics suited to facing the constant dilemmas forced upon us by modern technology.

**J. David Bleich** was the July colloquium speaker. Professor of Talmud and Philosophy at Yeshiva University in New York, Dr. Bleich is currently on leave of absence while doing research on bioethics at the Hastings Institute. The topic discussed by the Talmudic scholar was extraordinary versus ordinary means of preserving life. According to Judaic teachings, Bleich said, the mandate is clear and compelling: life is the greatest good and is to be preserved at all costs.

However, he noted, there are several other emphases in the Jewish tradition which tend to qualify this absolute principle in certain cases.
The Continuing Education Department of Georgetown University is sponsoring the 1975-76 Continuing Religious Education Series in which the Kennedy Institute is assuming a vital role.

Rev. Bernard Häring, C.S.S.R., S.T.D., will discuss the ethical concerns generated by advances in the behavioral sciences in a six-part lecture series entitled "Manipulation: Threat to Liberty." The lectures will be held on consecutive Monday evenings from September 8-October 13.

Rev. John R. Connery, S.J., S.T.D., will conduct a program entitled "The Ethics of Abortion" in which he will focus on the theological and legal views of abortion in Western culture. The course will be held on six Thursday evenings, September 25-October 30.

[Father Häring's and Father Connery's lectures are a part of their full semester, full credit undergraduate courses, the first six weeks of which are open to the public.]

In the spring a six-part program on "Issues in Bioethics" will be presented by several of the scholars at the Kennedy Institute's Center for Bioethics. Topics under discussion will include the ethics of suicide, the secularization of medicine and fetal experimentation. Audience participation will be encouraged at the Wednesday evening lectures scheduled to begin on February 18, 1976.

On May 11, 1976, Rev. Richard A. McCormick, S.J., S.T.D., the Rose F. Kennedy Professor of Christian Ethics, will deliver a lecture entitled "Bioethical Questions and Christian Action." His will be the last of nine theological lectures sponsored by the Continuing Education Department during the academic year 1975-1976.

The cost of the programs, all of which are open to the public, is minimal: $2 for the May 11 lecture ($10 for the entire nine-part series) and $10 for each six-week course.

To register contact: Joseph Pettit, Dean, School for Summer and Continuing Education, Georgetown University, Washington, D.C. 20057. (Telephone number (202) 625-3001). Checks are payable to: Georgetown University-Continuing Education.

Guido Calabresi, John Thomas Smith Professor of Law at Yale University, visited the Kennedy Institute in July to deliver two evenings of lectures on "Tragic Choices." For the past two years he has been writing and lecturing on how the United States and other selected nations make life and death decisions for the populace. Reflections on Tragic Choices (Norton & Company) is Professor Calabresi's latest work and will be published sometime in 1976.

Who gets the artificial kidney? Who fights in a limited war? Who gets to have children? These are examples of tragic choices, choices that a society must make yet cannot make without undermining values crucial to that society.

Tragic choices expose the tensions between our ideals and our actual practice: we cannot or will not preserve life at all costs; we cannot or will not give everyone an equal break; we cannot or will not be completely honest at all times about our motives behind these choices.

In this two-part lecture series Professor Calabresi described the processes by which we and other societies allocate our most precious resources. His intent was not to prescribe but rather to define the systems employed to approach these irreconcilable conflicts.

What we should face, Mr. Calabresi suggests, is that we have no well-ordered set of values. That state of affairs, he says, is a desirable one, for
only a totalitarian state can maintain the established hierarchy of values necessary for uncomplicated solutions.

In a working democracy it is a given that we shall struggle over life and death decisions, giving one group and then another the opportunity to enforce its values. It follows therefore that as long as we have a free society, these irreconcilable conflicts will remain irreconcilable.

The Institute, now in existence for almost four years, has in recent months given me intense personal pleasure on two scores.

First, the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research issued its recommendations on fetal research. The Commission contracted for papers on the subject with ten ethicists, three of whom were from the Kennedy Institute: Dr. Leon Kass, Fr. Richard McCormick and Dr. LeRoy Walters. A fourth, Dr. Paul Ramsey of Princeton, is a Georgetown alumnus in the field of bioethics.

No other university was so heavily called upon to contribute to this very tricky and emotional issue. This pleases me tremendously because (1) the Institute focuses on both human reproduction and bioethics and (2) because my own biological research has been precisely in fetal research.

No commission representing a national cross-sample of interests could, of course, come up with a perfect document on the ethics of fetal research. But it is clear that the Commission's work has been of high caliber and I think the Kennedy Institute had much to do with that. (A first-rate analysis of the actual document originally published in America by Fr. McCormick and Dr. LeRoy Walters appears in this issue.

A second cause for personal pleasure has been a series of recent legal decisions affecting pregnant women. First the Supreme Court ruled that pregnant women could not be arbitrarily fired (Cleveland Board of Education vs. LaFleur, 1974). Then the Second, Third, Fourth and Sixth Courts of Appeals, with some variations in detail, ruled that to deny pregnant women disability benefits runs afoul of Title VII of the Civil Rights Act of 1964. It discriminates against women on the basis of their sex. Again, the wider public will never fully know the Kennedy Institute's role in these legal battles. Let me simply say that the medical evidence in support of the women's position was fully developed at the Institute. Dr. Jeanne Clare Ridley and her coworkers in the Institute's Center for Population Research supplied the data on the effects of income and work on pregnancy outcome. Drs. Branson, Kass and Neale steered me to the right literature to tackle the difficult semantic question of defining words like health, disease and disability, key issues in the case of pregnancy. Dr. LeRoy Walters and Ms. Doris Goldstein supplied all needed articles from the Library and the Information Retrieval System. Dr. John Schruefer of the Reproductive Biology section contributed his findings regarding oxygen's effect on fetal development, an important issue when United Airlines stewardesses were prevented from continuing their flight duties once pregnant.
Incorporated within our new logo design is (1) the concept of the life cycle; (2) an eye, for inquiry; (3) a man with outstretched arms seeking to understand himself and his world; and (4) the initial "K" formed at the top in honor of the family that founded and supports this research institute.

The Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics Quarterly Report is published by the Kennedy Institute, Georgetown University, Washington, D.C. 20057. Ellen K. Wessel, Editor.

My own role was simple. It was to sort out the inputs from all these sections of the Institute and to act as expert witness at the various E.E.O.C. hearings and trials in Washington, New York, Rochester, Richmond, Chicago and Clarksdale, Mississippi. It was a pleasure to do so, knowing I had been given proper information from so many individuals of enormous competence.

With fetal research conducted under proper ethical guidelines and with pregnant women supported in their months of great need, I have had occasion to reflect that given ten lifetimes of caring for pregnant women and delivering their babies, with the best house staff in the country, I could not possibly have done as much for women and children as was done through the establishment of the Kennedy Institute at Georgetown University. It's a cheerful thought.

The Kennedy Institute is located on the East Campus of Georgetown University in the historic D.C. Transit Building. It was formerly used to store and maintain trolley cars.

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