Bioethical Challenges in the *New Millennium*

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If there is any field of interest that has engaged both philosophers (ethicists) and theologians (moralists) alike more than any other in recent years, perhaps it is bioethics. If one examines the literature in this area, one will discover a plethora of writings of both ethicists and moral theologians. The topic is interesting, for sure, but more so intriguing, generating as it does much debate and controversy. The reason is obvious. No other discipline has grown and developed in scope in recent years as to include wide-ranging issues that directly affect people's lives and have a bearing fir the fixture of humanity. No other discipline has posed such challenges of utmost urgency that require immediate scrutiny and discussion. This paper is about these challenges.

But first, there is a need to clarify the term "bioethics" and the sense of it that is used in the present discussion. It was actually *Van Rensselaer Potter* and *Sargent Shriver* (independently of each other) who coined the term bioethics in 1970.[1] Potter, in particular, used it to refer to that branch of ethics that can incorporate our obligation, not just to other humans, but to the biosphere as a whole. The accent in meaning is obviously ecological. As it is used

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[1] See VAN RENSSELAER POTTER, Bioethics: Bridge to the Future, Prentice Hall, Englewood Cliffs, N.J., 1971; C. BRYAN, "Bioethics: A Young but Relevant Discipline", Center for Bioethics and Medical Humanities, University of South Carolina, Columbia, p. 58-63.

• ***PHILIPPINIANA SACRA*, Vol. XXXIX, No. 115** (January – April, 2004) **77-96**

nowadays, however, it refers to the study of ethical issues arising from the biological and medical sciences. In fact, it also used to be called biomedical or simply medical ethics. In this more popular usage, it has become an interdisciplinary, albeit specialized, study. It is not surprising then to see how questions originally arising from health care issues, for example, have become a matter for bioethical discussions as well. Today, health care can no longer be isolated from bioethics.

And what are challenges? Usually, we think of challenges as referring to difficult, demanding and stimulating tasks. Thus, they can be events or occurrences in life that require attention and human effort; events that require the exercise of responsibility because the lack of it can mean harmful if not disastrous consequences for humanity. These developments are precisely what we face in the area of bioethics in the new millennium, There are methodological challenges, as well as challenges posed by technological advances in bioethics, and the challenge to put priorities in place.

CHALLENGES IN METHOD AND APPROACH

a) The Challenge of Inculturated Bioethics

First of all, globalization has become a fact of life in the new millennium. We see this not the least in the area of bioethics. Indeed, bioethical problems in the West are easily transported and communicated to the developing world. In fact, some if not many of the problems in the West have also become the problems of the developing world. In a way, there are no longer problems that can be isolated without affecting the global community as a whole. Still, it must immediately be said that the solutions to the problems that are horn in the West may not necessarily be the solutions that should be adopted in the developing world. These problems may even come in the developing nations not only as they are received in a different (e.g., Asian) context, but they may also come in different forms. Thus, solutions from the West should not be automatically imported as it were because they may be culturally determined and may not work in the culture where they are transported. In social ethics, for example, nursing homes may not necessarily be the solution to the problems surrounding the elderly in Asia where family ties are still strong. For such being the case, the best environment for the care of the elderly remains to be the family and the home.

Therefore, as in any other discipline, there is a need for an inculturated methodology and approach to bioethics issues. There is indeed a need to construct for example an Asian or more specifically Filipino bioethics. Instead of a bioethics that is built on Western values and principles, efforts must be made to draw out a bioethics that flows from the Asian or Filipino setting. Some attempts have already been initiated as far as this is concerned.

D. Miranda's *Pagkamakabuhay* is one such example,[2] but the task remains basically unfinished. As Miranda himself claims, the bases exist for constructing something which could eventually and properly be called Filipino bioethics and that Pilipino bioethics is possible in principle. Indeed, the principles are already there but it still demands quite a bit of work, not only to specify these values, norms and principles but also to systematize them into coordinated categories.[3]

The task of construction could be done from various perspectives, for instance from the scientific or medical view, or from the nationalist political view. But it seems more appropriate to do it from the soda-cultural view so that the bioethics drawn out of this perspective can truly be responsive to the bioethical problems of Filipinos today. Bioethics must have cultural and contextual relevance as well as cultural and contextual validation Bioethics can truly be recognized as indigenous and contextual if it is extracted from the Filipino-medical ethos and continuous with filipino basic ethics.[4]

The challenge then is for bioethics to reflect an awareness of cultural patterns. It must not overtly or subtly threaten to replace the religious and family tradition which are so much pan, of the culture of a society, It must not replace powerfully symbolic expres-

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[2] D. MIRANDA, *Pagkamakabuhay, On the Side of Life.* Logos Publications Inc., Manila, 1994; see also AT. ALOHA-J. LUMITAO, *Beyond a Western Bioethics, Voices from the Developing World* Georgetown University Press, Washington, DC., 2001.

[3] D. MIRANDA, *Pagkamakabuhay,* p. 45-58.

[4] D. MIRANDA, *Pagkamakabuhay,* p. 45-58.

sions of meaning, love and hope which come from a religious, ethnic, national or familial tradition. Bioethics in fact is impoverished if the human person's cultural context and resources are ignored. Thus, bioethics must strive to promote a sensitivity and respect for culture.

b) Christian Bioethics in the Midst of Relativism and Pluralism

The next challenge is that of relativism and pluralism. Pluralism is due to the fact that there is a plurality of ideals, as there are a plurality of cultures and of temperaments. In fact, epistemological pluralism holds that there is no single meaning or truth. Meaning varies as the consequences vary for the individual dual and truth is the expedient way of thinking. Because of this, there is a plurality of values which men can and do seek and these values differ. But values are objective, that is to say, their nature, the pursuit of them, is part of what it is to be a human being, and this is an objective given. So while values are multiple they are objective, that is, pan of the essence of humanity rather than arbitrary creations of men's subjective fancies. In the area of bioethics, relativism could pose a real danger because people can become too subjective: *"My values are mine, yours are yours, and if we clash, too bad neither of us can claim to be right."* Thus, one can feel free to proceed as one wishes. What this tendency has generated is not only diversity but also individualism in the interpretation of moral truth. Ethical judgment and decision becomes a matter of opinion or truth that is not amenable to argument.

Pluralism is actually the root of relativism. While pluralism cannot be avoided and that while it calls fix respect between systems of values, it cannot stand as a valid view or system itself or it degenerates into relativism. Pluralism can be the source of enrichment but it can also be the source of confusion. The challenge here is how the Christian view can stand up to this confusion and survive without getting drowned among the plurality of value systems.

Some theologians will argue that there could be nothing necessarily specifically Christian about an ethical approach because the values Christians uphold may also be values that non-Christians or even atheists can uphold, but there is a way that Christians can insist on a particular value given its sources (e.g. Catholicism's recourse to Scriptures, tradition and human experience and the natural law).

But that is not the real challenge. The fact is, the fragmentation and decomposition of the traditional tenets of the general ethics of the past and what we might call *popular morals* has led to the marginalization and near expulsion of religion/faith-inspired positions from the academic and public spheres and debates. The obvious result is the secularization of contemporary bioethics. Whereas bioethics drew heavily on religious tradition (v.gr. Christian and Jewish) in the past, this is already being overtaken by *r* philosophical ethics without any reference to any faith-inspired perspective. The root of this is moral and cultural pluralism. Accordingly, religion-based moral norms are no longer the rule of the day. Various philosophical systems instead now provide as it were the groundwork for any bioethical discussion.[5] While pluralism can result in mutual enrichment among the many philosophical systems and perspectives, it has also unavoidably sown confusion, if not outright discord. In the midst of such confusion and sometimes even dangerous situation, the ever renewed mission and responsibility of the – Catholic Church is to bring to everyone God's healing power and the liberating light of His Word. The Church is to proclaim the good news that brings with it the message of compassion, hope and redemption.

Christians cannot just "stand by" the flow of rushing bioethical challenges and allow themselves to be drawn by efforts underway in search for meaning of human life that is purely secular and shaping its destiny outside the purview of religious conviction. In the midst of these... *trends to secularization, deconstruction and derationalization of bioethics* there is *the need for an informed body of* Christian *health care professionals, who know the origins and foundations of their own faith, and its place in bioethical decisions and policies.*[6]

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[5] See "Foreword" of H. Pellegrino in P. CATALDO-A. MORACZEWSKI, eds., *Catholic Health Care Ethics: A Manual for Ethics Committees,* National Catholic Bioethics Center, Boston, 2001.

[6] See "Foreword" of E. Pellegrino in P. CATALDO-A MORACZEWSKI eds., *Catholic Health Care Ethics.*

That is for Christians to develop a sound and comprehensive stand on bioethical issues and offer their contributions with firmness, persuasive scholarship and commitment to their faith convictions. In these efforts the bioethics education that is inspired and informed by faith should form an integral and necessary part.

CHALLENGES OF TECHNOLOGICAL ADVANCE

While the foregoing challenges appear as urgent particularly in the developing world, the challenges in the West, where advance in bioethical technology has been rapid, and where governments or private enterprises can afford to fund such technology, go beyond these academic issues. Here, the basic question that requires scrutiny is whether everything that is technologically possible is likewise imperative, let alone morally acceptable. Scientific discoveries are raising questions that have become more pressing than ever in view of humanity's newly acquired capacity to manipulate the very process of life itself and have consequences that can alter human behavior. This has led to a wide range of questions from human cloning to the use of transgenic technology in agriculture for the production of genetically modified organisms.

Old questions linked to genetics are resurfacing once again, i.e. palliative medicine, care for the terminally ill, prenatal diagnosis, organ donation, medically assisted procreation, etc. New questions are also being raised on such issues as genetic data, stem cell research, pre-implantation diagnosis, participation of human subjects in experimentation and end of life care. In view of these new questions, values must be reviewed. Are they still defensible in view of new technologies?

Among these, *research on embryonic stem cells* is certainly one of the most controversial issues today. Such research should in the future make it possible to create organs and tissues, of which there is currently a severe shortage, for transplantation purposes. Stem cells are the unprogrammed master cells found in early stage embryos that can turn into nearly every cell type in the body *(totipotent)*. At first, scientists have only tried to research on these embryos (mostly donated) for purposes of studies on infertility and the detection of birth defects. But given the potential the stem cells that are derived from these embryos possess, scientists are now trying to use them for other purposes that are mainly therapeutic,[7] for example, transplants that would prevent or cure scores of illnesses like Parkinson's disease and diabetes. The idea is to extract stem cells front the embryo and allow these cells to grow (within 3 to 4 days) and to be manipulated in the laboratory to become any desired cell or tissue type that can be used for transplant. This way, neurons for example could be created to replace nerve cells in a brain killed by Parkinson's disease. Blood cells from the bone marrow could likewise be grown into nerve cells to repair a damaged spinal column or reverse the effects of *Altzheimer's* disease. Skin could also be fabricated to repair bums, and pancreatic cells could be manufactured to produce insulin for diabetes. All these show that through genetic manipulation, it is now possible to develop from these stem cells various tissues that can be used to repair damaged tissues in the body.

But the fact that these stem cells mainly come from human embryos is where the problem really is. It appears that embryos are being created for the sole purpose of facilitating research. May embryos be destroyed to obtain stem cells? Furthermore, can embryonic stem cells taken from embryos no longer destined for the purpose of procreation (for example, embryos frozen after in vitro fertilization) be disposed of? Other questions remain. For example, how does one gauge whether the research itself is acceptable and how does one guarantee that the rights of the donor parents are respected?

Opinions on the subject of embryonic stem cells differ widely, but the moral legitimacy of performing human embryonic stem cell research depends basically on the status which is attributed to the embryo. There are of course three principal positions: a) the use of human embryos for generating embryonic stem cells is intrinsically immoral; b) such use is morally acceptable for certain medical purposes and subject to rigorous safeguards; and c) taking into account the present risks linked with this research and its possible ethical implications (notably the risks of manipulation of the embryo), embryonic stem cell research should not be allowed.

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[7] There seems to be no indication yet in the literature that these embryos which are actually products of cloning ate being used for eugenic purposes.

The prospect of human cloning is also generating and provoking intense debate. There seems to be the persistent danger that cloning for reproductive purposes will be pursued and carried out, despite the fact that it has been banned both by the *Universal Declaration on the Human Genome and Human Rights,* which qualifies cloning as contrary to human dignity[8] and by legislation in many countries. Although the international community has already rejected human cloning for reproductive purposes as an unacceptable manipulation of the human being, questions remain regarding therapeutic cloning. Is it acceptable insofar as it may lead to the possible treatment of incurable and disabling diseases? Does accepting human cloning for therapeutic purposes imply taking the risk of making reproductive human cloning possible? In any event, the issue of the embryo remains, since therapeutic cloning necessarily and inevitably consists of creating an embryo for the sole purpose of obtaining stem cells.

Though less frequently raised, there are questions which are just as important from an ethical standpoint. Diagnosis, which is at the very heart of medical practice, is one of these questions. Bioethics has already had to tackle prenatal diagnosis and address the question of how to prevent the use of pre-natal diagnosis not only for legitimate medical purposes but for so-called "fetus-sex-identification," that is, to eliminate female fetuses in favor of male fetuses. With the progress of genetics, a new type of diagnosis, which also presents a threat, has come to light: pre-implantation genetic diagnosis. Such diagnosis – currently restricted for the detection of serious diseases – may yet be used again for eugenics, in other words, for eliminating undesired individuals. It may become very tempting to use this diagnosis technique for enhancement purposes or to select certain physical characteristics.

The status of the human genome is at the heart of another major question: who owns and controls genetic information? The person who has donated part of his or her genetic material? The researcher who has found an application for a discovery? The company that paid for the research? In principle, only real, useful inventions, or inventions likely to have industrial applications, can

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[8] UNESCO, 1997, Art. 11.

be patented. Nevertheless, there has been a rise in the number of requests for patents linked to the human genome and its applications, – including gene sequences, whose future applications remain uncertain.

Because of the explosion in the number of patents the costs of future therapies and genetic tests will become prohibitive for most human beings and nations. Should these discoveries be protected, depriving some people of their potential benefits? Or should intellectual property protection in this area be reduced, at the risk of deterring corporate investment because of diminishing profitability? Although discoveries in genetics compound this problem, it is not a new one, as can be seen from the debate regarding the cost of AIDS drugs, which are protected by patents and therefore too expensive for some countries.

The collection, treatment, storage and use of genetic data raise a host of ethical questions, such as questions on the aim of the collection, informing sample donors, free and informed consent on the part of donors, regard for particular sensitivities of particular social, religious and ethnic groups regarding human tissue; precautions which must be taken when conducting genetic tests (such as parentage testing) considering their implications for the people tested and others; the confidentiality; and fate of the samples.

Here too, the progress of genetics entails potential dangers. For example, the systematic compilation of files containing genetic data about individuals could open the door to many new types discrimination, not least, discrimination against individuals shown to have a genetic anomaly signaling disease or the risk of developing a disease. People could be barred from jobs by employers wishing to prevent the development of occupational diseases among their employees. They may also be refined, or charged more for, insurance. Some people may even be blacklisted by credit organizations. There is also a risk of other types of discrimination where the findings of a genetic survey conducted on a given population may lead to the stigmatization of entire groups.

Population genetics provide many examples of the complex issues bioethics must address. The study of genetic variations in populations, makes it possible to identify migrations or trace the spread of diseases. But here too we find some ethical issues already raised earlier. Populations being studied must give their consent, their informed consent. However, does the notion of individual consent, prevalent in western societies, mean anything, for example, among indigenous communities? In which language should the explanation required to obtain informed consent be given? And if research bears fruit, in the form of patents, without benefiting the community that donated the sample, would this not be tantamount to so-called bio piracy?

In fact, some of the problems concerning genetic data, such as confidentiality and consent, can already be found in conventional medical practice. As far as human organ and tissue donations are concerned, we can observe that the field of bioethics is expanding. This field has been facing major questions for some time. For instance, how could the emergence of trafficking in human organs, such as kidneys, liver and pancreas – or of human tissue: cornea or bone marrow etc. – for which there is a strong demand be avoided? Genetics now raise new questions about, notably, the use of xenotransplantation (the transplantation of genetically engineered animal organs into a human body) and genetic engineering in stockbreeding as a potential source of organs which are compatible with the human body.

The donations of human organs and tissues brings us back to the question already raised about patents. Even if the current imbalance between organ supply and demand were to be corrected, this success would come at a cost – especially heavy for the developing countries – and there is no reason to believe that some sort of equity will be found among those in need of organs and tissue. Here we face the more general, ethical problem of solidarity. If the human genome is the heritage of humanity, should not the benefits of research – mainly conducted in industrialized countries, often using material from other countries – be better shared?

The life sciences are constantly adding to these already numerous and often intertwined ethical problems The applications of genetic research, those already available and those yet to come, are having and will have a strong impact on health, the economy, social life and also on private life, on relations between generations etc – indeed they are now real challenges that can no longer just be ignored.

STEWARDSHIP ARID RECOGNIZING PRIORITIES[9]

a) *Resource Allocation as a Priority*

It is easy to think that the problem and challenges of the West are also in the developing world, considering the fact that what happens in the West in no time reaches the shores of time developing world. Given the fact of globalization, there is no longer any problem in the West that is not known and felt in some way in this poor side of the globe. Be that as it may, the problems and challenges in the developing world as already mentioned come in the particular context of poverty. In this context, what seems more challenging is not the threat and perils of technological advance as it is in the West because they may not yet even be easily available here, but rather much more of the task of recognizing and putting into place priorities in the area of bioethics and health care. What presses this idea to come to the fore is the revived interest among moral theologians in time *Principle of Stewardship* and its particular application in bioethics and health care.[10] In this area, the problem of *resource allocation* and the issue of *preventive health care* appear to be of paramount priority and importance.

The problem of resource allocation, in particular, is fit not only in the developing world but in wealthy countries as well. In a way, there is no country in the world today that does not face resource allocation dilemmas. It is a fact that health cue resources have always been rationed for one reason or another.[11] But in affluent nations, the issue is raised not so much in the context of poverty or the application of strict distributive Justice but rather

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[9] J. ROJAS, "The Principle of Stewardship", in *Vinculwn* 20/2 (March 2003), pp. 244-260.

[10] See B. ASHLEY-K O'ROURKE, *Ethics of Health Care,* Catholic Health Association of the US., St. Louis, Missouri, 1986, p. 29; G. KOPACZYNSKI, "Stewardship, Dominion, and Autonomy", in *Ethics & Medics* 20/9 (September, 1995), pp. 1-2. The *Ethical and Religious Directives for Catholic Health Care Services* (henceforth ERD) issued by the National Conference of Catholic Bishops of the United States in June 15, 2001 makes reference to the principle of stewardship at least five times in regulating behavior in health care situations.

[11] J. KILNER, *Who Lives? Who Dies?,* Yale University Press, New Haven and London, 1990, p. 8.

in regard to patient selection[12] based on other criteria other than simply economic.[13] The challenge is how to make policy makers, legislators and everyone involved in the whole bioethical enterprise to recognize these priorities especially in the developing world. Invoking the idea of stewardship seems to be a step forward towards this direction.

This development, of course, is rather relatively new since in the past, stewardship was usually discussed almost exclusively in the area of environmental and social ethics, and also particularly in relation to the application of the *Principle of Distributive Justice.* In bioethics and health care, distributive justice has also become an issue in many conflict situations, thereby inevitably raising the question of stewardship. Moreover, there has also been a growing emphasis on *proportionality* as a criterion of distributive justice, a consideration, which cannot be separated from the issue of stewardship.[14]

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[12] See for instance J. KILNER'S already cited book *(Who Lives? Who Dies?),* ASM, "Genetics and Dominion over Nature", *Ethics & Medics* 21/2 (February, 1996), pp. 3-4.

[13] ANONYMOUS, "Innocence and Life", in *Ethics & Medics* 7/8 (August, 1982), p. 3-4; P. MENZEL, "Rescuing Lives: Can't We Count?", in H. KUHSE/P. SINGER, eds., *Bioethics, An Anthology,* Blackweli Publishers Inc., Malden, Massachusetts, 2000, p. 351-353; N. RESCHER, "The Allocation of Exotic Medical Lifesaving Therapy', in H. KUHSE/P. SINGER, eds., *Bioethics,* p. 354-364; AB. SHAW, "In Defense of Ageism", in H. KUHSE/P. SINGER, eds., *Bioethics,* p. 374-379; S. REDMAYNE/R. KLEIN, "Rationing in Practice: The Case of In Vitro Fertilization" in *British Medical Journal* 306 (1993), p. 1521-1524; 111. KITZHABER, "Prioritizing Health Services in an Era of Limits", in *British Medical Journal* 307 (1993), p. 373-377; M. BUXTON, "Economic Appraisal and Prescribing Choices", in *Prescribers' Journal* 33 (1993), p. 133-138; J. SIMS, "Rationing Comes by Stealth", in *Healthcare Management* 1 (1993). p. 23-26. Press, Washington, D.C., 2001, p. 103-111.

J. Kilner lists social, socio-medical, medical and personal criteria (see 1. KILNER, *Who Lives? Who Dies?).* He evaluates these criteria and suggests what in fact among them are morally viable.

[14] The ERD implicitly links proportionality with stewardship when it states: *"The truth that is a precious gift from God has profound implications for the question of stewardship over human life. We are not owners of our lives and hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome."* The idea of "insufficient benefit" or "excessive burden" clearly indicates the application of the criterion of proportionality.

But how does the idea of stewardship become the basis for establishing priorities? Stewardship, in general, means the protection, care and proper use of this world's resources. The idea of proper use, however, also includes allocation and distribution, given the fact that resources are limited especially in the area of health care. Indeed, medical and health care resources remain scarce in many parts of the world even in affluent countries. Thus, the question is, how are they to be allocated, such that they are made available where they are needed in an equitable way. It is here where considerations of distributive justice come in and inevitably inform, and rightly so, the physician's or health care giver's decisions about resource allocation. The principle of distributive justice requires that life-enhancing opportunities afforded by health care be equitably distributed. In fact, how to accomplish this distribution has become the focus of disagreement.

Furthermore, the environment for the delivery of health care has become more varied. Sites of care are shifting and managed care continues to grow, yet health care systems do not seem to serve all citizens well. Major reform is definitely needed[15] especially in underdeveloped countries like the Philippines. It is, however unclear how this could be done so that health care becomes available indeed in an equitable way.

The point is that if ever people are now paying attention to the question of resource allocation in health care, this is due to the rowing awareness of the demands of stewardship, distributive justice and proportionality.

Christianity espouses stewardship but it is not unique to it. In ha, the world's spiritual traditions maintain that an essential aspect of the human state is the principle of stewardship of the created order. This is the universal belief that human beings are called by nature to nurture; protect, use; order, and adorn the earth and all living and nonliving creatures in harmony with and obedience to the fundamental laws written into the very nature of all things. Thus, the steward is a manager, not an owner. In an era of rising consciousness about the physical environment, humans

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[15] *Annals of internal Medicine* (A position paper), in *acponline. org/journals/ annals/0 lapr98/ethicman. htm,* p. 1.

are called to a sense of moral responsibility for the protection of the environment.[16]

While stewardship understood in this way means primarily the preservation and conservation of nature, it does not in any way preclude the creative transformation of nature. In performing this task, however, human beings must recognize that they can only proceed within a certain limit and that the resources with which they must work are not necessarily inexhaustible.

Thus, stewardship is not a license for doing anything or for trying out anything that is possible. Rather it entails more than anything else, restraint and responsibility in the use of this world's resources. No matter how human beings may progress in science; freedom, and power, they dare not abuse this responsibility and in the process contradict their own human nature without destroying themselves and their environment.

The sad fact is that, in the exercise of stewardship, human beings take it for granted that the world's resources are slowly being depleted in the name of progress and technology. Nature is not so much creatively transformed as it is rather relentlessly exploited. Above all, human beings have failed to identify and understand their authentic needs, and their potentialities. Simply driven by the desire to satisfy wants people have wantonly engaged in research and experimentation without taking into consideration the risks and the evil consequences involve.

Indeed, there is abundant evidence that the human presence on the earth currently disfigures the natural world. To make matters worse, the "advantages' that have been envisioned by such wanton plunder of nature are confined to only a few and do not really reach the majority they are meant to benefit. There is clearly here another issue, namely, how the equitable distribution of resources could be realized.

In the Catholic tradition, one concrete way in which this might be accomplished is through the application of the *Principle of Distributive Justice.* As an ethical principle, distributive justice refers to what society or a larger group owes its individual members

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[16] See W. BYRON, *Toward Stewardship,* Paulist Press, New York, 1975.

in proportion to: first, the individual's needs, contribution and responsibility; second, the resources available to the society or organization and third, the society's or organization's responsibility to the common good. Understood as such, the principle of distributive justice implies that society has a duty to the individual in serious need and that all individuals have duties to others in serious need. In decisions regarding the allocation of resources, such as rationing decisions, the duty of society is not diminished because of the person's status or nature of illness. Everyone is entitled to equal access to basic resources necessary for living in a human way. In other words, allocation decisions should not be based upon judgments of the quality of persons. Benefits and burdens should also be distributed in a just manner.

It is this idea that is now being invoked in the area of bioethics and health care. In this context, distributive justice requires that everyone receive *equitable access* to basic health care necessary for living a fully human life insofar as there is a basic human right to health care. This has to be explicitly stipulated especially because there is hardly an abundance of health care resources. In fact managed care can be seen as a means for rationing health care as a strategy to use limited resources more effectively and efficiently.

But the question is, how does one ensure an equitable distribution or allocation of health care resources? What criteria should be used? Moral theologians have proposed the application of the *Principle of Proportionate and Disproportionate Means.* According to this principle resources must be used in proportion to the health condition of the health care beneficiary, to his own or his family's capacity to avail of such resources given their cost, and to the good and needs of the community as a whole or other health care beneficiaries. The disproportionate use of these resources is a violation of distributive justice and thus of proper stewardship as well.

The principle is particularly helpful in the analysis of ethical questions arising from the general obligation to preserve human life and the limits of that obligation. For instance, the principle addresses whether the forgoing of life-sustaining measures constitutes euthanasia in certain circumstances. It also guides individuals and surrogate decision-makers in the weighing of benefits and burdens.

The distinction between proportionate and disproportionate means is in itself also based on general criteria. A proportionate means is any treatment that, in the judgment of the patient and in the given circumstances, offers a reasonable hope of benefit and does not entail an excessive burden or impose excessive expense on the patient, his family or the community.[17] What is a reasonable hope of benefit to the patient should be judged within the context of the whole person. Generally, a treatment or means is not too burdensome when it offers benefits that outweigh the burdens to the patient and others.

A disproportionate means is any treatment that, in the patient's judgment and in the given circumstances, offers no reasonable hope of benefit to him, or entails an excessive burden or impose excessive expense on him, his family or the community. In other words, the burdens or risks are disproportionate to or outweigh the expected benefits of the treatment.[18]

The distinction between proportionate and disproportionate means has been equated with the distinction between *ordinary* and *extraordinary means,* a distinction used by the 1980 Vatican Declaration on Euthanasia.[19] According to this document, one is not obliged to preserve his/her own life by making use of extraordinary means. In fact, one may forego with its use and that any insistence on its continued use constitutes a violation of distributive justice and stewardship.[20]

In any case, whatever treatment is contemplated, its impact on the community must be mentioned. And while the patient is said to be the person who must judge when the medical treatment becomes excessive, such judgments are not considered purely subjective within the Catholic tradition. In other words, the patient's decision must be based on an objective assessment of the reality of things. And even if a particular treatment were to hold out "a reasonable hope of benefit", the patient could properly and morally

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[17] ERD 56.

[18] ERD 57.

[19] Sacred Congregation for the Doctrine of the Faith *Declaration on Euthanasia,* Vatican, May 5, 1980.

[20] See also ERD 32, 56 & 57.

decline the treatment on the basis that it imposes "excessive expense on... the community."

If a patient can individually reach such a decision, why cannot a community of potential patients reach a similar decision, namely, that certain types of treatment in certain circumstances excessively burden the limited resources of the community and, as such, should not be available, even if they might offer sonic level of benefit?

Here is where the values of dignity of the individual, of the common good, and of the care for the poor come in. The American Bishops could not have stated it more clearly when they urged that,

> *"...a just health care system will be concerned both with promoting equity of care to – assure that the right of each person to basic health care is respected – and with promoting the good health of all in the community."*[21]

The overall concern in this statement is that there should be a determination to promote and defend human dignity, ensure adequate health care for the poor and underinsured, and exercise "responsible stewardship" of health care resources.[22]

It should be noted that respecting the dignity of the individual does not mean providing each person with every form of treatment he or she might want. Rather, it requires meeting the basic health care needs of each Individual. This does not stand in opposition to the common good for *"the common good is realized when economic, political and social conditions ensure protection for the fundamental rights of all individuals, and enable all to fulfill their common purpose and reach their common goals."*[23] Thus responsible stewardship requires that we use our limited resources in a way that meets the basic needs of individuals and raises the overall health of the community. The poor provide the vantage point from which one might judge how well this challenge is met.

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[21] ERD, Intro., Part 1.

[22] "Protection of Conscience for Health Care Providers", by the New York State Catholic -. Conference in *consciencelaws.org/Conscience-Policies-Papers/PPPcatholic01.html.*

[23] ERD, Intro., Part 1.

b) Basic Preventive Health Care as a Priority

The question of allocation as a requirement of stewardship also arises in the area of bioethical research and experimentation. Much is being said these days about experiments, for example, in reproductive technology, genetic engineering and human biotechnology. As already mentioned, there is recently this ongoing debate concerning experimentation involving the so-called *embryonic stem cells*.

All this discussion ultimately raises the question as to whether it is justifiable for science to spend too much resources on such expensive experiments. As seen in the foregoing discussions, tackling this question inevitably raises the issue of the morality of such experiments. But even if one were to prescind from any consideration of the morality of the procedures involved, do these experiments or their positive yield benefit the majority? While some of the results of these experiments, particularly in the area of reproductive technology (e.g. in vitro fertilization and artificial insemination) have already become available, generally they remain still too costly and unaffordable to most ordinary citizens, mainly because they are poor, or in wealthy countries, they are uninsured or underinsured fix experimental treatments.

Such being the case, these researches and experiments do not seem to be an exercise of stewardship. All the more does this become glaringly true in poor countries like the Philippines, which can hardly afford such expensive experiments. For how can a poor country spend so much public (or even private) finds on such expensive undertakings without being able to provide basic health care and medicine to its citizens? Even in developed countries, the disproportion does not disappear since these experiments remain too cost high, yet yield very lift le benefit. It is recommended then that stewardship might better be exercised if the dominant health care strategy is focused more on prevention rather than on cure[24] that is carried out through expensive means. That indeed is the challenge. Prevention of illness can benefit more people and could

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[24] T. SHANNON, "Human Embryonic Stem Cell Therapy", in *Theological Studies* 62 (2001), p. 811-824.

be made available in more proportionate means. We are not proposing here a stop to researches and medical advance. We only want to suggest that if funds were to be spent for these high tech experiments intended to generate high cost therapies, a corresponding proportionate amount should also be spent for providing basic health care, mainly through prevention of disease. Thus, while we do legitimate research, we should not forget to initiate "the kind of interventions that would he beneficial for all citizens and not just for the wealthy."[25]

CONCLUSION

The challenges that we face in bioethics today in a way depends on where we are. In the West and generally in wealthy and industrialized societies, the challenges revolve around the use of technology and its implications and consequences to human behavior. Here, bioethics and health care are distinguished by an extraordinary reliance on technology. The trend is to have control over nature through the use of technology. This trend is certainly creating new opportunities for human life. Technology, for instance, can now aid diagnosis and treatment with much more efficiency. This, however, has also given us the false courage and conviction that we can overcome every problem, conquer every disease and control every contingency if we work at it long enough and develop the right techniques and instruments. This passion for progress, mastery and control through technological achievement makes us somehow oblivious of our limits and makes us vulnerable to the tyranny of technological domination.

Just having medical technology around creates a mind set that technologies that can be developed ought to be developed; and if we have it, we ought to use it even if its use may create more harm than benefits. The availability of technology has raised ques-

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[25] T. SHANNON, "Embryonic Stem Cell Therapy", in *Anthony Messenger,* January 2002, p. 29-33, p. 33. In his conclusion, Shannon observes that "Perhaps, then, the more critical question to be debated is not the moral standing of the blastocyst and its use in research but the justice of the current U.S. health care system." [TS 62 (2001), p. 824] In effect, he is suggesting that this is more fundamentally a stewardship issue.

tions about its appropriate use. In a society that is captivated by science and its awesome results and efficiency, we can easily lose sight of the overall purpose to be served by technology, that Is, In service of the total good of the human person The temptation to be dominated by technological advance stands in opposition to the unrecognized wisdom that not everything that can be done ought to be done.

The picture changes in the developing world. Here, the challenge is not so much the appropriate use of technology because this is still scarcely available here. Rather, it is the perennial issue of poverty which not only deprives people of the advantages of technology but even of basic and preventive health cart What makes the situation worse is that not only are resources scarce, they are also inequitably distributed as they are usually available only to the rich, thus the challenge of resource allocation and distribution.

Challenges are meant to lead us to action. They call for decisions and rightly so because in the area of bioethics, these challenges have to do with the sacredness of human life and the dignity of the human person. Ultimately, in any bioethical decision, it is these moral values which are at stake. Only when these values are protected, ensured and safeguarded, can one truly say that a given course of action is morally legitimate. Progress in bioethics cannot just be pursued even to the point of depersonalization. There must be a larger concern for the dignity of the human person. Technology, in particular, must be made subject to the total good of the person rather than making the person subject to its power. If technology can lead to depersonalization, poverty also dehumanizes. It is equally degrading as it also violates human dignity. Thus, efforts must be made to create a just environment that makes health care available not only to the rich but most especially to the poor.

Bioethical challenges such as these, indeed, invite creativity, ingenuity and resourcefulness that brings out the best in humanity but they also call for moral responsibility and accountability. If challenges are tasks, they are only meant to ensure that the sacredness of human life and the dignity of the human person are guaranteed. ❑