

Supererogation and the Riskiness of Human Vulnerability

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What does it mean to *investigate* human fragility? And what counts as *knowledge* or *results* from such investigations? Theology and the empirical sciences will give different but related answers to these questions, answers which will, we hope, mutually illumine one another.¹

At least two strategies for answering these questions are pursued by theologians and scientists in this volume. One investigative strategy is to rearrange cultural conditions so that people are made to feel vulnerable under controlled and observable conditions. Another is to seek out those places in our own cultures where people say they feel vulnerable as a mode of social analysis. Both are empirical investigations, differing only in whether they investigate by *creating* or simply by *discovering* peoples' existing sensations of vulnerability. As Hans Reinders has already reminded us in his introduction to this volume, the *sensation* of vulnerability is related in complex ways to the *actual* vulnerabilities produced by mental and physical impairments. If our interest is in analyzing our own societies, we must keep both aspects of this complex field of relations in view.

In this volume Stanley Hauerwas asks us to begin our exploration of human fragility by thinking theologically about one existing reality that exposes the interplay of these two forms of vulnerability, the L'Arche community. In so doing he seeks to learn what this way of life teaches us about how to live with fragility in all spheres of human existence. He studies L'Arche as a "given" to be understood, moving out from there to suggest what sort of people we have to be if we are to take seriously the witness of that community of care. To attend to such a community of care therefore represents a discreet mode of investigating the virtues necessary to accept and live in solidarity with *all* human fragility.

This chapter analytically investigates a conceptual complex that seems to resist the embrace of the physically vulnerable lives around which a community like

¹ For a more detailed discussion of the *theological* expectation that these different sorts of inquiry will meet, see Brian Brock, Walther Doerfler and Hans Ulrich, "Genetics, Conversation and Conversion: A Discourse at the Interface of Molecular Biology and Christian Ethics." In *Theology, Disability and the New Genetics: Why Science Needs the Church* John Swinton and Brian Brock, eds., (London: T&T Clark, 2007).

L'Arche orbits. Put in the simplest possible terms, my suggestion is that supererogation is an ethical concept tempting us and others to believe that loving those who face special physical or intellectual hurdles, including our children, is somehow special or more sacrificial than loving other “normal” people.

I will be querying the accuracy of such a suggestion by way of a theological investigation of one influential account of medical ethics. My suggestion is that the concept of supererogation, as utilized in *Principles of Biomedical Ethics* by Tom Beauchamp and James Childress, functions to sustain, or at least erects no barriers against, medical forces which seek to eliminate human vulnerability and with it those human beings who are characterized as defective. I hope to show that their use of supererogation as a “moral get-out clause” combines in powerful ways with conceptions of genetic risk to render the carrying of a disabled foetus to term at best a heroic act, and at worst, a callous one. I am not suggesting that the concept of supererogation as used in textbooks of medical ethics is the *cause* of the suffering or elimination of the vulnerable, but will draw out why this account of medical ethics has no internal resources to stand against a rising tide of resistance to human vulnerability in one particular field: prenatal testing.

Being for and Bearing the Vulnerable: The Problem of Prenatal Testing

It is by now well-documented that many pregnant women in highly medicalized western societies feel strong, sometimes coercive resistance to their decisions not to abort what has been diagnosed as an “affected” fetus. Here the proximity of actual and felt vulnerability is particularly apparent. Liesa Whitaker, who has a form of dwarfism, relates her experience of prenatal genetic testing in terms only slightly more stark than that of many women.

I remember sitting in the [genetic specialist's] rooms listening as he explained that there was a 25 percent chance that our child could still inherit the dominant achondroplasia gene and the dominant psuedoachondroplasia gene—a combination that they had never seen before anywhere in the world. They had no idea of what effect this would have on the baby... Having told us this the specialist offered us an abortion. He asked us to think about whether we wanted to bring another dwarf baby

into the world. It was something I hadn't even thought of. This was our child! Why would we not want her? Why would the world not accept our child?²

Rayna Rapps's *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America* (New York: Routledge, 2000), attempts to give some sociological purchase on the forces producing the medical "common sense" that would lead to the assumption that the reasonable course of action for a pregnant woman would be to abort a "defective" fetus. It draws on extensive anthropological research collected in the late 1980's and 1990's on the main participants in the drama of amniocentesis in the city of New York. I will focus here on her findings regarding one of the many actors involved, the genetic counselor. Rapp found genetic counselors to play a prominent role in exposing the *conceptual* assumptions underpinning the sensibility of western medicine that bearing a disabled child is an irrational choice. What is simply assumed in related peri- and neo-natal fields comes explicitly to speech in the work of the genetic counselor.

Genetic counseling is a sub-field that grew from research genetics in the 1970's, taking over the pastoral and educational task of linking the worlds of the scientific laboratory and that of parents. As the title suggests, their task is conceived as primarily focused on counseling.³ Because of its alliance with counseling, it strongly reproduces the ethos of counseling toward the facilitation of non-directive value-neutral advice, with the stated purpose of assisting women's reproductive choice.

The basic aim of the discipline is on the surface straightforward: the genetic counselor provides information about hereditary risk to prospective parents. The practical task is to prepare parents to take the test, and explain the meaning of laboratory results. The counseling session therefore has four main goals: to establish the primacy of scientific discourse, to establish the authority of this discourse, to communicate risk, and to construct a family history narrated in medicalized terms.

Establishing the primacy of scientific discourse involves explaining what chromosomes are, how they work, and how "defects" produce disabilities. In this sense genetic counselors are science educators who simultaneously establish and

² Leisa Whitaker, in Melinda Tankard Reist, *Defiant Birth: Women Who Resist Medical Eugenics* (North Melbourne: Spinifex, 2006), 214. This volume collects 19 first-person narratives by women who experienced medicalized pre- and post-natal care as antagonistic to the continuation of their pregnancies.

³ Rapp, *Testing Women, Testing the Fetus*, 56-57.

maintain the authority of the scientific expert. As the accuracy of the geneticist's diagnosis is the premise of the counselor's work, there is a strongly pro-expertise bias built into genetic counseling.

Explaining the functioning of chromosomes is a prelude to introducing the crucial concept of *risk*. This is thoroughly statistical territory, in which it is assumed that rationality and choice can be meaningfully tied to percentages of risk. The aim of the discourse of risk is to construct an "appropriate" or "numerically rational" sense of anxiety, tied to those features of procreation that are susceptible to genetic analysis. Genetic counseling is thoroughly wedded to this medicalized and statistical understanding of pregnancy, continues Rapp.

The technology of prenatal diagnosis was developed explicitly to allow the selection and abortion of fetuses facing serious disabilities because of atypical chromosomes and genes. The language of genetic counseling is intended to enhance awareness of the age-related risk of chromosomal problems, but counselors rarely speak directly about disability or abortion decisions unless a problem is detected. Counselors describe their goals quite differently: to give reassurance.... This language of "added risk," "background risk," and "reassurance" is consistently deployed by all the genetic counselors I have observed at work. It thus foregrounds a statistical, medical, age-related, universal and wholly individual model of risk.⁴

Risk is communicated in more or less sophisticated ways, depending on the mother being addressed.

To someone perceived as scientifically sophisticated, at Middle or Elite Hospitals: "At 35, a woman's risk of bearing a live born child with Down syndrome is one in 385; at 40 it increases to one in 106; at 45, it is one in thirty."... Another counselor said of advanced maternal age: "It's like crossing a street with each pregnancy, and when you are older, it's a little easier to be hit by a car. But suppose there is a traffic light. Then, you want to cross on the green. This test puts you back to the green light. Oh, you might still get hit by a crazy hit-and-run driver, but it's not too likely. At the red light [without the test], your age makes you a more likely target for an accident."⁵

Though the heavy use of statistical language lends an air of objectivity and value-neutrality, the last quotation's comparison of some births with an "accident" that ought to be avoided highlights the value-laden nature of the exercise.

⁴ Rapp, *Testing Women, Testing the Fetus*, 70.

⁵ Rapp, *Testing Women, Testing the Fetus*, 68.

Until prenatal genetic testing is universally administered, for technical reasons testing must be targeted. The main goal of the early part of the counseling session is to teach and guide parents in renarrating their family history in medicalized, “diagnostic” terms. The parents are asked many questions that could be considered surprising or unsettling in normal life, such as “Have you recently come into contact with cats?” or “Have you taken drugs or had unprotected sex?” and even “Could the child’s father be your relative?” Such questions orient the laboratory’s investigation of specific anomalies which are linked with these behaviors. In this process the counselor teaches the pregnant woman to reconsider her own biography within the terms of the medical self-understanding, so constructing a subject who understands herself to carry a certain specifiable “genetic risk” on the basis of this newly constructed narrative of the self.

Rapp observes that there is an inherent confusion shot through these activities of the genetic counselor who thinks of herself as value neutral while playing the role of gatekeeper. The biomedical and public health establishments that employ genetic counselors assume that some conceptions are expendable or even burdensome. Genetic counselors simply reproduce this bias in an unreflexive manner that “assumes that scientific and medical resources should be placed in the service of prenatal diagnosis and potential elimination of fetuses bearing chromosome problems. In principle, then, counselors are trained to offer a value-charged technology in a value-neutral manner.”⁶ This lack of self-reflexivity is verified by the surprise of genetic counselors when their advice or even some of the information they have to offer is refused by parents who have decided abortion is not appropriate for some conditions.⁷

It appears then that prenatal diagnosis as just described expresses a biomedical account in which prenatal *screening* precedes and is more fundamental than prenatal *care*. At the point of the genetic counselor the prospective parents must learn to evaluate themselves and their growing offspring within the screening framework *before* making what is termed an “informed” decision for or against the pregnancy. Western society as a whole has learned to “live by the numbers,” and the genetic counselor ensures that pregnancy is also understood first in these terms. Rapp found,

⁶ Rapp, *Testing Women, Testing the Fetus*, 59.

⁷ Cf. Barbara Katz Rothman *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood* (New York: Penguin Books, 1987), 256.

however, that this statistical rationality not only framed the activity of amniocentesis, but barred some from it.

... ironically, the very populations most at risk—less privileged “older” women having more pregnancies with more partners; experiencing more reproductive, perinatal, and infant mortality; and higher death rates throughout their life cycles—may least be likely to live by the numbers precisely because they understand their risks to be spread over a greater territory than chromosome analysis in pregnancy describes. ... precise biomedical notions of risk are constantly put to empirical challenge by the encompassing and uneven life chances through which women and their supporters encounter them.⁸

Much of theological interest appeared in these cases where some parents could or would not evaluate their pregnancies in terms of this metanarrative.

Concepts like value-neutrality, individual choice, risk avoidance and the authority of expertise are not necessarily theologically problematic taken on their own, but become a cocktail poisonous to the most vulnerable when unreflexively teamed with decisions about whether to eliminate humans perceived to be a social burden. Genetic counselors perhaps unwittingly express the decision of a state whose offer of help to those mothers most in need social support has been reduced to the offer of an abortion. This political role is sustained as genetic counselors embrace of the psychologists’ self-understanding as non-directive (and therefore apolitical) while serving the widespread use of the technologies of elimination. In theological and pastoral terms, the net effect is the loss of attentive empathy and concern for the whole of life in service of the state’s interest in minimizing economic cost.

Supererogation in Medical Ethics

In the medical landscape just described, in which some pregnancies are considered too risky for a rational person to seriously consider bringing to term, the concept of supererogation cannot but colour the medical professional’s sensibilities about the moral nature of parents’ decisions to receive pregnancy as a gift rather than as a burden, risk or threat. My contention is that this is true even when introduced as solely an aspect of professional ethics.

⁸ Rapp, *Testing Women, Testing the Fetus*, 312-313.

Beauchamp and Childress's *Principles of Biomedical Ethics* (4th ed, Oxford: Oxford University Press, 1994), first published in 1979 and now in its fifth edition, has arguably been the most influential account of medical ethics to form the moral aspirations of a generation of medical students in the English speaking world. Its final chapter turns to describe the ideal medical professional, a moral agent who knows that "what counts most in the moral life is not consistent adherence to principles and rules, but reliable character, moral good sense, and emotional responsiveness."⁹ The authors' focus here is on the *virtues* a medical professional must possess, and this suggests that these traits of character cannot, indeed must not, be confined to professional life alone. Beauchamp and Childress are suggesting here what sort of *people* health care professionals ought to be. When the medical professional lives the virtues of caring in a consistent manner they build up social capital, coming to be seen as "persons of high moral character [who] acquire a reservoir of good will in assessments of the praiseworthiness or blameworthiness of their actions."¹⁰

Beauchamp and Childress need this thick account of the moral aspirations of medical professionals as a buffer against an overly rigid or heartless application of the system of rules and principles that the bulk of their treatment is devoted to explicating. In it they define the virtues of medical professionals: compassion, discernment, trustworthiness, and integrity. Again it is noteworthy that these virtues are universal; it is inconceivable to think of someone as compassionate, discerning, trustworthy and possessing moral integrity in their *professional* duties while being a callous, undiscerning, untrustworthy character in the rest of life. Beauchamp and Childress clearly want medical professionals to aspire to be certain types of moral agents. The question is whether the moral agents who admire these traits can set them aside when evaluating their patient's decisions.

Here the introduction of the conception of supererogation complicates matters exponentially. The concept of supererogation is defined as applying only to specific acts. These acts stand on a spectrum between what is commonly accepted as moral, the ordinary standards of behaviour expected of everyone in society, and heroic acts, which can never be demanded of everyone and are not undertaken out of any universal duty. A supererogatory act, then, has four features:

⁹ Beauchamp Childress, *Principles of Biomedical Ethics*, 462.

¹⁰ Beauchamp Childress, *Principles of Biomedical Ethics*, 464.

First, a supererogatory act is optional, neither required nor forbidden by common morality standards. Second, supererogatory acts exceed what is expected or demanded by the common morality. Third, supererogatory acts are intentionally undertaken for the welfare of others. Fourth, supererogatory acts are morally good and praiseworthy (not merely undertaken from good intentions).¹¹

Let us map this definition of the supererogatory act onto what we have learned about how medical professionals understand prenatal testing. Under the first and second criterion, it is safe to assume that common morality assumes that all things being equal, it is obligatory to continue an “unaffected” pregnancy. Therefore, to continue an “affected” pregnancy is by definition a decision to go beyond this lower threshold, moving in the direction of a supererogatory or even a heroic act.

The third criterion might also allow a mother’s decision to continue an “affected” pregnancy to be interpreted as a decision “intentionally taken for the welfare of others.” But as we have seen, many mothers today experience medicine very differently, their choice for the vulnerable repudiated as serving no one’s welfare, not even that of the unborn child. This points to the paternalistic sting in the final criterion which suggests that for an act to be supererogatory it must be *actually* good and praiseworthy, not just good *intentioned*. In a medical context in which the bearing of a disabled child is explicitly cast in terms of an avoidable accident, the bearing of a disabled child must be understood as a violation of the last criterion of the supererogatory act. If not interpreted as an irrational act because violating the last criterion, it can, in these terms, be at best considered a decision by idiosyncratic individual parents to go far beyond what the system of prenatal screening assumes parents can reasonably be asked to bear.

Furthermore, Beauchamp and Childress explicitly tie their definition of the threshold between morally obligatory and supererogatory acts in professional life to how much *risk* is taken on. It is the level of risk faced as one makes a decision that defines its demands as one of universal moral obligation or only one option that may be chosen by those so inclined. The point of the concept of supererogation is to “Refrain from holding people to standards that are arduous, risky, and frightening.”¹²

In this version of moral medicine it is the perception of risk that defines an action as supererogatory, or optional and beyond “normal” morality. While presented

¹¹ Beauchamp Childress, *Principles of Biomedical Ethics*, 483.

¹² Beauchamp Childress, *Principles of Biomedical Ethics*, 487.

only as a criterion within the professional ideal, we have seen how these moral aspirations are difficult to confine to strictly professional spheres. Maintaining this separation of professional and private moral aspirations is especially difficult when faced with a pregnant woman who has entered the sphere of medical care and who may deny that perceived risk is the basic criterion by which a moral situation is defined. When we bring this self-understanding together with the mechanisms of prenatal testing which systematically accentuate certain narrow aspects of the riskiness of pregnancy, we can see some of the reasons why human vulnerability appears to medical professionals in this context as something to be avoided. In this light the concept of supererogation functions to heighten the extant social stereotypes within which women who wish to accept the most vulnerable in their wombs are portrayed as at best making a heroic decision, at worst an immoral one.

The Theological Critique of Supererogation

Protestant moral theology refocused attention on Jesus' parable of the Good Samaritan and Paul's writings to raise a set of sharp worries about the concept of supererogation. For a range of historical reasons it may be wiser not to insist on a direct line of descent from the medieval to modern concepts of supererogation. While there may be a historical connection, at least one important disanalogy should be noted. Kant reintroduced the concept into modern moral discourse, and it is his definition of the term that shapes most modern usage, including that of Beauchamp and Childress. Kant's reasons for seeking a concept to distinguish between the duties owed to *all* people from those owed only to *some* under special circumstances draws on a conception of morality as transtemporal and exceptionless because based on a universal reason. In the medieval tradition supererogation was primarily an outlier to an *ecclesial* distinction, distinguishing between higher and lower paths of virtue. But the critical confluence between the two thought systems is the presupposition that there is a "regular" duty to the neighbor and a "special" duty not incumbent on everyone. In any case, the ethics of Kantian neo-Protestantism attempted to recover a distinction with this function, and so returned to this term.

Whether responding to the modern or medieval construal of supererogation, Calvin expresses the protest of the magisterial Reformation to any bifurcation of moral claims in this manner: "Since we are unduly inclined to hypocrisy, this

palliative ought by no means be added to soothe our sluggish consciences.”¹³ Such disavowals were to have a long history in Protestant theology, as marked by its anathematization in the Anglican Thirty-Nine Articles (Art. 14): “The works of supererogation cannot be taught without arrogance and impiety.” Indeed, it is not going too far to say that the Reformation began with exactly this worry about the notion of a “higher way” on which a long and developed theological account of supererogation and vocation had rested. Such moral exception clauses appeared to cut the vital cord of transformative faith to yield a culturally conservative and conformist Christianity.¹⁴

Luther was reacting at a fundamental and theological level against a medieval development of a firm distinction between following both Christ’s commands (charity, understood through the cardinal virtues) and his more strenuous counsels (poverty, chastity and obedience). This distinction was mapped onto the monastic-laity distinction, with the nomenclature of “vocation” linked to the higher way.¹⁵ In the theologies of the Reformation the concept of vocation was decisively reformulated, and applied both to activities as apparently different as the work of the priesthood, trade, parenthood, and government. This levelling or sacralisation of all spheres of human work has had a deep and enduring effect on the ways moderns conceive their lives and work, and again, has deeply problematized attempts like Beauchamp and Childress, which assume that sharp distinctions can be drawn between “personal” and “professional” ethics.¹⁶

The English term supererogation marks its direct descent from theological usage in being a derivation of the Latin *erogare*, meaning to pay or expend as prominently appearing in the (Latin) Vulgate, in Jesus’ parable of the Good Samaritan. The Samaritan, having rescued the injured neighbor, cares for him, takes him to an inn, tells the proprietor to care for him, and promises to reimburse his expenses, as it says in Luke 10:35: “...and whatever you spend besides” (*quodcumque supererogaveris*). Zaccheus’ superabundant restitution (Luke 19:8-9) and Paul’s using his own funds to support his ministry (Acts 20:34, 1 Thess. 3:8-9) also serve as paradigmatic examples of supererogation. Whereas Thomas Aquinas (and others) had

¹³ Calvin, *Institutes*, 2.8.58

¹⁴ Martin Luther *95 Theses*, theses 44-45

¹⁵ See Thomas Aquinas, *Summa Theologica*, 2a2ae 185.6

¹⁶ Charles Taylor, *Sources of the Self: The Making of the Modern Identity* (Cambridge: Harvard University Press, 1989), Part III, “The Affirmation of Ordinary Life”.

solidified the distinction between commands and counsels in a highly technical manner,¹⁷ Luther argued that we could in truth obey neither Christ's counsels nor his commands, and so are constantly thrown back on grace and into love of the neighbor without hesitation or moral hairsplitting—completely without reserve.¹⁸

Luther bequeathed to evangelical ethics a sensitivity to the difference between embarking on projects of moral calculation and justification yielding a two-tier morality, and the single tier morality of attentiveness to the neighbor. The Lutheran doctrine of spontaneous good works is among other things an insistence that it was no accident that Jesus answered the question of what it means to love one's neighbour with the story of the Good Samaritan. With this story Jesus revalues the Pharisee's question "Who then is my neighbour?", refusing his interlocutor's assumption that morality begins with trying to define the other "out there" to whom empathy and solicitude is due. His question is wholly different: *Who turned out to have been a neighbour?* Faithfulness here appears as a transformed consciousness in which one's own self-interest is wholly tied to the wellbeing of the other. Jesus thus suggests the moral force of a specific form of attentiveness to others. Jesus is depicted in the gospels as trying to inflame *this* sort of attentiveness in his hearers.

In terms of this attentiveness to the neighbour, the spontaneous responsiveness of the Good Samaritan turns out not to be "irrational" or "unpredictable", but a very practical rationality. Jesus asks us to become people whose investigation of human fragility does not begin by distancing ourselves from others as "subjects", but is trained to respond without excuse and without forethought to existing human need. I take this spontaneity to be the *premise* out of which a laboriously cultivated way of life such as L'Arche can emerge. As Jean Vanier himself puts it, L'Arche is a school for relationships, a community where people can discover the fecundity of divine love through attentiveness to others. To discover such spontaneity is a gift of the Spirit which cannot be ensured or legislated by any law, but begins in the prayer which requests it. Such love, as Jesus' parable suggests, requires *conversion*, not simply information or education.

¹⁷ Aquinas, *Summa Theologica*, 1a2ae 108.2-4

¹⁸ Martin Luther, "The Freedom of a Christian," in *Luther's Works, Vol. 31, Career of the Reformer I*, ed. Harold Grim (Philadelphia: Fortress Press, 1957), 348; "Treatise on Good Works, 1520," in *Luther's Works, Vol. 44, The Christian in Society I*, ed. James Atkinson, trans. W. A. Lambert (Philadelphia: Fortress Press, 1966), 33

This answer has appeared to most modern Christian moralists as an insufficiently broad account of the foundations of Christian ethics. This is to overlook, however, that the parable of the Good Samaritan also implies that a steady emphasis on the occasional and gratuitous nature of Christian responsiveness is not *opposed* to more hard-headed institutional thinking (*pace* Reinhold Niebuhr¹⁹), but in fact *demand*s it.²⁰ The Good Samaritan, after all, took his neighbour to an inn for care. Institutions are not the opposite of spontaneity: institutions may aim at or thwart our being turned out of ourselves and toward others. An inn as a meeting of economic, political and interpersonal cultures may be a better or worse place for the Good Samaritan to leave his ward. This insight grounds the cultural criticism of Christian ethics, which is at every point a social ethic.

This understanding of neighbour love combines with Christian commitments to the good of non-coercion in political affairs to yield a refusal of any suggestion that such Spirit-enabled spontaneity can be imposed on all of society. A properly Christian political ethic will therefore seek social structures that can protect and promote the space for spontaneous attentiveness to occur, even though the focus on Christ-like attentiveness to the neighbour cannot be reduced to or translated into the language of secular rationality. Christians living in communities like L'Arche can therefore be nothing more than witness, one which has *political* benefits which Christians have a duty to offer to a secular political society that cannot conceive it on its own terms.²¹ Such a witness stands as a word from outside and above us about the necessity of listening to the voices of those who challenge our presuppositions by wishing to bear and live with the most vulnerable of humans.

¹⁹ Cf. Reinhold Niebuhr, *Moral Man and Immoral Society: A Study in Ethics and Politics*, pub. 1932.

²⁰ Cf. Hans Ulrich, *Wie Geschöpfe leben: Konturen evangelischer Ethik* (Münster: Lit Verlag, 2005), 109

²¹ Bernd Wannewetsch, *Political Worship: Ethics for Christian Citizens*, trans. [from German] Margaret Kohl (Oxford: Oxford University Press, 2004), ch. 8. Wannewetsch is commenting on the influential claim to this effect of Karl Barth in "The Christian Community and the Civil Community", section 14.