ETHICS & MEDICINE

A Quarterly Newsletter

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EDITORIALS

A New Arrival

It is surely appropriate that a new venture in the field of medical ethics should appear in the year of the Warnock Report, whose publication marks an historic step in the development of moral reflection upon medical technology.

ETHICS & MEDICINE commences publication with aims and a format that are modest. We wish to provide a forum for discussion on a base that is recognisably Biblical and that stems from the stream of historic Christianity. We hope to pass on news of conferences and publications which will interest those in sympathy with our intentions. Whether the format remains as at present, or whether we are able to move on to a more impressive appearance, depends upon the circulation we can achieve.

We shall be very pleased to be offered correspondence or articles for publication, and to receive news which we can make known to our subscribers. We shall also be particularly grateful for response from our first readers to the appearance and content of ETHICS & MEDICINE.

Thank you for joining with us in this venture. We would ask you to join us also in our prayers for its success and its usefulness.

The Warnock Debate

Two members of the Editorial Board of ETHICS & MEDICINE had the pleasure, just before this issue went to press, of debating some of the ethical issues arising out of the Warnock Report before Durham Union Society. They had been promised Dr Robert Edwards to oppose the motion that *This House would not interfere with the natural beginnings of human life*, but in the event he was unable to be present. His place was taken by a senior gynaecologist who has for some time been associated with his work, sitting on the ethical committee of Bourne Hall; seconded by a Cambridge law lecturer.

Debate was lively. The gynaecologist defended research on the embryo, and reacted violently to the proposers' contention that from fertilisation the embryo, since it was biologically/genetically a member of the human species, was deserving of the respect we afford to other humans. If that were so, he said, it would make him a murderer; and a murderer he was not. He went on to make a number of interesting admissions. The 14-day limit on embryo research, proposed by Warnock, had nothing to do with concern for the development of primitive sentience on the part of the embryo. Its real criterion was the present inability of researchers to maintain embryos *in vitro* any later than this point. Moreover, the 14-day limit was just for the present. Those working in the field would soon be seeking an extension to 21 days, and then to 28. These were very candid statements from one close to those leading research in this area, and they plainly embarrassed his seconder, who had put forward a more limited case.

The proposition was at pains to point out that 'murder' had been introduced into the debate without any desire on their part, and that murder requires an intention to kill a human person. The problem which we had to face was that those opposing this motion did not recognise a human person in the

embryo. The analogy was drawn between the embryo and those many groups of human beings who at different times in history have been regarded as non-persons, despite their appearance of human status. Recent evidence of prisoners-of-war being used by the Japanese for experimental purposes illustrated the implications of any principle that would permit the use of human subjects for inhuman ends.

Perhaps the most interesting feature of the debate was the speeches from the floor, as students made able contributions to discussion. The great majority - to the embarrassment of those proposing the motion! - were firmly against not merely experimental use of the embryo, but the developments of which it is an integral element. One student spoke of her friendship with handicapped colleagues, and of how this made her feel about the discarding of embryos with abnormalities, and abortion for fetal handicap. Another speech, perhaps the most memorable, was from a woman with a teenage child with Down's Syndrome who spoke passionately of her revulsion at the attitude of those who would dispose of the abnormal. She added that her father had suffered at the hands of the Japanese who had degraded him and treated him as sub-human.

What of the vote? It was close. The floor debate was plainly unrepresentative, perhaps, one might suggest, because those who had reflected most on the questions at issue had been most strongly influenced against the *in vitro* process, while the unreflective assumed that recent developments must necessarily be good. But the motion was won: 97 for, 93 against, 12 abstentions. It may be that this is an augur of the public debate now in process.

N.M. de S. CAMERON

Medicine and Mores

As previously accepted mores crumble into the melting-pot of contemporary values, those involved in the social services find themselves beset by conflicting demands. This is particularly true in the medical field. What moral values, if any, can a doctor in practice maintain? Is he or she simply an agent of the state to meet any request a patient may have? Should a Christian doctor concede the "consensus morality" of the age rather than apply Christian principles? We believe that it is vital for us to understand what lies behind these issues, and to support each other in working out their practical application with God's help.

By way of background perhaps we should consider what the characteristic attitudes of our society are. These are difficult to appreciate when one is in the middle of it oneself and the perspectives of Alexander Solzhenitsyn who saw western society in a very clear light when he came from Russia are most illuminating. In his Nobel Lecture in 1970 he says, 'The intimidated civilized world has found nothing to oppose the onslaught of a suddenly resurgent fang-bearing barbarism, except concessions and smiles. The spirit of Munich is a disease of the will of prosperous people; it is the daily state of those who have given themselves over to a craving for prosperity in every way, to material well being as the chief goal of life on earth.

Such people ... choose passivity and retreat, anything if only the life to which they are accustomed might go on, anything so as not to have to cross over to rough terrain today because, tomorrow, see, everything will be all right.' [1]

Such an attitude can become part of our outlook on life unawares, depriving us of the courage to seek first the Kingdom of God - though we are left with an uneasy sense of guilt when faced with increasing rates of divorce, personal violence, incest and abortion (over 130,000 in Britain last year). A guilty conscience may make us align ourselves openly with Mrs Gillick, Mary Whitehouse or the pro-life movement. If we are to provide effective moral leadership in society and cross over to "the rough terrain" a more positive basis is needed - which is nothing less than a change of heart. The social reformers of the 19th century were effective because they spoke with conviction and were deeply aware of the value of each human being in God's sight. Dr Bernard Nathanson ran an abortion centre in America for some years before he came to the conclusion that the human embryo was a human being and that in fact he had supervised the destruction of 60,000 individuals. [2]

It is relevant that this is Christian Heritage Year, and we need to be reminded that, as Lord Tonypandy said, when Speaker of the House of Commons, 'the emphasis on the individual being precious in the sight of God Almighty - no-one an unimportant person - that is the corner stone on which we built our democracy'. Democratic freedom for every individual is conditional on absolute moral standards that are the basis for ethical decisions throughout society. Against this background we can challenge others to face the ethical questions confronting us - particularly relating to the control and exploitation of children, before and after birth. A human embryo either is, or is not, a human being. Children either are the responsibility of their parents, or are allowed to be subject to whatever their peers or other adults devise for them. Pornography is either harmless or it is an evil influence in society.

It is our desire that this newsletter will provide a forum for debate. May it also be a means of uniting all Christians concerned with ethical issues, with mutual encouragement, that in the name of Christ we may "raise a banner of duty and service against the flood of depravity and despair" in our society. [3]

1 Alexander Solzhenitsyn.
Nobel Lecture 1972, Noonday Press, N. York 1970 date given.

2 Bernard Nathanson.
New England Journal of Medicine, 28th November, 1974 p. 1189.

3 Sir John Glubb.
Fate of Empires, William Blackwood, 1976 p. 21.

PAUL K. BUXTON

DOCTORS AND THE GILLICK CASE

O.R. Johnston
Research and Education Director of CARE Trust
(formerly the Nationwide Festival of Light)

I

In April this year a letter to the Prime Minister was handed in at 10, Downing Street from some of Britain's top 'agony aunts'. Signatories included Katie Boyle, Claire Rayner, Marjorie Proops and Anna Raeburn. They urged the Government not to accede to pressure to rescind the existing guidelines published by the Department of Health and Social Security whereby doctors can provide contraceptive advice without the knowledge of the parents to girls under 16. Unpacking that last phrase: 'contraceptive advice' can include the actual provision of contraceptive drugs or devices, and 'under 16' refers to girls who, if they engage in sexual intercourse, are party to a criminal offence. Speaking strictly, it is the man who breaks the law and is criminally liable, since a girl under 16 is deemed to be too young to give realistic 'consent' (Sexual Offences Act, 1956).

As they have done for the past two decades, the agony aunts were protecting the secularist 'liberal establishment' which successfully worked its way into power in Britain in the late fifties and early sixties. The DHSS circular to Area Health Authorities, first promulgated in the early seventies and re-worded without substantial alteration of basic content in 1980, appeared to encourage or at least to condone unlawful intercourse. Opponents of the policy in the 1970's had a strong case. If a child under sixteen was issued with contraceptives, it could only be for one reason, it was argued-that she should participate in a criminal act. Surely that was wrong? Not all all, said the DHSS; the doctor should, and would, only issue contraceptives if it seemed that the girl was determined to embark upon, or persist in, a relationship of sexual experimentation. Should she not be saved from the risk and fear of unwanted pregnancy? At least 'the pill' could hinder that unwelcome event, and thereby prevent a teenage abortion, which might otherwise be the only choice for a pregnant child of that age.

DHSS regulations do not have the force of law. But the Medical Defence Union had all along told doctors that if they *did* prescribe contraceptives in rare cases to 'protect' the child without the knowledge or consent of the child's parents, they (the MDU) were confident that such doctors would not be held to have acted unlawfully.

In July of last year Mrs Victoria Gillick challenged the legality of the DHSS advice to Area Health Authorities in the High Court. Mrs Gillick is a happily married Roman Catholic lady living in East Anglia. She has ten children, five of them daughters. She sought declarations from the court:

(a) against the DHSS and her Area Health Authority that their advice was unlawful, and

(b) against the AHA that no doctor or other professional person employed by them should be permitted to give any contraceptive and/or abortion advice and/or treatment to any child of hers below the age of 16 without the consent of that child's parents or guardian.

Mr Justice Woolf refused both declarations (see *The Times*, July 27th 1983). Mrs Gillick, nothing daunted, is taking her case to the Court of Appeal. Many people have remarked on the fact that the case is not to be heard there until November 1984.

II

What are the ethical parameters for doctors in this perplexing field? The first is evident. The medical profession exists to care for the injured, the diseased and the disabled. The doctor's task is to diagnose illness and, wherever possible, to heal. It is not immediately obvious that the supply of contraceptives falls within the doctor's traditional obligations. Doctors, like teachers, are often loaded with unwanted responsibilities by feckless parents or a confused and uncaring public. Should doctors ever have consented to supervise this kind of provision?

The second principle is a red herring, only apparently relevant to the case. This is the matter of confidentiality. As a matter of morality, secrecy has no intrinsic merit. The members of the MAFIA are sworn to secrecy, and it simply compounds their evil. Medical confidentiality is of course an appropriate factor in the framework of the professional code which has developed. It preserves a decent privacy and encourages the sharing of experiences and anxieties which are often needed for proper diagnosis and cure. But it is not essential to the medical ethic. Therefore it cannot be called in as if it were some over-riding consideration. It may not be used to protect criminals or those intending to commit a crime, for example. Confidentiality in the case of an intending criminal could well be collusion in his crime. Confidentiality in the case of a 13 year-old girl against the presumed wishes of her parents is collusion in the deception of parents and subverts their presumed desire for the health and welfare (physical, moral and social) of their child. A child who alleges she has cruel or uncaring parents is not self-evidently telling the truth. Parents must be presumed innocent until they are proved guilty. Confidentiality at the imperious behest of a depraved teenage girl makes a mockery of responsible community medical provision, since it assists the disintegration of family duties and allegiances.

As a matter of public policy parents are responsible for the welfare of their children. If they neglect them or are cruel to them the state can intervene. Children can be made wards of court, or be put into the care of the local authority. Here, by contrast, the state appears to be intervening in order to do, or to facilitate, what no reasonable or caring parent would ever do.

Furthermore many medical procedures, from injections and inoculations to operations, need parental consent. However, common law and the BMA's *Handbook of Medical Ethics* (1984) both indicate that the consent of a minor to medical treatment *is* valid if he or she can understand the nature of the treatment and any risks involved, a competence summed up in the words 'sufficiently mature'. Is this the case with sexual experiment by a girl under 16 who asks for the doctor or clinic to provide 'protection' against the potentially harmful effects of intercourse?

It could be argued on the one hand that the most recent wording of the DHSS stress more strongly than before that doctors would always seek to persuade children under 16 to tell their parents, and only yield to the demand for contraceptives without parental consent as a very last resort.

It is said that these would be 'unusual' or 'exceptional' cases. It is

easy to envisage such interviews. Talk to any teacher. It is not difficult to conceive of certain aggressive fifteen year old girls in today's permissive climate who would see nothing wrong in demanding such 'contraceptive advice' coupled with the insistence upon total secrecy. It is also difficult to deny that there may be unusual situations in which even the most righteous doctor might feel that this was the only course of action open to him, as a last resort.

However, this does not necessarily mean that either the law or any Departmental guidelines should set out the circumstances in which such an action might take place,or even set it down as a possibility. Regulations and circulars from Government are not law, but they have many of the characteristics of law. They are public. They set standards. They shape professional conduct. They strengthen parents, teachers and other guiding figures. They help many of the populace towards a rudimentary morality when they have no other source of guidance from the family, school or church. Furthermore, 'rightness' in an extreme or highly unusual situation is an ethical category which often defies codification (compare euthanasia and the soldier trapped in the burning tank).

To make public the possibility, even as an exception, of a certain 'professional service' is to make people aware that it can be supplied, provided they apply in the right way, or at the right time. In this instance the conditions can be easily fulfilled by a perverse but insistent teenage girl: she must assert that she is already 'sexually active' (a most distasteful expression often used by the contraceptive lobbyists) or at least fully intending to be so in the near future, and she must give the impression that no-one can persuade her otherwise. Secondly she must insist that her parents be not told. Many girls will not find these requirements hard to fulfil.

There are several additional arguments which can be adduced in support of the rescinding of the regulation. Let us grant that God's law cannot always be translated directly into social legislation so as to outlaw sinful behaviour. Let us grant that *some* 15 year-old girls may be able to comprehend the social, mental, moral and spiritual significance or potential of the act of sexual union. They may be deemed, after rigorous questioning and/or sympathetic counselling, to have the maturity to assess the implications and consequences of intercourse, the emotional investment, the family adjustments, the loyalties aroused, the personal commitment signified and so on. They may still determine to persist. Three considerations can yet be adduced which should cause us to pause before approving the DHSS policy:

1. The declared policy should surely still be framed in such general terms as to protect the majority of girls rather than specifically providing a 'service' which is appropriate only for the mature minority.

2. The average doctor does not have the time to engage in such lengthy counselling/interview procedures as would enable him to be certain that he is faced with one of the 'mature minority' beyond any doubt. Nor can he set afoot an enquiry to assure himself that this girl has parents who are irresponsible or cruel, and therefore rightly not to be consulted.

3. The doctor *does* know of the failure of contraceptives to protect against sexually transmitted diseases (the inevitable accompaniment of increasing extra-marital sexual activity in any society). He also knows of the increased risk of cervical cancer to girls who engage in early or promiscuous sexual experiment. He also knows of the

health hazards of the contraceptive pill, which include thrombosis. Do not these multiple risks point towards a responsible negative?

But there is a more fundamental matter involved. The doctor's decision we are discussing scarcely concerns the child *as a patient*. A 15 year-old girl asking for the pill is not suffering in any obvious way. She has no ailment, no disease, no pain. She has no malfunction. Is the doctor's decision to supply contraceptives to a minor in any real sense a *clinical* judgement? If it were clinical, it could be maintained that the answer should always be 'No', granted the health risks the doctor would thereby appear to condone (see above). But if it is *not* clinical, then the doctor's special position vanishes. The sooner Parliament and the whole community (rather than the officials of the DHSS) decide what is to be lawful and what unlawful the better.

III

Christians believe in the Divine joining together of sexual fulfilment, parenthood, and the permanent covenant of marriage. Wilfully to separate any one of these triple blessings from the other two is to put asunder what God has joined. In the light of that principle - and even granting extreme exceptional cases - the DHSS circular ought never to have been issued, and would be better rescinded. It is unworthy to allow the medical profession to be put in the position - manipulated by the contraceptive lobby or by depraved teenage girls - of having to assist, condone or appear to facilitate extra-marital child intercourse, or to provide such 'protection' as *de facto* facilitates it.

A simple draft Bill exists to make it unlawful for any doctor to supply contraceptives to a girl under 16 without the consent of the girl's parents or guardian and without the knowledge of the girl's general practitioner. The Bill was drafted by the legal advisers of CARE (*Christian Action, Research and Education)* before Mrs Gillick's case came before the courts, and it is available for the Government or a private member to take up at any time. It is a simple two-clause amendment to the 1956 Sexual Offences Act.

Parliament has now received over 400 petitions asking for the law to be changed to protect parental rights and girls' morals. More than half a million signatures have been collected. Meanwhile the threat has been made by those who lead the medical profession that any doctor who does inform a girl's parents (and thus break 'medical confidentiality') would risk being brought before the General Medical Council and struck off the list. To their credit the Christian Medical Fellowship have asserted publicly that they consider this threat as a potentially disastrous move, and have called Christian doctors to what amounts to professional civil disobedience, obeying God rather than men. Let us hope that the whole profession will now see the CMF on the march, following the challenging Editorial in their journal (*In the Service of Medicine*, October 1983). Christian doctors disciplined in large numbers for the sake of family solidarity would not only make headlines. It might change the minds of the Civil Servants and the BMA. In English law, as in Christian theology, there is only one form of lawful sexual intercourse - that between a man and his wife. It is the swift disappearance of the priority and protection of marriage which lies at the root of so many of our present paradoxes in social morality and public policy. This larger issue remains as a challenge to *all* Christian citizens.

DOCTORS AND THE GILLICK CASE

A General Practitioner's Response

Dr Huw Morgan,
General Practitioner, Bristol

As the author of the editorial in the Christian Medical Fellowship Journal to which Mr Johnston refers, it is perhaps not surprising that I am very substantially in agreement with the points that he makes, although we have never communicated personally about this matter. I will seek nevertheless to amplify some of them slightly from a medical view-point.

Doctors and Contraceptives

Considering firstly the issue of doctors supplying contraceptives, it is, I think, a reasonable extension of the traditional role of the family doctor that he should provide those forms of contraception that require medical supervision to married couples on his list. Certainly this is a regular and important part of my own work. The problems arise when, by edict of the DHSS, the general public are encouraged to regard G.P.'s as the purveyors of pills to any young lady who happens to want them. Should he fail to come up with the goods, the government has provided 'family planning clinics' where other doctors *will* freely provide them.

The medical profession, some of whom like to be seen as trend-setters in what Mr Johnston calls the 'secularist liberal establishment', has allowed itself to be manipulated by that establishment into becoming the servant of our permissive society. Doctors are thus expected to provide unlimited contraceptives, abortions and treatment for sexually transmitted diseases, without comment on the pagan values that underlie this current epidemic of immorality and consequent ill-health. The Christian G.P. who stands against this may be given a difficult time by some of his patients and colleagues.

Confidentiality

With regard to the question of keeping confidences with a girl under 16, Mr Johnston is, of course, perfectly right to say that this would be collusion with a child's deception of her parents. In many respects I find this the most worrying aspect of this issue, as, for the first time in official statements, we have the state actually encouraging caring professionals to interfere with a vitally important family relationship, for the sake of allowing a person regarded in law as a minor incapable of taking full responsibility for herself, to get her own way irrespective of the potentially very damaging consequences to her, and in her family. It is encouraging to see the support Mrs Gillick has enlisted from many thousands of responsible parents in this country who are quite rightly horrified at this possibility.

Confidentiality may be a 'red herring' so far as morality is concerned, but it is at the heart of the case for the conscientious family doctor. If Mrs Gillick's appeal fails, the possibility of his having to face professional disciplinary proceedings for attempting to protect 14 and 15 year-olds from the consequences of their own irresponsibility are greatly

heightened.

As far as treatment of minors is concerned, no sane family doctor would give an injection to, or perform a minor operation upon a child under 16 without the explicit consent of her parents, despite common law and the BMA handbook of ethics. Still less, surely, should any doctor give her a potentially dangerous mixture of hormones that require a degree of maturity and understanding for proper use (in my experience beyond that of some 16 and 17 year-olds) without the explicit *request* of her parents, and even in that circumstance he would have good clinical grounds for refusing.

The Effect of DHSS 'Guidelines'

Mr Johnston's comments about the effect of departmental guidelines are supported and significant. It is statements of this kind that have led to any girl over 16 being entitled to contraceptives within the NHS, the consequences of which are so painfully evident in our sex-orientated society. Statements of this kind *do* shape public opinion and professional conduct, and have done so very successfully over the last two decades. I have had mothers bring their 16 year old daughters to my surgery saying 'we think it's time she was on the pill'.

Additional Arguments for Rescinding the Regulation

Mr Johnston's comments are again on target here. It is now clearly established that early age of first sexual intercourse and multiplicity of sexual partners (both of which will be encouraged by giving 14 and 15 year-olds contraceptives) are associated with an increased risk of carcinoma of the cervix, a still fatal disease that kills many women every year. In young adolescent girls, the pill may interfere with normal growth and developments as well as exposing her to the risk of various thromboses. The additional risk of sexually transmitted diseases (of which we are currently experiencing an unprecedented epidemic) is also of great relevance when considering giving a young teenage girl contraceptives. All these factors constitute good clinical grounds for *not* giving contraceptives to girls under 16. The DHSS view must thus be seen to have little in the way of clinical grounds for support. Its view is really the result of pressure from the permissive society lobbyists, who try to frighten everyone into submission with cries of: 'but we can't let them get pregnant'.

The General Medical Council's Position

Turning finally to the amended clause in the GMC's booklet 'Fitness to Practice', issued in 1983 just before the Gillick case hit the headlines, the implication of this was that a doctor could be in breach of professional etiquette for breaking confidentiality with an under-16 year-old girl over the matter of 'contraceptive advice'. He could thus find himself subject to disciplinary proceedings, and although it is really not likely that this would mean being 'struck off', it would be a traumatic experience and a slur on his future professional career. The alarming thing about this statement is that for the first time the GMC is stipulating a code of behaviour which:

1) Allows no freedom of conscience for doctors who consider the issuing of contraceptives to minors without parental consent to be wrong.

2) Condones the doctors becoming *effectively* an accessory to a criminal

act.

For the BMA and DHSS to deny the latter point is simply double-think. It remains illegal for a man to have sexual intercourse with a girl whom he knows to be under 16. For a doctor to give a girl contraceptives for that explicit purpose, is, logically, colluding with a criminal activity.

It is inevitable that as our society becomes more pagan and hedonistic, Christian doctors are going to have to draw a line at which they will stop bowing to the demands of that society, even if this should provoke the wrath of the GMC. We cannot give medical support to behaviour that so blatantly transgresses the law of God. We need the prayers and encouragement of the wider Christian community to act appropriately in this area, which now threatens the integrity of family life in our nation.

FREE TO MEDICAL STUDENTS!

The publishers of ETHICS & MEDICINE are particularly anxious to help Christian medical students think through the grave questions facing Christians in medicine today.

As a result, free subscriptions are being offered to medical students during their time of training.

Applicants must give their
- home address
- medical school/university
- year of course
- expected date of completion.

We would invite our readers to bring this to the attention of those students known to them. If you wish to apply on behalf of someone else, please ensure that the information requested is given in full and add a note signifying that the person nominated to receive ETHICS & MEDICINE has agreed to your suggestion.

We shall be pleased to receive the names and addresses of students (and others) to whom we can write with details of the newsletter.

DOCTORS AND THE GILLICK CASE

A Legal Comment

Alan Gamble
Lecturer in Private Law, Glasgow

O.R. Johnston's article canvasses many of the varied issues, ethical, medical and legal arising from the decision in *Gillick V. West Norfolk and Wisbech Area Health Authority*. This comment will focus more specifically on some of the legal issues involved.

At the outset, it is significant to note that Lord Devlin, one of the most distinguished judges of the immediate past has categorised the case as possibly being "socially the most important to come before the courts in this decade". As he goes on to point out that is due not so much to what the trial judge, Mr. Justice Woolf, actually decided as to the broader implications of legal and indeed social and moral policy which are involved. As is so often the case with legal judgements in the U.K., these were somewhat side-stepped. It is important to grasp that the actual decision in the case was reached on fairly narrow and relatively technical grounds. One gets the definite impression that the judge clearly felt that these were determinative of the issue and that these having been decided, he could ignore broader aspects.

There were three issues at stake in the legal arguments in the *Gillick* case. Two are fairly technical, though not unimportant. These were (a) *The Criminal liability point* and (b) *The Consent point*. The third issue which is in a sense the nub of the case for the social and moral points of view is (c) *The Parental Responsibilities point*. The judge largely subsumed the third issue in the second. It is highly arguable whether he was right to do so. The decision he took on the consent issue is, it is submitted, not necessarily conclusive of the third point and thus not of the whole case even if it was correct of itself. In general, I think it deserves to be stressed that the judgement emphasises the technical rather than the policy issues of the whole question. It does not properly ventilate what attitude the law should take to parental care and control of the moral and sexual development of children and young people.

The Criminal Liability Issue

It was submitted on Mrs. Gillick's behalf that a doctor who prescribed contraceptive measures to a girl under 16 was an accessory to the criminal offence of unlawful intercourse, (of which the male partner alone can be guilty). The first point to be made here is that this argument really goes too far for Mrs. Gillick's purposes in that if it is correct the doctor would thus be liable even if parental consent was given or the parents notified. The judge pointed this out and went on to rule, rightly, it is submitted that parental consent is an irrelevance to the question of the doctor's potential criminal liability (if any). He did however discuss the circumstances in which a doctor might be criminally liable and although he rejected the wider submission that a doctor is always liable, he did instance a situation in which he might be.

The reasons for rejecting the wider submission seem fairly sound in that

the contraceptives are not so much a direct instrument of the crime as a means to prevent a possible consequence and in general the link between the crime and the prescription was usually too remote. However it was stressed that if the doctor knew of the circumstances in detail and not merely that there was a risk of intercourse with someone at some place and at some time and prescribed contraceptives to encourage intercourse he would be guilty of an offence.

The Consent Issue

As a matter of general law, medical treatment if it involves any physical interference with a patient is unlawful in the absence of consent. The age by which consent can validly be given is fixed by Act of Parliament for England at 16 but the relevant section preserves the validity of consent at common law. What the judge decided was that consent could validly be given at common law by someone under 16 to medical treatment depending on maturity and understanding and the nature and effect of the treatment. As a general statement of law, this is probably correct. It would also be consistent with Scots law which has for centuries recognised a considerable discretion in so-called minors (i.e. boys over 14 and girls over 12). Although the question of consent to medical treatment does not seem to have been decided in the case of a minor in Scotland and the statutory rule recognising consent at 16 does not apply there general principles e.g. in the law of contract recognise a power of choice and judgement for them.

Although the decision on the point of consent is probably correct as a matter of law, it does not necessarily dispose of the case, although Mr Justice Woolf considered that it did. Firstly, the judge completely subsumed the consent issue and the question of parental rights and responsibilities. He stated that parental consent becomes irrelevant if the young person's consent is given. This is logically correct if the issue is approached only *via* the question of the technical law of assault or trespass to the person. It is not necessarily the case if a wider concept of parental responsibility be invoked. Secondly, the contraceptive pill, presumably the most common form of prevention used for young girls is not covered by the consent point at all as its prescription does not amount to an interference with bodily integrity and is therefore not an assault. (The judge conceded this). Thirdly, is it entirely fair to equate contraception with medical treatment as the judge does? This ignores the obvious point that the girl is in no sense sick or in need of medical aid to relieve illness. Further there are social, moral, psychological factors involved in intercourse and contraception especially in the case of an underage girl. All of this seems to support another view being taken. Fourthly, application of the judge's test by valid consent will not be easy in practice for doctors especially in the case of contraception largely for the reasons outlined above. Unless it is assumed as seems to be strongly hinted in the judgement that girls of 15 at least are to be deemed mature enough to give consent as a matter of course. These points taken together lead one to submit that the judge should have had recourse to a wider ground of decision.

Perhaps all of these issues are involved in the question. Is it not illogical that what is popularly called "the age of consent" be fixed at 16 for the purpose of sexual intercourse while consent to contraception can be given at some variable but earlier age of so-called maturity? The "age of consent" is fixed in the best interests of the young people involved but such a concept did not seem to weigh in the judge's decision. (Fairness demands that it be pointed out that it is assumed that parental consent will be the normal situation, but how realistic is this?)

The Parental Responsibilities Issue

This is really the nub of the matter. What the DHSS circular, held to be lawful, does is to remove parental direction and control in the vitally important matter of sex from parents, and transfer responsibility to the young person and her doctor. Legally this was accomplished by the subsuming of the consent issue with this broader one. For the reasons given above this is questionable especially as the consent issue in the context in which the judge discussed it can, by his own admission, have no relevance to the contraceptive pill. The judge should also have had regard to two other arguments related to parental responsibilities.

Firstly greater emphasis should have been placed on the relevance of the underlying criminal law which seeks to secure the protection of young girls against exploitation and abuse and even their own immaturity. This surely fits ill with the decision and points at least to parental involvement. Secondly, it is surely a fundamental principle of law that, in general, the responsibility for the care and protection of children and young persons lies fundamentally with their parents. If these responsibilities are abused or not properly discharged the state, no doubt legitimately, may step in and remove them. But by definition that is an exception. The rule is surely that the law will recognise, protect and foster the vital protective and caring role of parents. The grounds on which parental rights and responsibilities can be abridged or indeed removed themselves support the general proposition. It is submitted in a sentence that the judge should have had regard to this wider principle in deciding the case and that its application would have led to a different result.

An American Perspective

It may be of interest to note briefly some relevant and parallel developments in the U.S.A. In 1973, the US Supreme Court decided that restrictions on abortions in state law infringed a so-called right to privacy. The principle was later applied to a requirement of parental consent for minors' abortions which was also invalidated.

In 1977, the same so-called right was used to hold unlawful under the US constitution a New York statute restricting the issue of contraceptives to young people under 16. American courts use broader methods of reasoning and in general articulate their assumptions and pre-suppositions more openly than British ones. This is true especially of the US Supreme Court. However in preferring the privacy of the young teenager over the state's right to regulate morals the American judiciary went further along the same line of reasoning as used in the *Gillick* case in emphasising the autonomy of the young person.

However, in somewhat of a reaction, the US Supreme Court has now distinguished in the case of abortion between parental consent and notification to parents and have upheld the constitutional validity of the latter being required.

This represents a recognition of parental interests which is to be welcomed.

Obviously the legal context is very different but these examples are interesting as demonstrating a more open discussion of the underlying social issues. It is to be hoped that the Court of Appeal will focus more closely on some of these.

Conclusion

It appears that in view of the grave risks involved in under-age sexual relations physically and psychologically as well as morally, what is really at stake is parental guidance and responsibility. Christians and all citizens have a right to insist that these be continued to be supported by the law. Sadly the *Gillick* case, however correct its reasoning may be on some questions, fails to grasp this pivotal issue of parental care being legally respected and upheld.

The Warnock Report: A Christian Response

A Day Conference sponsored by the
Medical Ethics Group of Rutherford House
University of Edinburgh
David Hume Tower, Lecture Hall B

Saturday January 19th, 1985,
10.00 a.m. to 4.00 p.m.

The recent publication of the Report of the Committee in Inquiry into Human Fertilisation and Embryology, chaired by Dame Mary Warnock, D.B.E., marks a milestone in the development of medical and social ethics.

The Medical Ethics Group of Rutherford House is seeking to stimulate an authentic Christian response to the Report and its recommendations. We are particularly pleased to welcome as a guest speaker to this Conference Professor John Marshall, a member of the Warnock Committee who signed the second dissent to the Report, opposing the use of human embryos under any circumstances for the purposes of experimentation.

Speakers:

Professor John Marshall F.R.C.P. Ed., F.R.C.P., D.Sc., M.D.
Professor of Clinical Neurology in the University of London
Member of the Warnock Committee

Professor Ian Donald C.B.E., M.D., F.R.C.O.G., F.R.C.S. Glas.
Professor Emeritus of Obstetrics in the University of Glasgow

Dr George Chalmers F.R.C.P.
Consultant in Geriatric Medicine, Glasgow

The Very Revd Professor Thomas F. Torrance M.B.E., F.B.A., F.R.S.E., Dr. Theol., D. Litt., D.Sc.
Professor Emeritus of Christian Dogmatics in the University of Edinburgh

There will also be a Panel Discussion with other participants.

Cost: £7.90 (students £4.90) including coffee and lunch. Applications to Warnock Conference, Rutherford House, FREEPOST, EDINBURGH EH6 OJR.

MEDICINE, SCIENCE OR ART?

Reflections on the Doctor in Society

Dr. Paul K. Buxton
Consultant Dermatologist, Fife and Edinburgh

Two families both facing the ultimate reality that confronts us all. The one had lost an older man, long retired, suffering from a stroke and in the fulness of years. The other deprived of an active working man - husband, father and leader in the community. I met them in turn as a young resident hospital doctor whose job it was to meet the relatives of any patient who died on the ward where I worked. The first woman, whose elderly husband had died, was accompanied by her sister. She was distraught, angry and full of recrimination against the hospital, the nurses, her dead husband and herself. No words of comfort from her sister nor my attempts to calm the bitter outbursts of her grief impinged at all. The second family - a mother and her children - what of them? I was prepared for desolation, despair and bitterness, and there was deep grief in their faces but also a calm and peace. As I endeavoured to explain the catastrophic and untreatable episode that had suddenly removed the head of the family the widowed woman said, 'It's all right, doctor, we understand. You see we know that he is with the Lord, and we have the comfort of Christ's presence with us.'

This episode apparently has little to do with the ethics of medical research, but it does illustrate one of the fundamental issues in the practice of medicine today. As we struggle with the implications of in vitro fertilisation (IVF), the question of abortion and the ethics of health care it is essential that we understand the nature of the conflict between good and evil, and are clear as to the basis of our own stand. If there is to be a clear Christian witness in the medical field it can only come from those with an underlying commitment to obey God. This is not just a nebulous concept, but is rooted in the realities of life, as shown by these two contrasting bereaved families - and equally real for the general practitioner facing a crowded surgery with a patient broken by a partner's infidelity, a promiscuous youngster or a housebound incurable in a crumbling tenement. It must also be the reference point for the hospital gynaecologist expected to do abortions as part of his normal hospital work.

In the field of medical research, opinions, reports, conferences and papers are spawned from the surging sea of controversy on ethical issues. What are we Christians to make of them? Should we try to influence the progress of medical research, and what is our authority for doing so? Can we affect legislation that changes the whole framework of human relationships in the family?

The objective of this journal is to encourage, inform and support Christians concerned about ethical issues, whether as patients, nurses, doctors or research workers. It also aims to provide an understanding of the principles behind ethical issues that confront us.

There are many different motives for undertaking research, and one of them is the satisfaction of the purely academic pursuit of knowledge. One of the rewards of a successful research programme is the sense of power it gives to those involved - not only power to control environment

but to change it as well. There has always been a realisation of the moral responsibility of scientists. This has led at times to agonising questions over the use of scientific discoveries. For example, Nobel had many qualms about the use of explosives, but in the end felt he was a researcher primarily and others had to decide the use to which his discoveries were put. The question becomes of a different order when we consider research not on man's environment, but on man himself. The injunction to do 'no harm' is still a guiding principle of ethical committees who have to approve medical research programmes. But what of research into the human embryo? What is 'harm' in this context? How do you argue with those who are committed to a mechanistic view of man, and who regard ethical considerations in medical research on adults as a tiresome restriction and irrelevant to research on the foetus? It is here that Christians have a prophetic role, to proclaim the authority of God as Creator and the need for obedience to Him and His Laws. This may seem a broad generalisation, but nothing else will do as a starting-point in our modern, pagan, pragmatic society. Once we have made clear that obedience to Almighty God is an essential condition for clear thinking and wholeness then there is a strong, certain base for defining the ethical issues that confront us. We may doubt if any researcher whose basis for life is obedience to the Lord would contemplate continuing research on embryo cultures in the laboratory knowing that at fourteen days the majority would be discarded. [1] The justification for such research is often said to be the provision of babies for infertile couples. However, where individuals are prepared to accept their circumstances in the providence of Almighty God the demand that every desire, including that of children, must be necessarily fulfilled ceases to be of primary importance. The party that is answerable to God can have a firm assurance that its activities, including scientific research, will be directed towards fulfilling God's law and for the benefit of society in general. This has been appreciated by a number of eminent scientists such as Michael Polanyi, Professor of Physical Chemistry and Social Studies at the University of Manchester. In his book, *Science, Faith and Society*, he points out the devastating effect of an amoral, godless society in which expediency is put before principle in the use of science for purely utilitarian ends. On the other hand, the firm base for progress in scientific research comes from a belief in God and acknowledgement of that moral absolute. [2] Indeed it is probable that without such a basis science degenerates into the mere accumulation of data without coherent meaningful progress. Historians who have recorded the progress of science have often come to this conclusion. [3] The individual seeking the meaning of life is lead to belief in some form of absolute, whether it is the party for the Marxist, the destruction of social fabric for the anarchist, or the realisation of the Kingdom of God for the Christian. As Jacques Ellul has pointed out, our age is characterised by non-meaning and a dissociation between man and society where obedience to God is discounted. [4] One consequence of this is the view of science which treats it as an almost autonomous force, and speaks of science as the search for truth with the implication that this justifies any direction that research may take because 'the truth is surely a good thing'. This is a mis-conception. It is true that the founders of modern science were men of strong principle with a high regard for truth - but they regarded this as an overall governing principle of their lives, and did not confuse it with the process of scientific discovery, the observation and interpretation of phenomena. Francis Bacon is often quoted as calling this 'thinking the thoughts of the Creator after him'.

Behind all social systems in the world stand certain moral absolutes that are universally acknowledged, and in fact are a presupposition of

religion. This is the 'categorical imperatives' of Kant. So it is not enough that we should seek to return to Christian ethics or persuade others to do so. Rather it is a question of a return to Christianity, not as a system of ideals and ethical injunctions, but rather to find forgiveness and freedom from guilt with the power of God through Christ to enable us to fulfil moral laws. It is of course important to proclaim strongly the fundamental moral absolutes in the world and always with a parallel proclamation of the Christian faith.

As C.S. Lewis pointed out, Christianity did not bring any new ethical code to the world, but a demand for repentance and an offer of forgiveness which is based on the assumption of a moral law that had been both known and broken. [5] Once this is clearly understood, we can return to the dilemmas posed by the advance of medical science and the expectations of society, with a message of hope and good news which enables the individual (whether doctor or patient) to find an ultimate peace and security. This offers a firm basis from which the practical problems can be tackled, an alternative to desperately manipulating the options confronting us with no hope of a solution.

The final subject is that of communication between doctors and society. Those of us who are doctors have a security in our status which seems to be threatened by such a dialogue. In fact such openness is essential if we are to have any continuing credability as professional people. This was well explained by Ian Kennedy, the Reith Lecturer in 1981, and I for one was impressed by his advocacy of a more open dialogue between doctors, society and lawyers, where ethical questions were concerned. He recently put his arguments succinctly in an article in *The Times*. [6] Such communication will help doctors to find their own moral base, and as this is understood by society will avoid arbitrary regulation of issues such as the prescription of contraceptives to underage girls by edicts from the DHSS and recommendations from the BMA or General Medical Council. These tend to reflect the expedient view of bodies who really have no right to make what is virtually legislation, which will have profound implications for both individual morality and the family in society.

I believe that an open communication between doctors and their patients is also essential as a basis for the 'medicine of the whole person', in the phrase of Paul Tournier. He advocated this approach by doctors to their patients long before 'holistic' medicine became popular. If we set out to meet the emotional and spiritual needs of our patients, we have to be prepared to be known as the people we are, and with the beliefs that we truly have. There is consequently a demand on our emotional and spiritual resources, with a risk that we may lose objectivity. But this is not a threat to the doctor who has resources beyond himself, found in a faith in the Living God.

1 Warnock Report.

2 Michael Polanyi, Science, Faith and Society
University of Chicago Press, 1964.

3 Herbert Butterfield, The Origins of Modern Science,
G. Bell & Son, London.

4 Jacques Ellul, Ethics of Freedom,
Wm. B. Eerdmans, Grand Rapids, Michigan, P. 461.

5 C.S. Lewis 'On Ethics', in Christian Reflections
Wm. B. Eerdmans, Grand Rapids, Michigan, 1967.

6 Ian Kennedy, The Times, Tues. Sept. 8th, 1981,
'Where Doctors and the Law Meet'.