MEDICINA NEI SECOLI ARTE E SCIENZA, 21/3 (2009) 1017-1036
Journal of History of Medicine

Articoli/*Articles*

SHALL I BECOME A ZOMBIE? STORIES OF ILLNESS, ETHICAL DILEMMAS AND VISIONS OF SOCIETY

PAOLO CATTORINI
State University of Insubria, Varese, I;
National Committee for Bioethics (Rome) and National Commission for the Fight against Aids (Rome), I

SUMMARY

Three controversial ethical issues, among others, stir the debate in health care institutions, in medical associations, and in the whole society: the care of patients in persistent vegetative state, the regulation of artificial procreation, some individual requests for reshaping an healthy body. Dealing with these dilemmas, typical of advanced medical science and technological practice, implies not only balancing carefully the burdens and benefits for suffering persons, families, equipes, hospitals, cultural and religious communities, but also imaging and realizing new visions of a just society, of a beneficent (without paternalism) medicine and generally of a good life, where each moral agent could write in front of all and in worthy, convincing ways, the next chapter of the book of his/her own life.

Visions of medicine

Shall I become a zombie? Some cancer patients silently raise this anguished question, when they envisage their progressive, unavoidable decay. In an excellent book by Philip Roth, the author wonders whether suggesting his father, Hermann, to prepare his own advance directives. The father, 86 years old, famous for his physical and moral strength, suffers now from a brain tumor and does not seem

Key words: Vegetative state - Assisted procreation – Circumcision - Ethics

to have the energy to pass a surgical intervention about twelve hours long and the following rehabilition, that would imply learning again to walk[1]. Hermann, a Jewish retired insurance broker, surprisingly accepts to sign the preprinted paper and to refuse the artificial ventilation, if the disease irremediably worsened.

When literature redescribes real situations, it deeply tests our moral assumptions and makes us rethink the past sensibility and rationally justify the rules, principles and theories, that guide our common professional practices and our private personal choices. Narrative and theoretical philosophy, story telling and conceptual analysis are not sworn enemies, but two sides of the same searching for truth, for an happy and worthy solution of moral dilemmas.

Now, what will be the Hippocratic heritage in this new century? Which moral dilemmas will provoke that legacy and challange its primary duty of beneficence: to act in the interest of the patient, by preventing harm, promoting good, removing evil? This article tries to underline three problematic areas and some theoretical issues at stake[2]. The main thesis we defend, is that we need to rebuild medical ethics, beyond the so called "principlism"[3], taking in account the role of emotions, of moral symbols and leading narratives.

The analysis of important moral dilemmas (as the ones presented in the following pages) will show us the importance of an interdisciplinary, pluralistic and socially constructive dialogue and it will draw the key role of moral evaluation, making every effort to rationally justify hard decisions in health care policy and at the patient's bedside. In this reflective work, visions - as we have said - play a crucial role. As the philosopher Plato has explained once and for all, the myths are not the tomb, but rather the ground of the reason. Philosophical and especially ethical interpretations have in *mythos* and *logos* their systole and diastole, the double wing of the same passionate search for truth. *Logos* critically reflects upon the *mythos*, we believe in, and reshapes such narratives, but in no way it can

replace or get rid of them. The truth-search, we have mentioned, takes each time the form of thinking by means of concepts (theories) or by means of images (metaphors, tales). To decide the right way of dying, of procreating, of practicing medicine, we need not only a logically coherent use of intellectual concepts, but also a convincing, enchanting, promising and leading vision of a good personal and societal life.

At the beginning of life

The topic of assisted procreation produced a cultural turmoil in Italian society, since a very restricted law has been approved by the Parliament in 2004 (a law recently declared partially unconstitutional, in 2009). The prohibition of gametes' donation, of embryo freezing and of pre-implantation genetic diagnosis, prompted libertarian associations to demand a public referendum in order to amend the law. The referendum took place but did not reach the quorum required to be effective.

Beyond the result, what astonished and disappointed several expert of bioethics, like me, was the atmosphere and style of the debate: wall against wall, slogan against slogan, parody of adverse positions. A grotesque tug-of-war was played between embryo life defenders and procreative rights supporters. A liberal Catholic stand point like mine was completely ruled out and obscured. The most amazing show was the recourse to biologists in television talk programmes: some of them swore that the zygote reveals at the microscope its complete, individual identity, so it is visibly a human being already complete and having the same dignity level of a person and therefore it has to be treated as such. Others tried to convince that no biological mark of an unified human soul could be traced in the first days of embryo development, so that the initial ensemble of separated cells, without any sketch of a nervous system, has nothing to do with an individual human being, and *a fortiori* with a person.

Not to imitate this humiliating fight, advanced ethical issue, as the one regarding the nature of embryo, has to be dealt with a more correct *interdisciplinary approach*. Neither embryologists alone nor philosophers or theologians alone can solve, and even understand a question like that: "is an embryo a person?". The reason is that in the same sentence two terms appear, belonging to different disciplines: embryologists know well what can be seen at a microscope in the phase of morula, but they ignore what the word person means (and usually no biological handbook offers a definition). Person is indeed a classic key word of philosophy and theology, but their initiates don't have conceptual tools by themselves, if they do not previously attend medical lessons, to deal with the scientific side of the issue, for example to explain which are the growing factors of an human fertilized egg. Interdisciplinarity, one essential feature of bioethics[4], implies the duty that different disciplines sit at the same table, dialogue each other, mutually translate their languages, look for bridge-concepts (the concept of individual, for example, in the case of embryo debate), which enable a cognitive exchange. In the next years, it will be more and more important the effort to interpret another science or practice from our own scientific or technical point of view, and, reciprocally, to let another scientist to read our data from his own perspective and to force us to rethink our conclusions in the light of discoveries made within another scientific domain. Neurosciences and "neuroethics" could be an excellent test bench of this challenge.

Another essential methodological caveat for impending ethical dilemmas is taking seriously the *pluralistic arena*, we live and work in. As in the case of procreation law, it may happen that almost all the citizens see the necessity of a law, to avoid the so called "tube-babies Far West", but their opinions diverge about the legal contents: admitting or prohibiting insemination from donors, surrogate motherhood, embryo selection and so on. If a debate becomes a war based on the

principle "nothing or all", whoever wins (libertarian of conservative wing) will prevent the loser from following coherently his moral supreme value in such an intimate and private field like the generative decision. The minority opinion, not being legally recognized at all in its requests, will feel a deep wound (whose consequences are likely to disturb and hinder the future dialogue on similar topics), will try to sabotage the implementation of the bill, to conceal forbidden behaviours or to find alternative solution, like procreative tourism.
On contrary, if a mature society liked to frame *common criteria* for a new, controversial law, it should abandon fanatical and fundamentalist hypothesis and ask each thinking family to rank the priority of the moral points, it believes in, distinguishing what can't be renounced from what might be altered or even delayed and postponed. In the Italian law, the Catholic position, in some way, has prevailed, but, as a Catholic thinker, I have been asking - in articles and lectures - the following question: what would happen if my religion were minority in a Huxley's State[5], where only extreme forms of artificial reproduction took place, and if were neglected or fought the rights of natural procreation within an religious heterosexual marriage? Wouldn't we Christian families oppose such a law? Wouldn't we ask an abrogative referendum? Wouldn't we judge as an unfair offense the decision of the presumed majority not to partecipate in the vote and to recommend the abstension? The Italian results of the wrong strategy of inviting to escape the polls are serious: a negotiating atmosphere has been darkened and we still don't know if the greater part of Italian people actually favour the presenting restricted law in a convinced and informed way, because in the large portion of absentionists there have been also lazy, misinformed, indifferent citizens.
As you see, dealing with this kind of problems entails not only that we deepen our personal ethical position, but also that we image and trust a vision of a just society, where minorities and vulnerable people rights are protected, and where - at the same time – condi-

tions are set for an open, transparent, respectful debate, in the hope that the best solution will persuade reluctant interlocutors, instead of imposing them heavy forms of veto. I am morally against in vitro fertilization from donor (for the reason that a stranger gets in an intimate loving story of a couple, gives birth to someone, and then completely disappears without bearing any responsibility for what has happened), but I would oppose a prohibitionist law. We have got no sociological evidence that children born from an heterologous insemination suffer severe mental disorders or that family institutions are destroyed. Therefore my Christian position suggest to bet that my vision of a worthy "coming into the world" would convince, day by day, social experiment after social experiment, the supporters of a different cause. Moral traditions have to put themselves to the test of bew technological alternatives and historical choices, just to know if and how much they are rich and fruitful perspectives.

At the end of life

A common front, established among secular and religious moral traditions, can oppose - we hope - medical overtreatment, improve advance directives, prevent paternalistic attitudes, implement hospice solutions for poor and lonely terminal patients, defend terminal palliative sedation. But an hard point of disagreement remains, as regards ill persons in persistent vegetative state (PVS), that we define, in the context of this article and for the benefit of a clearer discussion, as the *permanent* condition where no awareness (no sentience, no feeling of pleasure, pain, thirst, hunger and so on) is anymore possibile, forever.

Some ethical agency affirms that artificial nutrition and hydration (ANH) are always morally proportionate and ordinary (in the sense that it is morally wrong to withdraw or withhold them), if they produce the nutritional results foreseen, if economical resources exist and if no adverse effect or physical inconvenience arise. This

is also the conclusion of the Congregation for the Doctrine of Faith, responding (on Aug. 1, 2007) to some U.S. Bishops' questions. Even if this position underlines a precious presumption in favour of life, defends the personal dignity of disabled patients, recommands a just allocation of resources for ill persons and their families, and gives voice to the weakest members of our human family, its peremptory style and simplistic final statements[6] have caused some perplexities in several ethicists. We summarize here the main critiques.

First. It is impossibile to ethically evaluate a moral action without taking in account *its meaning* and such a meaning can be understood only within a human *story*, the story of a moral agent with his/her values, feelings, style of living, relationships, ideas of beauty, vision of a good life[7]. Precedent events, consequences, cultural background, subjective affections and intentions, all this cluster of ingredients make up the *context*, that guarantees a faithful interpretation of the *text*, represented by each human deed[8]. The same kind of action, as described from an external, detached and impersonal point of view, might have different and even opposite meanings, if it is made and then judged in the concrete light of specifically different situations and stories.

Now, PVS is a tremendously new condition, usually created in the last decades by intensive care unit, a condition that legitimately receives different interpretations and therefore reveals different meanings. Some people would like to be indefinitely sustained by ANH, if they fell in PVS, because they recognize this condition as not particularly repugnant, but rather an amplified, extreme figure of the weakness and dependency, that mark every limited human life, that needs an adequate recognition, care, attention by the entourage. Other people, who still respect patients in PVS as living persons, having the same right to care of every other patient, think notwithstanding of this condition as a painless torture, an artificial stop of the dying process (caused by a severe encephalic injury), an invis-

ible prison, a defacement of personal dignity, an exile in which a person is confined, without the possibility of even expressing the primary message "please let me go".

This last position can be rightfully taken also by Christian and even Catholic believers, because this opinion does not undervalue the sanctity of personal life and does not adopt a suicidal attitude. They rather make a discernment of the meaning and consequently balance benefits and burdens of the life sustaining treatments, to conclude (signing a specific advance directive) that their life has not to be prolonged at any cost, not at the cost of this kind of survival.

As you know, in Christian moral tradition, life is a fundamental, basic, but not a supreme or absolute value, so that the main duty is living a good life (good in a Christian sense) and not expanding it as more as possibile. Life has rather to be spent for just causes and in achieving supreme values, even if that implies putting life at risk. This is the only way of honouring and not morally impoverishing its dignity.

If we don't recognize and respect both these different personal evaluations of ANH in PVS, we stifle one original vision of world and suffocate one kind of religious spirituality. It is not necessarily an overtreatment if we sustain for years and years people who need ANH and it is not a passive euthanasia[9] if we stop such a treatment, if the patient had beforehand requested one of the two alternatives in an informed, free and competent will, and if the society has freely offered all the resources needed, anything the subject decided.

It is an amazing vice to shift from a personal dimension to a professional one, giving the physicians the last word in the matter, and asking healthcare professionals to decide if a treatment (in this case ANH) is or not a proportionate one. The only thing that a clinician may evaluate is the efficacy of a therapeutic mean, that is the capacity to obtain some biological results. But when we use the term "proportionate" (an aesthetic term, one of the classic essen-

tial features of a beautiful work of art), it means the congruity, the fitness, the harmony existing between that form of care and the human world, the personal values, the existential style of a patient. It is neither a physical nor a psychological matter: it is an ethical one, and no technical expertise or scientific knowledge could transform a doctor in a moral judge. If this shortcircuit sometimes happens, due to social or ideological pressures or to professional arrogance, technicians usually cast their moral shadow in the bedside situation and substitute their own ethical stance for the patient's one.

We deeply worsen the quality of reasoning if we define ANH not a medical treatment but a daily, elementary form of caring[10]. If you attend a symposium about artificial nutrition (a kind of treatment originally thought to aid transient digestive diseases), you have to realize that an entire staff of technical competences is needed (surgeon, internist, gastroscopist, nutritionist, specialized nurses and so on) to position, control, monitor and periodically evaluate the efficiency of the device and its biological consequences. Relatives or friends of the patient may learn and implement some manoeuvres (as it happens also for artificial ventilation at home), but the methodology needs a technological leadership and responsibility. It is something completely different from keeping a body warm, clean and dry or from stripping sweetly a bed.

As we have shown in other texts, metaphors and narratives interweave ethical and even clinical reasoning[11]. Then it does not astonish us that rhetorical figures connote both daily and scientific discourses. But this dimension has to be critically analized, not to become a subtle form of propaganda. "Giving water and food" or "offering somebody something to drink and eat" is something quite different from artificially nourishing a comatose patient. Daily language words are stripped out from their authentic use and twisted to normalize something that is morally controversial. This linguistic tactics hides an ethical evaluation, that rather deserves to be rationally justified and debated.

"Eating" is voluntarily putting something in our mouth, tasting and usually enjoying it, chewing and swollowing it, and then feeling a sense of satiety. "Giving something to eat" usually means helping someone to make such an experience, filled with psychological, cultural and moral significance. Is this what happen in ANH? We understand the ethical meaning and importance of feeding someone. It means expressing, in an elementary way, the respect and care we owe to every member of our society, especially to the weakest and most vulnerable ones. But this respect, not to fall into a paternalistic bias, has to be thought and revealed through the interpretation of the *meaning* of the action, and some people, who thank anyhow the social helpfulness toward them (the readiness to hydrate them with devotion and skill), have the right to tell anyone in advance that they consider a wrong decision the choice of prolonging artificially and endlessly a sort of "dreamless sleeping".

Finally, it is absolutely bizarre to redefine these life sustaining procedures as "natural" instead of "artificial", stating that they would guarantee the normal alimentary needs, by giving stability to the nutritional functioning of a non terminal patient. If "natural" is used in a medical sense, it sharply contrasts the scientific consensus statements, that actually talk of artificial NH[12]. If "natural" is used in a prescriptive sense, it presupposes the ethical conclusion that rather should still be demostrated: the conclusion that is always a moral duty prolonging ANH in PVS. In this case some ethical questions have to be raised: why such a primary importance is given to the digestive system? Its functioning is of course essential for life, but the same thing could be said of the respiratory, cardiac or urinary systems. In the condition of PVS, should all these biological systems, in case of their failure, be indefinitely replaced by artificial devices (artificial ventilation, dialysis, an so on), for the reason that the patient is not strictly terminal (in the sense that his life may go on, if medically assisted)? Wouldn't this attitude lead us to the so called technological

imperative: "apply any available technological resource to keep life at any cost!", an imperative that sounds terrifying even in a science fiction tale? Furthermore, if the word "natural" or "normal" is identified with "proportionate" (in the sense that ANH reach their biological aim), you give rise to an ethical misunderstanding, because the proportionality of a treatment has not to be referred to the homeostasis of the living organism and it is not measured with reference to the hydrosalty equilibrium, but to the global interest of a person, with his values, belief and preferences. It would be "unnatural" and "abnormal" ignoring this anthropological dimension.

Instead of building rigid decision-charts, hard medical dilemmas have to be prepared through an advanced, informed, competent and non-directive communication, that takes in account the critical, general interest of a person, who is writing something like the final chapter of the most precious book (his life), looking for an happy, just and worthy end[13]. Such a dialogue might be improved by the presence of an *ethics consultant*, not to substitute or deprive patients, families, health operators, psychologists of their voices and responsibilities, but to facilitate the interdisciplinary debate and deepen the ethical nuances of the decision. Consultation is a land of frontier, at least in our European Countries, but the challenge has to be taken up, not to leave the matter in the hands of charlatans, of frauds, uninformed dogmatizers, of primitive and savage moral gamblers[14].

Reshaping the body.

Another important issue, which ethics in advanced medicine deals with, refers to the aims, scopes and limits of medicine[15]. Medicine has become a sort of secular religion and questions, that traditionally had been addressed to priests or philosophers, are now matter of medical or psychotherapeutic decisions. Ethics is now fortunately regaining some of what has been expropriated by science, but the fight for independency is quite hard and some people have difficulty in understanding the

difference between *how* questions (how to manage this disease? how prolonging the life? how in vitro inseminating an infertile woman?), and *why* questions (why looking for a delayed but worse death? what is the moral meaning in generating a child? why telling patients the truth?). With the excited complicity of some pharmaceutical market, powerful health care institutions and celebrated specialists, medical knowledge has settled regions of life and of ordinary experience, that normal people were used to live, handle, share and administer with their own wisdom, practical skill and mutual cooperation.

One of the most impressive example of "cultural iatrogenesis", to use Illich's words[16], is the palliative myth, the illusion of a pain free world and of a suffering free life, under the governance of anaesthesia vestals, who declare pointless bearing the pain and living crisis situation in an aware way, instead of artificially taking consciousness completely off. Fostering the moral strength to keep own's one feeling power, in spite of pain and through suffering phases, is deemed a primitive, out of fashion, foolish masochism, when sedative medical devices are available (drugs, Caesarean section delivery, epidural anaesthesia, and so on).

What scope the medicine should have? My opinion is quite simple: it is *properly medicine* every act who tries to heal a sick person, using scientific competence, technical skills and/or empirical knowdledge. The reason is that, in my philosophy of medicine, the core of medicine is the *clinic*, that is the moral enterprise of caring for an ill person. In this sense medicine is not, first of all, an applied science, but a covenant between a suffering person and a caring expert (an individual or a team): two allies who decide how much knowing and doing for the benefit of the weaker. As you can see, the heart of the matter is the *intention*, along the Hippocratic tradition (but avoiding any past paternalism[17]) of healing the sick, in the different directions that the purpose of beneficence can take: to cure, to care for, to sedate, to prevent, to rehabilitate someone who suffers for an illness.

What exceeds this field does not deserve, in a strict sense, the title of *medicine*, even if it possesses some material elements belonging to medicine: technological competences, for example, or scientific doctrine. If an unjust government causes social malaise, this is not a medical problem (the ideological use of psychiatry in totalitarian regimes was unfortunately an eloquent example of this confusion). If a technically skilful dentist drills the teeth of a marathon man (as in the movie picture directed by Schlesinger in 1976) not to cure his caries, but to torture him in order to obtain some informations regarding diamonds, that dentist is not practicing medicine, but simply making use of medical expertise. Another instance: some kind of aesthetic surgery (the Hastings Report says) are non-medical, but socially acceptable use of medical knowledge. Take for example a television star, who asks for a surgical intervention of breast reshaping, neither because of some somatic disease nor anxiety disorder, but - she confesses - because she needs new contracts and her beautiful and healthy breast forms are out of fashion. Well, this is not a medical need and a physician should decline, on principle, to satisfy the request.

The same thing might be maintained about granting the demand of a body artist, who needs an abdominal incision for his next performance: a public exhibition in a well known museum. Not even the desire of a deep, invasive piercing can justify a medical intervention. The physicians' duties are not to make everything that might have serious psychophysical consequences, if done by an incompetent layman (like a piercing inserted in septic and antihygienic manners), but to follow the social promise to act in the interest of the patients, and not to serve other aims: economical, scientific, political or whatever else. This is the basis of a beneficent profession and of its code of ethics. On contrary, if advanced society needs a technician, ready to fulfil every desire formulated by informed, free, competent, paying clients or by customers associations, then medical schools

will have to create (besides the traditional figure of physician) a second kind of profession, free from Hippocratic Oaths and from ethical boundaries. We suggest to call iatrotechnicians these new kinds of body-rebuilders.

In the first legal trial, where I have been invited, as ethicists, to act in front of an Italian Court as an expert appointed by the lawyer for the defense, the prosecutor asked the conviction of an African woman for complicity in abuse of medical profession. The woman was a Catholic one, but she wanted her son be circumcised, one month after his birth, for ethnical reasons, as a sign of cultural and geographic origin. Such a practice was and it still is quite common, and it is even known and tolerated by the Catholic priest, African himself, pastor of that Afro-Italian spiritual community. Unfortunately something went wrong: another woman, friend of the mother, who was used to make the intervention in a private flat and in hidden ways, made the child bleeding. He was brought to an emergency department and the visiting doctor reported the fact to the police. The public defender (the mother had no money for private lawyers) asked my help because he found out that, some years before, I had written an opinion dissent in a statement by the Italian Committee for Bioethics[18].

My dissent was quite simple: a *religious* male circumcision is not justified on a clinical basis[19], but on ritual grounds. Therefore the intention is not a therapeutic one and the act doesn't deserve the label of "medical" in the strict sense we have explained above. In other words, I cannot see ethical reason to qualify as clinical intervention a religious act that generates a (even though little) physical breach, generally produces some discomfort in the child and leaves indelible and irreversible bodily marks (I'm translating some Committee Document's terms), even if no impairment of sexual and reproductive functions is created. An act, I would like to add, that obviously cannot be approved by the informed consent of the (under age) citizen involved.

Moreover, I can see no substantial difference between religious, ethnical or simply private bodily injuries ("private" means: based on the individual, secular value preference of someone). To avoid any sort of discrimination, the consequence of our point of view is that no physician (working in public or private institution: it doesn't make difference) has a duty to perform such kind of gestures. What's more, an health care professional should not violate the social promise, that he will act only for the good of ill people. Religious circumcision should remain out of the medical sphere, unless a specific article in the professional code of ethics and an explicit state law require physicians' help, for the sake of public order, but these exceptions must remain few, democratically approved and transitory. We can allow a surgeon to heal the broken wing of an eagle, if no veterinary is available. But it must be clear that this is not his duty.

To avoid interferences between religions and medicine, to prevent undue medicalization of cultural traditions and to oppose dramatic collusion between medical power and arbitrary individual desires, medical ethics should defend its beneficent intention. In the case of male circumcision, my proposal is that it is admnistered by imams, rabbis, generally speaking by religious ministers, who will bear the legal and moral responsibility of their performances. Of course, it would be useful (and perhaps legally required) that they attend preliminary lessons and make a good training, under the supervision by medical experts, to assure a satisfying level of hygienic and sanitary safety (as it happens for piercing offices). When the circumcision is performed in adult people and the intervention becomes quite similar to an invasive surgical intervention, the only solution I see is to require that the religious minister is a medical doctor in every respect.

Conclusions: what symbols of care?

In the three contexts we have examined, it is clear that advanced medical science and practice require an ethics, based not upon

abstract, impersonal and general principles, whose meaning may seem *prima facie* univocal, but admits, in a hidden way, so many different points of view, that the theoretical structure and the intellectual coherence of the syllogistic moral deduction collapse in front of the relevant dilemmas, we have to face in our society. To make an effective use of terms like "proportionate care", "responsible desire of child", "properly medical scope", we have to rediscover the stories of origin, the mythical narrative, the visions of just society, where theories, concepts and principles take roots.

A *narrative ethics*, that recognizes the symbolic dimension of our thinking, the generating metaphors of our language, and the aesthetic feature of our decision-making framework (also in the medical field), cannot be explained in this article[20].We have just the room to say that the good action (and also the good medical decision) is like a well-made work of art, that, at the same time, is absolutely original (because it is created by an individual artist) and universal (because it claims the approval of all the audience)[21]. In a similar way, a good action deserves to be made unconditionally, for the reason that it honours the moral agent's desire both of happiness (the old Greek people would have said "of *eudaimonìa*") and of justice (by opening a world, where everyone is treated with equal compassionate care).

Advanced medicine needs these symbols of solidarity and the strength of an ethical vision (about the beginning and the end of life, the meaning of care, the value of body), not to stumble in an embarassing humanistic stammer. Acting for the good of a suffering persons requires a rationally justified synthesis of scientific knowledge, technical expertise, sense of justice, moral integrity and sensitive style of relationship. There has to be aesthetics in medical ethics, because there is creativity, emotional involvement and perceptions of elegance in medical practice.

When Hermann Roth lost his competence, his son reminded the advance directives and decided, even in an affective turmoil, to have them respected. Philip asked to remain alone, remembering the life, the faith and the spirit of his father and rejecting the easy rule "life at any cost!". Son's flash back and forward reconstructed a whole life story and he could get closer to the unaware Hermann to whisper him something like: daddy, I must let you go. He was a loving, careful son, still holding his parent's hand, caressing his forehead and chatting with a deaf father.

BIBLIOGRAPHY AND NOTES

1. ROTH P., *Patrimony. A True Story,* 1991, Ital. transl. *Patrimonio. Una storia vera,* Torino, Einaudi, 2007 (we did not consult the English original version).
2. This text reproduces and deepens, translating it in English, our Editorial article *La professione medica oggi. Dilemmi etici*. Riv. Ital. Med. Leg. 2008; 6, 1205-1225.
3. The famous book *Principles of Biomedical Ethics*, by BEAUCHAMP T.L. and CHILDRESS J.F., Oxford, Oxford Univ. Press, 1979, 2001 (5th ed.), has raised several disappointments over the last years. See for example DU BOSE E.R., HAMEL R., O'CONNELL L.J., Eds., *A Matter of Principles? Ferment in U.S. Bioethics*. Valley Forge, Trinity Press Int., 1994.
4. See our book *Bioetica. Metodo ed elementi di base per affrontare problemi clinici*. Milano, Ed. Elsevier-Masson, 3rd Ed., 2006.
5. HUXLEY A., *Brave New World,* 1932; ID., *Brave New World Rivisited*, 1958 (Ital. transl.: Milano, Mondadori, 1971).
6. The elliptical literary genre itself of the Document hasn't been quite helpful to justify analytically the conclusions.
7. For the notions of biographical unity and vision of a good life see MACINTYRE A.C., *After Virtue. A Study in Moral Theory.* Notre Dame, Univ. Notre Dame Press, 1981. We have rethought this book referring to end-of-life clinical cases in CATTORINI P., *La morte offesa. Espropriazione del morire ed etica dela resistenza al male*, Bologna, Dehoniane, (2nd ed. with a new Afterword), 2007. For the problem of PVS see: CATTORINI P., REICHLIN M., *Introduction* and *Persistent Vegetative State: A Presumption to*

Treat, *Theoretical Medicine, Issue on "Decisions of Medicine at the End of Life*" edited by CATTORINI P., RECHLIN M., Sept. 1997; 18, 3: 217-219, 263-281.

8. For the notion of action as a text, see Paul Ricoeur's philosophical researches, for example RICOEUR P., *Soi-même comme un autre*. Paris, Seuil, 1990; Ital. transl. *Sé come un altro*, Milano, Jaca Book, 1993.
9. Catholic moral tradition condemns both active and passive euthanasia, as they are both seen as forms of rational assisted suicide.
10. Against the thesis affirmed by the *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the PVS*. Neurology 1989; XXXIX, 125-126.
11. CATTORINI P., *Un buon racconto. Etica, teologia, narrazione*. Bologna, Dehoniane, 2008. See also our articles: *The Desire for Children and the Experience of Illness. A Christian Ethical Perspective*, I supplementi di Tumori, 2004; 3, 3: 171-175, and *Narrating Pain: The Role of Medical Humanities*, Eubios Journal of Asian and International Bioethics 2006; 16, 6: 177-181.
12. To deepen these aspects, read TOLLEFSEN C., Ed., *Artificial Nutrition and Hydration. The New Catholic Debate*. Springer, Dordrecht, 2008.
13. See. DWORKIN R., *Life's Dominion. An Argument about Abortion, Euthanasia, and Individual Freedom*, 1993 (Ital. transl. Milano, Ed. Comunità, 1994).
14. CATTORINI P., *Bioetica clinica e consulenza filosofica*. Milano, Apogeo, 2008.
15. A famous international Report by Hastings Center is devoted to the issue. We have read it in the Italian translation *Gli scopi della medicina: nuove priorità*, appeared in Notizie di Politeia (Milan) 1997; 13, 45.
16. ILLICH I., *Limits to Medicine – Medical Nemesis: the Expropriation of Health*. London, Marion Boyars Publ., 1976.
17. PELLEGRINO E.D., THOMASMA D.C., *For the Patient's Good*. New York, Oxford Univ. Press, 1988.
18. Comitato Nazionale per la Bioetica (CNB) (Roma), *La circoncisione: problemi bioetici*, Sept. 25 1998, Presidence of Council of Ministers. Beyond my dissent, within the Committe the positions were not unanimous. All the experts condemned female infibulations, but for some members, the male religious (ritual) circumcision in a newborn (usually Jewish children are circumcised at the 8th day; later on for Islamic ones), could be made by religious ministers specialized in the practice and having trained an appropriate and acknowledged competence (even if they are not health care professionals),

because the intervention is deemed quite simple. The ministers should also warrant the assistance that might become necessary, if something goes wrong after the rite. The reason of this tolerance is expressed in the Document: those members evaluated as inopportune the fact of encouraging the medicalization of religious practices. I completely agree with this concern.

19. Anyway, as I know, there is no certain, complete and final epidemiological evidence that circumcision prevents genital diseases, in such a way that it should be universally recommanded by pediatricians.
20. See for example our book *Bioetica e cinema. Racconti di malattia e dilemmi morali*. Milan, FrancoAngeli, 2006 (2nd Ed.) and our articles: *Application or Interpretation? The Role of Clinical Bioethics Between Moral Principles and Concrete Situations*. Analecta Husserliana 2001; LXXII: 99-115; *Clinical Bioethics. Identity, Role, Aims*, Medicina nei Secoli - Journal of History of Medicine 2001; 13, 1: 187-197; *Moral Norms and Hermeneutics in Clinical Bioethics*, Medicina nei Secoli - Journal of History of Medicine 2001; 13, 1: 199-209.
21. *Estetica nell'etica. La forma di un'esistenza degna* is the title of the book we are now preparing.

Correspondence should be addressed to:

Paolo Cattorini, Dip. Medicina Sanità Pubblica, Fac. Med. e Chir., Univ. Studi Insubria, via Rossi 9, 21100 Varese, I
paolo.cattorini@uninsubria.it