



Introduction

This resource supports teachers in exploring an anthology extract for Pearson Edexcel A Level Religious Studies.

Subject specialists have annotated the extract to highlight key terminology, scholarly ideas, links to specification content and opportunities for discussion. The annotations are intended as a starting point rather than a definitive commentary.

Teachers may wish to adapt or expand them with their own notes, examples and teaching approaches. The full anthology extract can be accessed via the image or link opposite.



How to Use this Resource

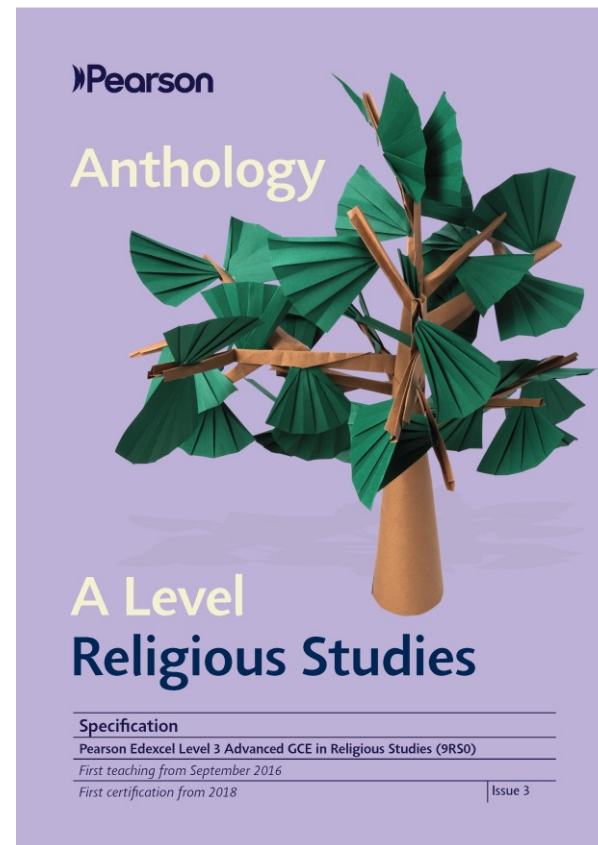
Alongside the anthology extract, this resource includes expert commentaries that highlight key ideas, debates and connections within the text.

The commentary is intended as a guide rather than a definitive interpretation. Teachers may wish to add their own annotations, examples, discussion points or specification links to reflect their approach to teaching the anthology.

Space is provided throughout the resource for further annotation. Use this resource as a starting point for exploring the extract, identifying key themes and developing a deeper understanding of the ideas and issues it raises.

Access the Full Anthology Extract

Click the image or link below to open the complete anthology extract.



[Anthology extracts](#)



Medical ethics in late and postmodernity (2024)

Adapted from: Thobaben, James. 2024. 'The History of Medical Ethics', St Andrews Encyclopaedia of Theology. Edited by Brendan N. Wolfe et al
<https://www.saet.ac.uk/Christianity/HistoryofMedicalEthics>

About This Extract

- This is Extract 4 from Paper 2 of the anthology.
- The extract explores how medical ethics has developed in response to social, cultural and technological change.
- It examines key ethical debates surrounding issues such as abortion, euthanasia, patient autonomy, public health, genetic engineering and emerging medical technologies, alongside the different ethical approaches used to address them.
- The text considers how ideas about personhood, rights, responsibility and the role of medical professionals have evolved over time and highlights the challenges of reaching ethical agreement in increasingly diverse societies.
- Teachers should note that the extract presents a range of viewpoints and ethical arguments designed to encourage critical analysis and discussion.

Additional annotations

Commentary:

① Late modernity is the contemporary phase of modern society in which globalisation, individual choice, rapid change and awareness of risk have intensified, while traditional sources of authority have become less influential.

Post modernity refers to the social condition which emerged from mid to late 20th century.

The first few paragraphs introduce medical ethics as an area of ethical study.

② Links to papers: 4B 4.2, 4D 6.3, 4E 4.1, 4F 4.1.

③ Links to paper 2 4.2.

④ People questioning traditional deontological moral decision-making approaches in 1960's, like Natural Law.

⑤ Fletcher argued that one principle could determine right and wrong in every situation: love (1 Corinthians 13). In Situation Ethics, this love is agape, the Greek term for selfless love. Link with paper 2, 2.2.

⑥ Personalism - emphasises the importance of people, people are more important than rules.

1 ➔ 6 Medical ethics in late and postmodernity (2024)

6.1 Late modernity: lost commonality, professional moralists, and the boundary of life

Into [the] cultural confusion [of the late twentieth century] came a new academic discipline, 'medical ethics'. The term, by then, was far more expansive than merely defining how physicians might properly interact with patients and each other. While initially having strong Christian

2 ➔ foundations, bioethics quickly secularized. North American and European cultures were abandoning common mediating institutions, including the church, and so lost generally-shared moral mechanisms and notions of the 'good life'. Falling back on the only values that seemed to

3 ➔ still be broadly operative, the new field emphasized utility and autonomy.

4 ➔ Medical ethics as an academic discipline developed after 1954 when then-Episcopal priest (later self-designated humanist atheist) Joseph Fletcher published *Morals and Medicine*, offering an early version of what became known as 'situation ethics'¹. Narrowly understood, this

5 ➔ is moral decision-making using a utility calculus with overall 'love' (not clearly defined) serving as the value to be maximized. Fletcher initially asserted that this was a way in which to fulfil the Christian command to 'love the neighbour', but eventually made his argument on the basis of

6 ➔ personalism. Within medicine and academia, some heartily endorsed the project as 'progressive' and fitting the times. His work was rejected by others as contrary to the Hippocratic Oath, being egocentric and inconsistent. His most important counter came from Paul Ramsey, a Christian theological ethicist.

Commentary:

- ① In this context, lifeboat ethics refers to ethical situations where resources are limited and not everyone can be helped, so decisions must be made about who should receive treatment or support and who should not.
- ② Medical ethics was becoming overly focused on resource allocation and technical debates, creating a need for a more holistic ethical approach that considered patients, doctors and the wider effects of healthcare on society.
- ③ This part of the extract identifies Joseph Fletcher as an important figure in the development of modern medical ethics and links his work to Situation Ethics.
- ④ A Just Coercion Framework is a set of ethical criteria used to determine whether a government is morally justified in restricting people's freedom for the sake of the common good.
- ⑤ Christian Realism is a political approach based on three Christian beliefs:
 - 1 - Humans are sinful and can misuse power.
 - 2 - Humans are free because they are made in the image of God.
 - 3 - Humans are called to love God and their neighbour.
 Because these three ideas can pull in different directions, Christian Realists believe politics should aim for a balance of power and show humility, recognising that there are often no perfect solutions.
 Take abortion as an example. If the focus is on human sinfulness, people might argue that individuals should accept the consequences of their actions.
 If the focus is on loving your neighbour, people might support a woman's right to choose. If love is focused on the foetus, people might oppose abortion to protect its life.
 Christian Realism does not provide one clear answer. Instead, it recognises that different Christian values may be prioritised in different situations.

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- ① In the popular press, medical ethics was often defined in terms of 'lifeboat ethics' and deciding
- ② who would take priority in the use of scarce resources. Coupled with this, the increasingly bureaucratic management [in medicine] resulted in the near mutual anonymity of patient and physician. Finer and finer casuistic distinctions were endlessly debated. Clinically, it became apparent that a more coherent moral approach was required, one that considered the patients and physician, but also the social and cultural impact of the health sciences.
- ③ In 1970, Joseph Fletcher's longtime intellectual opponent, Paul Ramsey, published his most significant work, *Patient as Person: Explorations in Medical Ethics*². Ramsey made
- ④ deontological arguments within a 'just coercion' framework, similar to Christian Realism, but
- ⑤ here applied to healthcare and emphasizing the 'patient as person' warranting respect (specifically as a rights-holder). For Ramsey, the autonomous individual was not an anonymous individual lost in the crowd, but a person entitled to choice within a covenantal relationship between patient and practitioner.

Commentary:

① Specification links:

- Natural Law
- Deontology
- Utilitarianism
- Religious approaches to medical ethics

The comparison of the above theories could provide an opportunity for students to consider how different ethical theories arrive at different conclusions about the same medical issue.

② In the UK and later the US, legal arguments for abortion increasingly focused on a woman's right to make decisions about her own reproduction.

Critics argued that autonomy and privacy are not absolute rights because decisions can affect other people.

As a result, the debate centred on whether the interests of the foetus should limit a woman's right to choose.

Much of the disagreement focused on the question of personhood: whether the foetus should be considered a person with rights. The language used (e.g. "foetus", "preborn child", or "product of conception") often influenced how people approached the issue.

This part of the extract suggests that defining the foetus as a non-person was key to legalising abortion in the US through *Roe v. Wade* (1973).

Note that abortion has been 'effectively' legal. Pro-life advocates observe that it is effectively illegal since the law allows for exceptions, not a blanket legalization.

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- Amongst themselves, Catholics had been addressing modern medical ethics within moral theology for decades, but Catholic external influence was limited until the early seventies. A prominent voice was Richard McCormick, who tended toward liberalism (in the American sense) but supported Catholic positions on abortion and euthanasia. Though simplistic, one can see Fletcher using utilitarianism, Ramsey deontology, and the Catholics natural law virtue ethics. While each was to some extent helpful, none provided a mechanism for common discourse, even though all set out to do so.
- The ineffectiveness of bioethics was obvious in the abortion debates. Abortion had been effectively legal in the U.K. (other than Northern Ireland) since 1967 (efforts to completely decriminalize continue) using privacy arguments. Through the late sixties, pregnancy termination in the US was only allowed in some states, usually needing to be justified on the basis of the 'health of the mother'; the typical diagnosis referred to mental health. Eventually advocates shifted toward the assertion that personal liberty over reproduction was the path to female empowerment, a previously politically and economically marginalized class.

However, autonomy (or liberty) and privacy are never absolute. 'Autonomy' requires both a 'right to' and 'capacity for' effective choice. Privacy depends on the non-intrusion by uninvited others. Adult women [are presumed to] have the capacity for choice (though some prolife advocates claim this is not always so, given pressure from various family members, etc.) and healthcare typically is 'between the patient and the physician'. Therefore, the debate came to centre on the limitation on a right to choice created by the interests of others.

Commentary:

- ① Non-dichotomous – not just limited to two parts / categories e.g. ‘yes’ or ‘no’.
- ② Some bioethicists argued that the foetus is human but not yet a full person, which they believed could justify abortion in some circumstances.
This led to a three-part framework: person, intermediate being, and non-person.
Foetuses were often placed in the intermediate category. Some ethicists also applied this category to people with severe cognitive impairments.
The passage is critical of these classifications, suggesting they raise concerns about assigning different levels of moral worth to human beings.
- ③ This part of the extract highlights debates over the moral status of the foetus and the tension between autonomy and the interests of others

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This competing interests question took shape around the definition of ‘person’, usually with fights over terminology, specifically whether the entity was a preborn or a foetus or a product of conception. The setting of the term could determine the outcome of the argument. Abortion was effectively legalized in the US in 1973 when the US Supreme Court ruled in *Roe v. Wade* (1973) using a combination of privacy and autonomy arguments. Though written evasively, the Court determined that the ‘entity’ was non-person, an essential move since personhood under the US ‘social contract’ (literally, the Constitution) appears to assert a right of life prior to liberty/autonomy.

- ① → Some bioethicists recommended that non-dichotomous language was needed. While rarely making the connection to the ‘three-fifths of a person’ period under US slavery, some suggested that the entity was a distinct human but not a full person and, therefore, abortion could be regrettably allowed (The three-fifths standard arose when slave states, at the foundation of the U.S., wanted their non-voting, enslaved population to count for the totals in determining the allotment of representatives in the legislature; later it was popularly asserted that the reduced representation for a population also indicated a
- ② → correspondingly diminished human worth). For some in bioethics, the nominal categorization of ‘person/non-person’ gave way to the [three-way] ordinal categorization of ‘person/a-teleologic-being/non-person’. The potentially-aborted were generally
- ③ → assigned to that middle category, along with those with severely diminished capacities due to disabling conditions (so-called permanent ‘incompetents’).

Social movements for the legalization of abortion and then for active euthanasia won political victories in a number of jurisdictions, often on the basis of liberty/autonomy and the inability to find consensus on the concept of ‘person’³. Some states have expanded abortion access (e.g. Ohio) and others increased restrictions (e.g. Texas). At a federal level, the status of entity has not been determined and is not seemingly resolvable in the federal legislative branch.

Commentary:

① Debates about abortion and euthanasia revived older philosophical questions about when a human becomes a person. It also notes that these issues led to greater cooperation between Catholics and evangelical Protestants, despite historical differences. They shared the belief that all humans, as body and soul, have value in the eyes of God.

② This paragraph contrasts different denominational viewpoints on abortion and euthanasia.

③ Passive euthanasia is widely accepted in many places. Some European countries have gone further by allowing active euthanasia or assisted suicide. It may be worth highlighting that the Terminally Ill Adults (End of Life) Bill which has been defeated in the Commons after years of campaigning and having got to the House of Lords the first time it was put forward.

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Similarly, there is significant variation among jurisdictions on euthanasia. Nation-states allowing some form of active euthanasia (either practitioner-assisted or self-administered or both) include: Australia, Belgium, Canada, Colombia, Luxembourg, the Netherlands, New Zealand, Portugal, Spain, and Switzerland, as well as various jurisdictions within the United States (although it is not a right in the US, neither can it be prevented if allowed by a state⁴). Interestingly, several of these countries are secularizing Catholic nations. A similar de-sacralization of human care, including healthcare, is occurring with abortion liberalization in 2023 in (once strongly Catholic) Mexico and Ireland.

- ① ➔ Ironically, these debates echoed, yet again, those overhylomorphism from a thousand years earlier⁵. An unexpected consequence of the abortion and euthanasia debates in the US has been the increased ecumenical cooperation of evangelical [Protestants] and traditional Catholics (who, in the US and Britain, had previously tended to be associated with the urban labour left wing). They share not only roughly-similar epistemological assumptions about scriptural authority, but also claim the whole person as physical body and soul is valued by God.
- ② ➔ Catholics and evangelical Protestants have tended to oppose what they considered to be a loss of state protection for the vulnerable, both those with disabling conditions and the preborn/foetal, unlike [theologically liberal] Protestant [churches] and the secularized, [which] tended to support both abortion rights and active euthanasia. Disability-rights advocates have also protested [against] active euthanasia on the grounds that inordinate pressure or resource deprivation would be used to harm 'outliers', many of whom, unlike the preborn/foetus, can assert their human status.
- ③ ➔ Many more nation states now allow passive euthanasia (withdrawal of treatment when further procedures are deemed futile) including all US states⁶. Usually, when paediatric euthanasia is allowed in the US, it is passive/withdrawal, though active is permitted in some European nation-states. Controversially, some nation-states have allowed assisted suicide for psychiatric reasons and/or underaged patients.

Commentary:

- ① This paragraph defines different forms of euthanasia and the ethical principles behind them.
- ② Respect, justice and beneficence reflect the duties of Kantian deontology and particularly W D Ross' idea of prima facie duties.

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- ① ➔ Differentiating characteristics of end-of-life choices can clarify the decision process for those in clinical settings, even if not eliminating all the moral grey areas. 'Active euthanasia' is either practitioner-delivered or physician-assisted. The term 'passive euthanasia' is best used in reference to the withdrawal of treatment that directly results in death, usually on the basis of treatment 'futility' and demonstrably poor survival prognosis. The moral argument for passive euthanasia tends to be one of 'lessening pain' using a consequentialist calculation, or a double-effect claim that death is not intended even if very likely. Active euthanasia tends to be asserted on the basis of autonomy. The 'autonomy' of the patient, both as a right to decide and as the competence to decide, can be differentiated as voluntary (wanted), non-voluntary (opposed) and a-voluntary (unknown or unknowable). Advanced directives are used to establish patient intent and/or allow the substituted judgment of a surrogate decision-maker. If a decision is moved to the courts, it is usually made using 'best interests' criteria.

Rancorous debates about abortion and euthanasia, as well as genetic modification, cloning, etc. continued through the seventies and into the eighties. Perhaps this was inevitable, given the rapid expansion of medical technology, the continuing decay of pre-industrial family structures, and a general suspicion of authority figures (especially among young adults during and after the Vietnam conflict, and disappointments following the early civil rights movement).

In response, governments formed various committees in the hope of finding consensus on medical ethics. They made important contributions, but their impact was diminished by the tendency for political leaders to select a membership that conformed to and then confirmed the political positions of the party in office. In the US, the most important was the Belmont Report (1979) which did not provide answers as much as an ethical method. The Report asserted the need to balance three values: respect for persons, justice, and beneficence, with respect centred on autonomy in decision-making. While focused on research, it rapidly came to be applied more broadly.

Commentary:

① This part of the extract introduces the influential Four Principles approach developed by Beauchamp and Childress:

- Autonomy
- Justice
- Non-maleficence
- Beneficence

Teachers may find this useful as enrichment material because these principles underpin many modern healthcare decisions and help explain how contemporary medical ethics often operates in practice.

Principlism is a practical approach to ethics that uses a set of core moral principles to resolve real-world dilemmas without getting bogged down in complex philosophical theories.

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In Britain, the response was the Warnock Committee of Inquiry which reported in 1984, ultimately leading to the Human Fertilisation and Embryology Act 1990 requiring licensure for clinics performing in vitro fertilization procedures and banning research on fourteen-day post-conception embryos (immediate pre-embryonic blastocyst). Later, Mary Warnock's prestige in bioethics lent gravitas to her work on animal experimentation and her personal support for active euthanasia as a means to relieve the very sick from 'being a burden', a moral claim reflecting strongly consequentialist thinking

- 1 ➔ The dominant version of what was soon called principlism was that presented by T. Beauchamp and J. Childress⁷. It consisted of (1) autonomy (deontological category of self-authority), (2) justice (understood in both deontological and consequentialist senses), (3) nonmaleficence, and (4) beneficence (the latter two on a continuum of actions defined by utility and virtuous motive). Principlism is an expression of its age and place, of late-modern bureaucratic and reductionistic medicine, but it can be a helpful starting point for ethical discussion, even though it rarely – if ever – leads to moral consensus.

Only autonomy (as right to and competent use of liberty) has survived as a culturally-shared value for bioethics. Justice was simply too dependent on other political and religious considerations to be helpful (though a version of 'fairness in procedure' can facilitate discussion). Nonmaleficence works, but that is simply the traditional 'first, do not harm'. Beneficence looks a lot like paternalism⁸.

Commentary:

① Late modernity is a period in which people have greater access to information, place less trust in traditional authorities, expect more equal relationships, and make decisions by choosing between competing options and outcomes.

6 Medical ethics in late and postmodernity (2024)

6.2 Late modernity: professionalization of medical ethics

The twentieth century concluded with extensive efforts to professionalize and license clinical ethicists. Even though it is erroneous to assume that medical ethics grew out of crises in late modern healthcare centres, it is true that the effort to create a body of literature and a distinct academic and professional category of 'moral expert' for healthcare did.

Across the globe, academic bioethics programs proliferated, promising to provide legitimate credentialled experts. Advocates argued that such credentials might provide quality and satisfy accreditors (as well as facilitate insurance reimbursement for services). Those opposed claimed that medical ethics should remain an ancillary discipline for persons with expertise in medicine, nursing, philosophy, and theological ethics. Further, the latter asserted, there is no shared corpus, so very little can be coherently taught as 'standard' except principlism, which does not solve much of anything.

However, recognition of this lack of foundational commonality does not eliminate the need for cooperation in decision-making within clinical settings. Arguments about abstract social questions of resource macroallocation, research limits, and defining the person become very personal at the bedside. A number of institutions established 'ethics committees' to provide guidance. These bodies sometimes advised on clinical decisions but more often developed organizational policies and provided instruction. When various accreditation bodies began to require 'ethics mechanisms', the demand for 'trained' bioethicists grew. The solution in a bureaucratic state is to add more bureaucracy.

- ① → Late modernity (or early postmodernity, if one prefers) has been marked by direct access to information, egalitarianism in moral authority, horizontal or levelled social relationships, and often market-driven decision-making (not just in the economic sense, but rather as choice between alternatives that have opportunity costs).

Commentary:

① Possible link with Paper 4B 4.3, global development of Christianity.

② Medieval hylomorphism is based on Aristotle's idea that everything in nature is made up of two parts: Matter (potentiality) – the physical material something is made from, which has the potential to become different things.

Form (actuality) – the structure, nature, or essence that makes a thing what it is.

In other words, matter provides the possibility for something to exist, while form makes it the specific thing it is.

Example: A wooden table is made of matter (the wood) and form (the arrangement that makes it a table rather than a chair or a pile of wood).

An example of how it applies in this content: a body is made of matter, but the form is the person who inhabits that body.

Possible specification link to paper 1 6.2 life after death

6 Medical ethics in late and postmodernity (2024)

6.2 Late modernity: professionalization of medical ethics

- ① → Indeed, with the collapse of Christendom (even while Christianity continues to grow globally) there is little shared moral understanding in the late modern West beyond a very thin notion of social contract. Medical practice depends on finding human life of value, but society is increasingly anomic, made up of syncretistic hyper-subjective individuals.

Stanley Hauerwas was correct in saying:

Kings and princes once surrounded themselves with priests for legitimization. Politicians today surround themselves with social scientists to give those they rule the impression that they really know what is going on and can plan accordingly. Physicians, in an increasingly secular society, surround themselves with medical ethicists⁹.)

Neither traditional medical paternalism nor late-twentieth-century principlism, let alone the mid-twentieth-century neo-utilitarianism of 'situation ethics', provided ready answers when improved healthcare led to greater moral uncertainty over financial costs for families, the emotional costliness of extended dying processes, experiences of significant on-going pain, or the existential sorrow and theodicy conundrums experienced as one sees the 'self' of a loved one seemingly slipping away even as the physical body goes on. Medieval hylomorphism debates had never really gone away.

- ② →

6.3 Twenty-first century and end of modernity: claims of scientific impotence and public health authoritarianism

Extraordinary technical advances evidenced the effectiveness of the scientific method and organizational structure. Without a doubt, recent basic research, pharmaceutical development, public health interventions, and treatment improvements have been extraordinary. Even so, the scientific community has not been of one accord. Accusations of impotence, hubris, and even authoritarianism arose in the face of two epidemics: AIDS and COVID-19.

Commentary:

① Ethical questions arose about whether people with HIV should be isolated or quarantined, and whether they had a responsibility to disclose their HIV status. There was debate about balancing patient confidentiality with protecting others, including sexual partners and healthcare professionals. Healthcare workers were generally understood to have a duty to treat patients with HIV, while patients were expected to share their HIV status confidentially with relevant practitioners and potentially at-risk partners. Questions were also raised about the financial cost of treating illnesses linked to high-risk behaviours. Some argued for higher insurance costs, but in Western societies sexual behaviour was largely seen as a matter of individual autonomy and personal choice. Over time, advances in medical knowledge, safer healthcare practices, blood screening, public education, condom use, and effective antiviral drugs (such as AZT) reduced both the spread of HIV and the intensity of these ethical debates. The extract extends this debate by raising ethical questions about smoking: should individuals bear greater responsibility for healthcare costs linked to choices they make, or should treatment be provided equally to all?

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6.3 Twenty-first century and end of modernity: claims of scientific impotence and public health authoritarianism

AIDS struck in the 1980s, serving as a massive, albeit temporary, check on the expansion of sexual openness initiated after the development of antibiotics and the birth control pill. Some proclaimed that the disease evidenced the impinging of divine judgement, others called it a sad consequence of poor decision-making, while still others asserted that it was an indicator of the marginalization of a sexual minority (this assertion was made in the West and Far East; in sub-Saharan Africa HIV centred in the heterosexual population).

- 1 ➔ Medical ethical questions were expressed over the isolation or even quarantine of high-risk [segments of the population] (as [happened] in Cuba) and obligations to reveal HIV status. For the latter, the concern was not only for potential partners, but also for practitioners. The 'duty to treat' was affirmed, distantly echoing an expectation for practitioners during the Black Death. However, a duty has come to be assumed (informal or legal) for the patient to discreetly and confidentially reveal HIV status to potential partners and under confidentiality to practitioners.

A question also arose about the costs of treatment. High-risk sexual behaviour can create significant financial burdens for healthcare and society. An argument was made that such behaviour warranted high-risk insurance. The same is true for smoking cigarettes, using intoxicants, riding motorcycles, climbing mountains, etc. Generally speaking, sexual choice in the West has been deemed a protected autonomous decision.

Eventually, AIDS was controlled by epidemiological understanding and the subsequent expanded use of universal precautions in healthcare, testing of blood supply, increased education on the use of condoms and the dangers of casual sexual relations, and, very significantly, the development of antivirals for AIDS suppression. In the end, the development of AZT and similar pharmaceuticals (at least in the West) diminished the tone of those debates.

Commentary:

① During the COVID-19 pandemic, similar issues of confidentiality, autonomy, and public safety re-emerged. Governments often prioritised public health measures such as lockdowns and restrictions, which limited individual freedoms to reduce the spread of the virus. This reflected a shift from emphasising personal autonomy to prioritising the greater good of society (a utilitarian approach). The pandemic also raised concerns about fear in public discourse and the ways some media outlets and politicians criticised people who were hesitant to comply with public health measures.

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6.3 Twenty-first century and end of modernity: claims of scientific impotence and public health authoritarianism

① → The same arguments about confidentiality and autonomy came back with COVID-19. The previous moral power of autonomy, both in bioethics and as a central claim within traditional liberty-based societies, gave way to 'shutdown' when, just before the turn of 2020, COVID began to rapidly pass through 'virgin-soil' populations. Given the presumed disease transmission mechanisms, there was far less allowance for freedom of choice in personal behaviours. A mixture of strong medical paternalism and public health utilitarianism led to the abrogation, to a greater or lesser extent, of individual rights in the vaccine-naïve populations. Fear was aroused in the mass media and seemingly not discouraged to any significant degree by governmental officials. In some countries, members of the media and politicians supportive of strong intervention used moral pollution language against those who hesitated to comply.

They also ostracized the non-compliant, eventually silenced contrary medical opinions (both those of 'quacks' and of those with substantial epidemiological and infectious disease knowledge), and, in some nations, even 'imprisoned' the resistant. In some Western societies, strong policing power was used (e.g. Canada) while others did so notably less (e.g. Sweden). In some cases, corporations were asked to participate in limitations on liberty.

Generally, the assertion of western governments (Sweden aside) was that only the highly trained could assess risk, generally defined as 'Risk = Probability of Frequency x Hazard' (or, in the case of this contagious disease, 'Risk = Transmissibility x Virulence'). Similar arguments, with less mathematical sophistication, had been used at least as early as the Justinian Plague (sixth century) and the Black Death (fourteenth century), and more recently with Mary Mallon ('Typhoid Mary' in the early twentieth century). With COVID-19, the initial uncertainty legitimated precaution, but the long-term continuation of controls became less readily justifiable, especially as a lack of official transparency became evident.

Commentary:

② This part of the extract explains how medical ethics and public health became entangled with wider political and cultural debates during COVID-19, rather than remaining purely medical questions.

6 Medical ethics in late and postmodernity (2024)

6.3 Twenty-first century and end of modernity: claims of scientific impotence and public health authoritarianism

[The wearing of masks], with proper protocols, may well have been effective in limiting spread to some degree, but the extent of such given the infectiousness of COVID and the general ineptitude in or lack of understanding about such use made population-wide mask [wearing] largely ineffective. The various vaccines had notable benefit, yet seemingly did not prove to be as effective in preventing spread as initially claimed (.

- ① → Medical ethics is no longer limited to the bedside; bioethics does not occur in cultural isolation. Unsurprisingly, the response to COVID-19 was fitted into various political narratives. Most notably, doubts about the governmental responses dovetailed with broader populist questions about the bureaucratic state. Suspicions about the supposed commercial motives of pharmaceutical companies, claims of a lack of transparency on 'gain of function' research, uncertainty about the competence of nation-state public health experts, and a general distaste for the self-presentation of public health authorities as seeming self-aggrandizing fit the narrative of populists. The internet made communication much easier, and any effort to limit such on the part of multinational social media corporations simply reinforced the claims, as strong doubts about the competence and trustworthiness of what was labelled 'the medical establishment' were raised. In response, the protesters were labelled demagogues whose desire for power would harm the public's health.

This bioethical conflict remains a factor in current debates about US governmental and EU bureaucratic authority.

Commentary:

① This part of the extract argues that COVID-19 restrictions raised important ethical questions about when governments are justified in limiting individual freedoms.

Just Coercion Theory: the idea that government restrictions on people's freedom should only be used when they can be morally justified according to criteria such as legitimate authority, proportionality and a reasonable chance of success. You could think of Just Coercion Theory as applying ideas similar to Just War Theory to public policy. Just as a war requires moral justification before force is used, the state should have moral justification before restricting citizens' freedoms. This is why the author believes it could have provided a clearer ethical framework for evaluating COVID-19 restrictions.

Link with the wider medical ethics question about sanctity of life

6 Medical ethics in late and postmodernity (2024)

6.3 Twenty-first century and end of modernity: claims of scientific impotence and public health authoritarianism

① Lower expectations would perhaps have made the use of restrictions seem far more of a 'victory'. Amongst Christians, uncertainty about the on-going restrictions was exacerbated by two factors: what appeared to some as selective enforcement, and the use of foetal material in vaccines. These became political issues, especially in the US and Canada, with the claim that governmental force requires proper moral justification. Arguably a better moral approach that might have addressed concerns of both populace and experts would have been the transparent application of an analytical tool from the Christian moral tradition: 'Just Coercion Theory'. After all, public health restrictions are, for better or worse, coercive (a common listing of the criteria for coercing with policing power include: Justifiable Cause, Right Intention or Motive, Legitimate Authority, Proportionality of Response, Reasonable Chance of Success, Reasonably Last Resort, and Discrimination in Protecting Bystanders).

Policing in the name of public health has been employed against using vaping devices, consuming soft drinks, owning guns, evicting squatters from rental properties, etc., as well as for and against marijuana legalization. Arguably, state authority should be used to protect the population, though the use of a greatly-expanded definition of 'health' is morally problematic in a society with fewer shared values as an unethical claim of authority legitimacy. Unfortunately, during the initial COVID-19 outbreak, medical ethicists provided 'expert' talking points for the media, but seemingly contributed little to the broader social discourse about closed schools, businesses, churches, and borders.

② At least one COVID vaccine used live foetal cells, as do some of the vaccines for rabies, varicella (including one for shingles), rubella, and hepatitis A. During the COVID outbreak, some evangelicals and a few Catholics refused vaccines for conscience's sake. Other Protestant responses have varied widely. The Roman Catholic Church allows such vaccines if no alternative is available [as confirmed by the] Secretariat of Pro-Life Activities [in 2021].

Commentary:

① Christian responses to ART (assisted reproductive technologies) vary. Some oppose it because they believe conception should be left to God, while others accept it under certain conditions, particularly if embryos are not deliberately destroyed

② A non-interventionist argument says that people should not interfere with natural reproduction through medical technology. Instead, they should trust God or the natural process to determine whether conception occurs.

You could link this to:

Natural Law, sanctity of life and the debate over "playing God": whether humans should use technology to control reproduction.

6 Medical ethics in late and postmodernity (2024)

6.4 Twenty-first-century postmodernity: contagious anomy and redefining embodiment

By the second decade of the twenty-first century, expanded definitions of 'health' included not only meeting biological potential, but also exceeding the natural standard. Some redefine 'health' such that it requires changes to the essential individual human or even the species, and they want medicine to facilitate those changes.

Altering genetics through controlling conception is as ancient as arranged marriages and as recent as twentieth-century eugenics. In 1996, however, the speed and manageability of such alterations changed dramatically. In Scotland, Dolly the sheep was born from a cloned and implanted cell (using somatic cell nuclear transfer), the first mammal so bred. Within a few years, the technologies were expanded and applied to humans as assisted reproductive technologies (ART). A number of these methods are generally accepted in the US and Europe.

- 1 ➤ Christian communities still debate whether ART is morally permissible. Some use a non-
- 2 ➤ interventionist argument, based either on scriptural references about 'trust' or natural law, that persons should leave the outcome up to God. This, however, would seem to disregard the fact that all medicine has an interventionist component. Some do allow ART, but only if there are no intentionally-lost fertilized eggs (using a genetic definition of person and a deontological right to life argument). Others deem ART legitimate as long as the rate of lost fertilized eggs does not exceed typical natural loss is (another version of a natural law argument).

What was and is morally unacceptable for most religious persons is the instrumental use of embryos or foetuses, be they unimplanted ART zygotes or aborted foetuses (see above for exceptions). Western Christians seem to be generally willing to tolerate the use of adult-derived stem cells (multipotent¹⁰) conditioned by the expectation that no effort would be made to further undifferentiate the cells back to pluripotency¹¹. Laws on the clinical use of stem cells and research vary across Europe, and within the US (though federally unfunded, several states provide incentives). The counterargument to the general Christian position has been that totipotent¹² and pluripotent stem cells could provide significant benefits as research materials and as a source of treatment products. In some parts of the world, efforts proceed with little impediment, such as in Singapore and China.

Commentary:

① The ethical risks and possibilities of human genetic engineering, particularly the idea of using it not just to treat disease but to enhance or redesign human beings.

Recommended viewing: Gattaca (1997) takes a deep dive into the ethical implications of genetic engineering as a social norm.

6 Medical ethics in late and postmodernity (2024)

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① → ART does not involve genetic engineering per se. Genetic engineering of human beings became a genuine possibility, even to the point of permanently altering the species (as some 'transhuman' advocates have long sought)). Genetics might be altered somatically for beauty or prowess or intelligence, but more significantly the germline might be changed to 'positively' improve one's future offspring, as determined by those with political or corporate authority. The increased genetic engineering precision allows targeting specific diseases for personalized genetic care, yet also opens up the possibility of creating new categories of beings (species) through 'gain of function'. It would be naïve to think that dictatorial nation-states and aggressive corporations are not currently working to genetically 'improve' the human body. This will become even more morally complicated if genuine transhumans can be created, whereby genetically altered bodies are yoked to artificial intelligence (AI).

Changing the body to match some ideal is ancient. Tattooing has existed for millennia. Cosmetic plastic surgery has been readily available for half a century. These tend to be relatively minimal, more like permanent make-up. Medical ethics problems arise, however, if sought procedures are more extreme. These procedures occur as the patient (or his/her surrogate) seeks a 'cure' in the form of radical alteration of appearance through pharmaceuticals and/or surgeries such as elective alteration of limbs, facial alterations inconsistent with the species (e.g. horns, tattooed eye whites), etc. If considered harmful, facilitating such would violate the first duty of the physician. Yet, if the patient seeks such procedures, to not assist might be deemed paternalism.

Commentary:

① The author argues that modern medical ethics has moved from simply tolerating individual choices to expecting others to actively support them. This creates conflicts between patient autonomy and healthcare professionals' conscience rights.

② When children are involved, there is further disagreement about whether parents, doctors, governments, or young people themselves should make decisions. The author concludes that because society no longer shares common beliefs about identity, authority, and the human person, it is difficult to reach agreement on many medical ethics issues.

Recommended Viewing – Best Interests (BBC/Netflix drama) 2023 focusses on parental disagreement over treatment of their daughter who has muscular dystrophy.

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6.4 Twenty-first-century postmodernity: contagious anomy and redefining embodiment

Currently, the medical ethics debate that is culture-wide has occurred over the use of medical procedures to change appearance such that it purportedly matches 'true' identity. The patient (or surrogate) believes that medical technology can provide a solution or cure to a social and existential crisis. The decision to proceed assumes that one's biological identity is 'wrong' or 'inadequate', and therefore that the physical body as configured is an unessential modality accidentally imposed on the true self. Unlike Christian hylomorphism (that the self on this earth is, in some sense, the physical body and soul/mind), or modern physicalist reductionism (the self is only the physical body), the argument uses a version of non-material idealism reducing the physical body to instrument.

- ① → Unlike traditional liberty, this newest expression of autonomy means that neutrality and toleration are immoral. This can result in medical professionals being required in some institutions or jurisdictions to not only tolerate or respect patient choices with which they might not agree, but to affirmingly facilitate. Debates over practitioner conscience rights versus patient autonomy quickly follows. Large hospital systems in the US (excepting those affiliated with Catholicism, the Seventh Day Adventist Church, and some other Protestant groups), the National Health Service in Britain, and the various national professional bodies have tended to align with the affirmation position, at least for adult patients.
- ② → In the case of potential procedures with those under-age (children or adolescents), moral authority might be shifted to the parents under legal subsidiarity, yet the epistemological problems remain. The legitimacy of parental decisions are increasingly being challenged by legislatures, schools systems, and bioethicists on both sides of the issue. Not only is the status of the physical body increasingly uncertain at the end of modernity, disagreement over sources of moral authority (e.g. church, parents, etc.), and the possibility of functional middle axioms (e.g. Constitutional standards, English common law) seems to leave medical ethics with no basis for ethical discourse, let alone moral agreement.

6 Medical ethics in late and postmodernity (2024)

6.4 Twenty-first-century postmodernity: contagious anomy and redefining embodiment

1 Fletcher, Joseph F. 1954. *Morals and Medicine: The Moral Problems of the Patient's Right to Know the Truth, Contraception, Artificial Insemination, Sterilization, Euthanasia*. Princeton, NJ: Princeton University Press.

2 Ramsey, Paul. 1970. *The Patient as Person: Explorations in Medical Ethics*. New Haven: Yale University Press.

3 Key court cases after *Roe v. Wade* included *Webster v. Reproductive Health Services* 492 US 490 (1989), upholding the denial of state funding under certain circumstances, and *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992), upholding parental consent for minors. Most importantly, *Dobbs v. Jackson Women's Health Organization* effectively overturned *Roe v. Wade* and *Planned Parenthood v. Casey* by returning legal authority to the states.

4 According to two Supreme Court rulings: *Washington v. Glucksberg*, [1997]; *Gonzales v. Oregon*, [2006]

5 Christian hylomorphism, primarily developed by Thomas Aquinas from Aristotle, defines human beings as a substantial unity of body (matter) and soul (form). The soul is the 'substantial form' that animates and organizes the body, making it a living, rational human, rather than just a ghost in a machine.

6 In the US this position was reached through a series of court cases: the *Karen Ann Quinlan* case in New Jersey (1976) allowed removal of a ventilator; the *Nancy Cruzan* case, coming from Missouri and decided in the US Supreme Court (1991), allowed withdrawal of assisted nutrition and hydration with 'clear and convincing evidence' of the patient's wishes; the *Terri Schiavo* case in Florida was rejected several times by the US Supreme Court, thus allowing family member decision authority.

7 Beauchamp, Tom L., and James F. Childress 1979, *Principles of Biomedical Ethics*, New York: Oxford University Press.

8 Paternalism was the dominant ethical and practical framework in nineteenth century medicine, in which where physicians made decisions for patients without their input, believing they were acting in the patient's best interest.

9 Hauerwas, Stanley. 1996. 'How Christian Ethics Became Medical Ethics: The Case of Paul Ramsey', in *Religion and Medical Ethics: Looking Back, Looking Forward*. Edited by Allen Verhey. Grand Rapids, MI: Eerdmans, 61–80.

10 Multipotent stem cells are stem cells that can turn into a limited number of cell types.

11 Pluripotent cells are able to turn into any type of cell except for embryonic or placental.

12 Totipotent stem cells have the ability to form embryonic and placental cells.