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A Christian Perspective

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Rutherford House Medical Ethics Project

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The Project is currently engaged in publishing and in organising conferences, and hopes to be able to expand these and other areas as support allows.

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Back on the Agenda

Behind every statement, pro and con, on the Powell Bill and the many possible successors which are waiting in the wings lies the subject of abortion. The fate of the embryo before 14 days may seem of small import when laid beside the fate of the foetus on the threshhold – or over the threshhold – of viability. The relations of these two questions are complex: certainly there are opponents of abortion who have no qualms about embryonic research and supporters of abortion who oppose it. But there is no doubt that the vigour with which so much of the establishment has supported the Warnock settlement and rejected Mr Powell's dramatic attempt to undermine it owes much to the implications of the Unborn Children (Protection) Bill for the broader question with which its title might more naturally be associated. At the same time, the energetic campaign which has supported Mr Powell is directed by men and women who have their eye on a dramatic extension of the principle of protecting unborn children. This can hardly be a secret, or detract from the fundamental significance of the embryo question *per se*. Abortion is back firmly on the political agenda.

At the same time, and seemingly by coincidence (since the embryo question has been thrown up more by developments in medical technology than by anything else), this same question has found its way back onto the agenda of the Christian church. Two years ago the General Synod of the Church of England passed a strongly anti-abortion motion, almost unopposed. In May of this year the General Assembly of the Church of Scotland moved away from the Kirk's middle position (which saw abortion as bad but necessary in cases *a, b* and *c*) and dominated the front pages of the Scottish press by explicitly repudiating rape as a ground which would justify the taking of foetal life. In fact the Report accepted by the Assembly was a balanced statement which recognised in rape as in other agonising circumstances the presentation of a dreadful choice, but which refused to yield the principle of the inviolability of human life. The publicity given to rape resulted from the unsuccessful attempt made by the Report's opponents to force a concession on this one issue. Supporters of the Report, however, held their ground, recognising that allowing such an exception would undermine the ontological case they were seeking to argue – that the unborn human must be treated in accordance with what he or she *is*. The child conceived after rape remains *Homo sapiens* and therefore a bearer of the divine image. So the Report was accepted, though by a margin that was narrow.

One of the most interesting features of the debate, which is a feature of wider public debate on this issue too, was the involvement of both 'conservatives' and 'liberals' (in general theological terms) on the one side. Despite some media attempts to present it as a coup for theological conservatives, it was nothing of the kind. There are many themes in more radical theology today which have readily lent themselves to an opposition to abortion. The revival of Biblical concern for the weak and defenceless and their rights, and of the equally Biblical interest in peace and not in violence, have brought many to the same conclusion to which traditional theology and ethics have brought others. Every informed observer can see a gradual shift away from the easy acceptance of abortion which led to the passage of the 1967 Act with scarcely a note of discord. The 1985 decision of the Church of Scotland, the Kirk of which David Steel himself is an elder (and his father, another David, a distinguished minister), is incapable of isolation from a dozen other indicators. Professor Thomas F. Torrance, winner of the Templeton Prize and one of the world's leading thinkers on the interface of science and religion, was among those who spoke in favour of the Kirk's Report. He has elsewhere written of the 1967 Act as the 'greatest blot on the British Parliament and people this century'. The foundations of the liberal society of the sixties are, at last, being shaken. It may well prove that the onset of the new reproductive technology is the catalyst for which we were waiting.

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In Christian circles, books have begun to appear – always a sign of intellectual sea-change, as authors are burdened by a message, and publishers sense a market. The present writer has himself collaborated with another member of the editorial team of *Ethics & Medicine* in a volume scheduled for the early part of next year *(Abortion and the Christian Conscience,* forthcoming from Inter-Varsity Press). The Paternoster Press have just given us *Abortion and the Sanctity of Human Life,* a symposium under the editorship of Hugh Channer which includes essays from both E. L. Mascall and Oliver O'Donovan, representing both streams of Anglican conservatism, Anglo-Catholic and Evangelical. We devote the remainder of this editorial to a survey of this important contribution to discussion.

A new book on abortion

Professor Mascall contributes the Foreword, and he begins:

> The most striking thing about the Abortion Act of 1967 is that it has entirely failed to fulfil the prophecies which were so confidently made by its proponents and which led many to give it their reluctant support even against their natural instincts. (p 7)

But 'it is not the primary purpose of this volume to offer alternative solutions to the problems, social or other, which abortion claims to meet'. Rather:

> That purpose is to maintain that, whatever its advantages, real or apparent, may be, abortion is immoral because it is the deliberate killing of an innocent and helpless human being; it is an attempt to solve human problems by the short cut of eliminating human beings. (p 8)

Thus the intent of the volume is plainly set out.

Philip R. Norris begins the volume proper with an essay on 'Medical Aspects of Abortion', which takes its starting-point in the Hippocratic Oath and then proceeds to a survey of the processes of reproductive biology which is informative but also (to a layman) intelligible. Mr Norris adds some interesting remarks on what he calls the 'misuse of medical terms to degrade the unborn', and the question of viability. He notes that, before long, 'the smallest zygote will be capable of being nurtured until it has reached the stage of viability' (p 27). The printing in full of the Hippocratic Oath and the 1948 World Medical Association's Declaration of Geneva is particularly useful.

Next we have a philosophical argument from J. Foster, Fellow of Brasenose College, Oxford. He argues

> that abortion is to be prohibited because it is a grave violation of natural justice. It is to be prohibited for the same reason that any deliberate killing of an innocent human being is to be prohibited because it is, or is morally tantamount to, murder (p 52).

But he adds three theological considerations which, for the Christian, place the argument in context: the doctrines of creation, incarnation and redemption, which spell out for us the specialness of human life in a manner which must make fundamental moral demands of those who accept it. 'Are we to condone', the writer asks, 'the destruction of what God himself has sanctified and has loved at such cost?' (p 53)

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Other papers in the collection make a variety of striking points. For example, discussing IUD's and other abortifacient contraceptives the point is made that

> There is a certain analogy between the operation of the intra-uterine device and the ancient practice of 'exposing' unwanted infants, in that in both cases the organism is separated from the environment it needs for survival and growth. The exposed infant, however, was in better case than the impeded zygote, since there was a chance that it might be found and nurtured by someone else. (p 71)

Another writer, after admitting perhaps too readily that the Bible has nothing to say *directly* about the subject, says rightly that

> What it does is to challenge us to include unborn children along with the defenceless and minorities whose task it is for the strong to defend. What it does is to ask us whether at one and the same time we can assert our faith in a God who seeks the unworthy and the unwanted, and be indifferent to the fact that thousands of unwanted unborn children have their individuality terminated. (p 91)

It is hard to see how much of the liberal writing and thinking which Christians have done on this question would be possible if the firmness of the explicit tradition of the church were known and properly appreciated.

A particularly important chapter, by G. Bonner of the University of Durham, summarises the thinking of the early church on this issue, setting it in the context of the Greek and Jewish thought of the period. This essay is referenced extensively, and the book is valuable for these references alone. It is hard to see how much of the liberal writing and thinking which Christians have done on this question would be possible if the firmness of the explicit tradition of the church were known and properly appreciated.

But perhaps the most important, if at the same time the most impenetrable, of these essays comes from the pen of Professor Oliver O'Donovan of Oxford, whose book *Begotten or Made?* (Oxford, 1984) will be known to many readers of this journal. His argument is concerned with the question of 'personhood'. Given that the embryo is, from the start, in biological continuity with the rest of us, a member of the species, how are we to treat him or her? He ends his essay, and, with it, the book (save for a legal appendix), as follows:

Given that the embryo is, from the start, in biological continuity with the rest of us, a member of the species, how are we to treat him or her?

> The scientific evidence about the development of the unborn child does not prove that the unborn child is a person, because that cannot in principle be proved. We cannot accept any equation of personhood with brain-activity, genotype, implantation, or whatever – for that is to reduce personhood, which is known only in personal engagement, to a function of some observable criteria. However, what the scientific evidence does is to clarify for us the lines of objective continuity and discontinuity, so that we can identify with greater accuracy the 'beginning' of any individual human existence. It is, of course, a purely 'biological' beginning that biology discloses to us; how could it be otherwise? In adopting it as the sufficient ground of respect for the human being, we are not declaring that personhood is merely biological. We are, rather, exploring the presuppositions of personal commitment. The only ground we have for risking commitment in the first encounters with the new human being is biological 'appearance' . . . . We know another person by his unfolding manifestation through appearances, and we know him to be something more than the sum of his appearances only as we attend with seriousness to what the appearances manifest. The Samaritan, who proved to be the Jew's neighbour, was the one traveller upon that road who reckoned that he could trust the evidence of his eyes: 'When he saw him, he had compassion.' (pp 136,7)

It is to be hoped that this volume will be widely read, and its summary of historical, Biblical, moral and philosophical arguments disseminated amongst, not least, the doctors and nurses and social workers who hold in their hands the moral decisions of so many. Perhaps even the politicians will read, mark, learn and inwardly digest.

★ ★ ★ ★ ★

This issue of *Ethics & Medicine* includes articles on a number of subjects, but attention must here be drawn to one by a consultant gynaecologist, in which with unusual candour he explains how he changed his mind about abortion. His simple integrity and moral seriousness will commend what he has written, and what he has done, to others who find themselves on the horns of a grave dilemma.

NIGEL M. DE S. CAMERON

J. H. Channer, ed., *Abortion and the Sanctity of Human Life,* Paternoster Press, Exeter, 1985; £2.90, pp 151.

Student forum

Dr George Chalmers introduces a student forum page which aims to stimulate discussion on issues in medical ethics which today's students are facing.

When I was a student and even when I was first qualified the subject of Medical Ethics was a very different matter from today.

It mainly concerned relationships between doctors and doctors, between doctors and their patients and, perhaps to a lesser extent than nowadays, between doctors and society as a whole.

The main areas of interest were in the realm of the personal behaviour, or misbehaviour, of doctors, their charging excessive fees, associating with unqualified practitioners, setting up in practice too near the doctor with whom they had previously worked and "stealing" his patients, forming illicit relationships with patients, and so on.

All important issues in their own context, but much nearer what we should now call medical etiquette.

Many of the issues which now beset us, were hardly even conceived, let alone defined, at that time.

Today's student may well ask "Why has this change taken place? Why are doctors constantly having to answer questions from the press, from ministers, from politicians and even from their own patients, about matters of Medical ethics.

Well, I think there may be several answers to that and I should like to try to stimulate some thought and discussion about them in these pages.

I would suggest first that *expectations have changed.*

Doctors, traditionally, have been mainly concerned with illness and disease.

More recently, however, we have had to be much more concerned than we used to be with matters which are less related to illness or disease, than to how people live and how people want to live their day to day lives.

Problems related to infertility, to contraception, to abortion, are not matters of disease, there is little pathology involved in any of them, but, because of the background and training of the doctor they are falling into his remit. Embryo research has much more to do with the spirit of scientific enquiry than with the treatment of disease, but it carries great medical ethical significance.

Questions of life and death are possibly more pointed than they have ever been because the answer may lie more in the doctor's hands than it did when his resources were more limited.

The possibility of pre-natal diagnosis, with abortion as an option, for instance lays a new responsibility upon the diagnostician.

Similarly, at the end of life, the question of whether someone should be treated or not; whether they should be allowed to go on living after they have reached a certain age or have contracted a certain type of problem, or not; whether they ought to be afforded hospital resources in old age or not, are all questions which the doctor appears to be called upon to answer, but, are they really medical questions?

These are, again, manipulative decisions, and except insofar as the doctors must be involved because they have the requisite knowledge and skills, they are decisions which hinge upon society's resources and expectations.

This is not to say that doctors are any better equipped personally to handle such matters. Some doctors are, some are not, but they are forced to do so by society's expectations.

Then, also, the *technology has changed.*

One of the main reasons why some of these issues did not arise before, is that the technology was insufficiently developed to make a descision about how to use it relevant.

Physical technology – The tools of diagnosis and treatment with which to see, to test, to change the course of illness, many of them electronic, fibreoptic or isotopic were not invented, or even conceived at that time.

Because there is now the possibility of knowing things which we could not know previously, there goes with such knowledge, the desire, rightly or wrongly, to try to do something about what is known.

There is a very real problem to be faced when knowledge increases which may be best defined in the question "Because you know something, does that, of necessity mean that you must do something?" and this, in turn begs the question "because something can be done, does that mean that it must be done."

Preventive technology, The use of vaccines, etc. to prevent illness has also changed the shape of society, and has changed expectations of the quality of life as well as the length of life. Immunology has done more, in fact to defeat the infectious diseases like tuberculosis and smallpox than antibiotics or any other single group of drugs.

Society, as well as Medicine has changed.

Social patterns are altering. We live in a more egalitarian, but less structured society than previously, and much inherent authority and responsibility has been eroded and diminished.

Communication and information patterns have also changed and with a wider spread of educational opportunity society is better informed about medical as well as other matters.

The pattern of morality too, is changing and actions and attitudes which are commonplace today would not have been countenanced some 20 - 30 years ago. Behaviour has been given a different norm with apparently less restriction, but we should not imagine that this in any way changes the nature of morality itself, nor is it a new phenomenon. The Roman Philosophers complained about the same thing – but we should note – they were doing so when Rome was in decline and we should perhaps be careful about dismissing trends on the grounds that there is always a moaner somewhere!

The spiritual pattern, the pattern of faith, as expressed in church membership and attendance *has also changed*, but, in a curious way it may have changed for the better, insofar as those who still attend a place of worship are, increasingly, doing so because their faith is meaningful, rather than as an expression of mere respectability.

This too has an effect upon the medical situation, since quite a number of people are turning to doctors for advice where they might previously have sought the counsel of a minister or priest. Do we have the skills, the training, the capacity, the faith to handle this?

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The Issues Facing Mankind

PAUL RAMSEY
Harrington Spear Paine Professor of Religion at Princeton University

Professor Ramsey, the distinguished American ethicist, prepared the following submission to the Warnock Committee. He is author of a number of works on ethical issues including Fabricated Man, The Patient as Person and The Ethics of Foetal Research. We are grateful to the Society for the Protection of Unborn Children for permission to reprint it here. The article first appeared in their book The Question of In vitro Fertilization: Studies in Medicine, Law and Ethics (1984).

In 1970 I wrote (concerning many of the procedures now under review by the British Government Inquiry into Human Fertilization and Embryology):

> We need to raise the ethical questions with a serious and not a frivolous conscience. A man of frivolous conscience announces that there are ethical quandaries ahead that we must consider before the future catches up with us. By this he often means that we need to devise a new ethic that will provide the rationalization for doing in the future what men are bound to do because of new actions and interventions science will have made possible. In contrast, a man of serious conscience means to say in raising urgent ethical questions that there may be some things that men *should never do.* The good things men do can be made complete only by the things they *refuse to do.*[1]

Some things to which those words referred have now been done. Others are soon to be done. All were, or are, about to have become inevitable. Persons of frivolous conscience make anticipatory surrender to futures coming upon them, voicing ethical commentary and minuscule reservations about scientific developments that always run ahead of them. Only a people of serious conscience can hope to cut athwart the momentum toward the technological dehumanization of mankind. We must seek our rendezvous with some Nevers, and the good reasons for them.

Only a people of serious conscience can hope to cut athwart the momentum toward the technological dehumanization of mankind. We must seek our rendezvous with some Nevers, and the good reasons for them.

I cherish the hope that the British Government Inquiry will take the lead in the English-speaking world, and in the industrialized nations, in this urgent matter. After all, Great Britain gave us George Orwell, Aldous Huxley, and C. S. Lewis. The latter two – writing in years still under the shadow of Nazism – had the prescience to discern that the final assault upon humanity was not to be from the abuse of political power but of our knowledge of pharmacology and genetics. The questions to ask are: Have we skipped the year 1983? How far are we from Huxley's East London Hatchery with its "Decanting rooms"? Is *This Hideous Strength* already inevitable? Can we stop the passage into *The Abolition of Man*[2]? Are these futures already so far our present that we have lost the ability to say it was not right to go there?

If it is objected that I have begun my testimony in a rather emotional tone, I agree. I have invoked imagery fitting in literary works. But this can be immediately translated into statements of ethical principle. My themes, measures or tests will be (A) the moral repugnance in moving from procreation to the manufacture of our progeny, (B) the integrity of marriage and the family, and (C) respect for an individual human life, however small. These principles sometimes work together, sometimes separately, in moral assessment of medical-technical possibilities that now are about to have become – some will then say – unavoidable. Scientific medicine that does not know where to draw the line of refusal *before* these violations is no longer civilized medicine. It would rather threaten than tend the human condition.

I

The statement of the British *Medical Research Council* on "Research Related to Human Fertilization and Embryology"[3] laid claim to the noble word "ethics". I find – and judge that any person instructed in the traditions of Western morality must find – its ethical analysis fundmentally flawed; or at best, so exceeding thin as to be an example of the sort of new ethics that can aptly be described as rationalization for things men are bound to do because of interventions science has now made possible.

This is clear from the fact that, . . . against the background of a treatment-ethic that justifies in vitro fertilization and embryo transfer, there is then no fundamental limit upon what may be done to a human embryo in order to learn from it . . ., provided only that his research is not still intended for transfer. The latter reservation stays within treatment-ethics. No research-ethic is offered, however, except having a definite research aim and the informed consent of relevant donors.

These are easy to come by. Even so notice how this advocacy-ethic is played out in the Council's statement. Ideally, sperm and ova should have been collected, originally, for definite research purposes if used for such purpose. But donors may also be sought out and their consents obtained where the collection was for therapeutic purposes only. This weakens the limitation, and surely must be intended to do so. Are not people, who no longer want or need surplus stored sperm and ova for their original purpose, more likely to change their minds, when asked, than they are to consent to give semen, or to the procedure for obtaining ova, in the first place for research purposes? Thus research aims are governing, almost solely. Participants in sperm and ova banks are a consent-prone population. And are they not wanted so to be, if embryos are wanted as pure research subjects? Such donors may be informed; but in a strong version of "informed *consent*" – if the donation is to be fully *voluntary* – should not the rule be that *no* embryos be used in research unless donated in the first place for a specific research aim?

Even so, there is more respect given to the informed consent of conscious individuals than there is respect for the human embryo. Of the latter, there is none at all. There are, indeed, two stipulations upon what may be done with human embryos in experiments. These stipulations, which seem to surround the embryo with some protection, are not principled ones; and for them there is no justifying reason, so far as I can see.

The first is: "Human ova fertilized with human sperm", i.e., human embryos, "should not be cultured in vitro *beyond the implantation stage*" (my emphasis). Why not? Since such research subjects are not intended *ever* to be transferred to the uterus, is not this stipulation quite arbitrary? Then, is not the line drawn open to be moved on in time when some definite research aim, requiring that, comes into view? And even if such research aims are, step by step, primarily directed to the care of *other* future individuals, is not the way opened toward the extracorporeal gestation of human embryos, and the manufacture of our progeny? I see no other outcome unless some line can be drawn based upon respect for the human embryo, a unique individual (to claim no more for it) of our species. One can always un-stipulate a mere stipulation.

The second concerns "interspecies fertilization".[4] Such "fertilized ova", i.e. hybrid embryos, "should not be allowed to develop *beyond the early cleavage stage*'" (my emphasis). This stipulation parses the arbitrariness of the first. Why not to the outer limit of the implantation stage in humans, or in the "donor" animal species, or the average of the two? It is sun-clear that drawing lines upon research with the human embryo cannot properly be based on extrinsic considerations only, or on emotional revulsion to culturing interspecific products longer, nor upon some moral reasoning also from respect for a human life however small.

In the discussion of the British Government Inquiry in the House of Lords,[5] Lady Saltoun asked whether the Government would "find it possible to suggest to the medical profession that, pending the report of the committee, they should call for a halt in experiment in the meantime?" In reply Lord Trefgarne stressed that "The main purpose of the inquiries relates to the promotion of viable pregnancies in women who could not otherwise achieve them", adding that "Your Lordships may have seen the guidelines issued last week by the Medical Research Council which will greatly assist in these matters".

I have said enough to indicate that, in my considered judgement, those guidelines do not constitute a good beginning toward determining what the medical profession and a civil society should refuse to do to make complete the good they do. I respectfully express the hope that the Committee will be initially prepared to say "Never" to a number of things that are now being done or proposed that are now proximately possible to be done, and not merely to things that may be only remotely possible. Remote possibilities are soon proximate, and soon done.

II

The paper provided by Mrs J. C. Croft, Secretary to the Inquiry, entitled "Medical and Scientific Developments Relavant to Human Fertilization", was intended to outline existing techniques and future developments that will be discussed by the Inquiry, as reference points to guide respondents who may wish to submit testimony. This paper has been submitted to me; and I recognize, of course, that it is descriptive only and intends no evaluation of the procedures mentioned and sketched.

Nevertheless, it will be convenient – and perhaps helpful – for me to arrange some evaluative testimony around items and statements in this paper.

It is difficult to see that all these procedures are immediately relevant to the treatment of human infertility, or that they are primarily intended, as Lord Trefgarne puts it, to promote "viable pregnancies in women who could not otherwise achieve them". If they are, the meaning of "achieving a viable pregnancy" is stretched beyond recognition and beyond reason.

That is the way I would express my overall evaluation. Another way to say the same thing is in terms of the task given to the Inquiry. That task is terribly difficult and terribly urgent, namely, to distinguish between things that now or proximately, in intention and primary effect, are for the promotion of viable pregnancies in women who cannot achieve them, on the one hand, and, on the other, things that proximately promote and whose primary effect promotes (A) the replacement of procreation by the manufactury of our children, (B) an assault upon and a fundamental violation of marriage and the family, and (C) exhibit and nurture no respect for that "intervening" individual human life – the human embryo – that is now for the first time in human history almost literally "in our hands", i.e., to manipulate as a research subject.

Granting the many "gray areas" and "borderline cases" falling under the Inquiry's mandate, I suggest that at least some light may be thrown upon them by endeavouring in each instance to discriminate between the *intention* of the research (which may be therapeutic) and the primary effects or consequences it may be reasonably expected to have upon one or more of the *moral matters* listed above. Is the way to those outcomes paved with therapeutic intentions? What regulations – including prohibitions – should be issued in Great Britain by some legitimate authority, professional or governmental?

But here, my comments on selected items in the sequence in which they come in the informational paper:

1. Par. 9(b) describes the case of IVF with the egg of a woman (unable to bear and birth a child) and her husband's sperm, the embryo transferred to the uterus of a surrogate mother who carries the child and returns it to its genetic parents after delivery. Par. 10 describes the case in which a husband and wife contract with a surrogate to conceive, carry and birth a child fathered by that husband by AID, to be returned to the married couple, of which only the husband is its genetic parent.

In the first case the husband achieves a pregnancy and the wife achieves a pregnancy, and the pregnancy they achieve is in the surrogate's uterus (if I understand the usage of the term "pregnancy"): she, too, achieves a pregnancy, I also suppose.

In the second case, the donor achieves pregnancy; and, I would say, so does the surrogate. The wife in the contracting couple achieves an infant.

I venture to say members of the Inquiry will have difficulty agreeing upon a different term by which to refer to these different cases in their discussions. More important it is to say that either one is another step toward the manufactury of our children, and both are further assaults upon the integrity of marriage. To suggest that the second "pregnancy, in effect, was no different from other AID pregnancies" is a mistake, even descriptively. The *pregnancy* was no different, of course; but where, in whose uterus, and perhaps other circumstances (money payment, as in the USA) makes a decisive difference in any moral appraisal, and in public or medical policy concerning the matter. The AID *procedure* was the same. But two steps of the same *sort* are still two steps – unless we are to say that by going to the practice of AID this next step was *then* already about to

have become inevitable, and is *now* thereby rendered morally justified.

Consider next the surrogate woman in either case and what we are to say about the competence and power to be ascribed to her "informed consent". in morals or in medical and public policy. *Choice*, I suggest, does not make right right, or wrong wrong. Our *common law* held that no one has property right in his or her own body; nor did the family of a deceased person have any property right in the body. This language protected persons from – voluntarily, I shall presume – abusing their bodies by using them in commercial transactions – today, say, by selling a paired organ to pay a child's $12,500 a year tuition at Princeton University: parents were to be barred from such well-meant devotion. As for the family of the desceased, to say they had no property right in the body was to say their right over it was to provide decent burial.[6] In the US, the Uniform Anatomical Gift Act was needed to change the common law by statute. In doing so, that Act legislated precisely the protections from commercial use of one's own or another's body. A pre-mortem power to give an organ was instituted, but not a power in families to give parts of the deceased's body without that pre-mortem gift. I conclude that charitable intentions do not morally warrant violation of one's own or another's body, not to mention money payments (which the British Government Inquiry may readily agree should be given an effective Never).

Choice, *I suggest, does not make right right, or wrong wrong.*

It is the supposed rightful power of "charitable" voluntarism on the part of the surrogate woman to place herself at the disposal of medical technology and of the husband-wife couple in both the above cases that needs to be questioned. Distinguishing between the *therapeutic intention* of procedures and their *primary effects* and consequences, whatever the intentions were, is the way to parse these "developments", if they are viewed as gray or borderline. Their objective results in promoting self-violation, further assaults upon the natural foundations of the integrity of the marriage relation, and new ways toward manufactury of children are, in my view, evident and sufficient reason to say No to such procedures for promoting viable pregnancies in women who cannot otherwise achieve them. To argue the contrary renders women substitutable for one another in procreation (by consent, of course).

2. **Cloning an embryo.** Therapeutic aims are stated here, i.e., to culture and test for chromosomal diagnosis some of the clones while one or more is frozen awaiting the test results before transfer (par. 12), and to determine the sex of the one to be transferred and given birth (par. 24). These are definitions of viable pregnancy, provided in the second case the unwanted sex is a defect of a foetus. With no more defect shown, genes for other traits desired in a child can be used to satisfy other definitions of a wanted pregnancy. Do we know no more how to define *desirable* than that something is *desired?* That was one of J. S. Mill's fundamental mistakes, it is universally agreed by those who know anything about moral reasoning.

If, however, the description – "the embryo would then be allowed to develop to the two or four cell stage where it would be cloned" (par. 12) – were turned into a *norm* in morality and for policy, it would be an evidently *arbitrary* stipulation, with no justifying reason that I can see. But *if*, in the alternative, the fact is that the procedure of cloning is *not* (or not now) possible beyond the four cell stage, the procedure could be repeated on each of the four cells when they in turn reach the four cell stage. So we have 16, and so on to an indefinite number of identicals cloned for research from an original fertilized egg. If there is objection to the storage of frozen embryos for some indeterminate research purpose (or for soliciting consent from people who had them frozen for some passing therapeutic purpose), there certainly should be the same objection to their multiplication.

Speaking as one of those clones helped to continue to develop (as I might if only I had been conceived in 1984 instead of 1913), why should anyone be so fearful of a host of us identicals, since there are so many good uses to which to put us if cloning is done again and again during the early cleavage stage?

And why put an end to any of us? Each is the same as the one chosen, by present primitive early transfer, to enter the human community; or, given only time, finally to be placed in Research Park to supply organs to favoured grown "twins".

Cloning as a method of choosing the sex of a wanted child (or the wanted sex of a child), par. 24, requires maintaining a clone obtained at the four-cell stage until that determination is possible (if this is later).

And par. 30 of the informational paper gives already another benefit to come from preserving cloned embryos, beyond sex determination, until foetal organs develop that are suitable for – are we to suppose – *foetal* transplants? Some organs will be *usable* for transplant later in gestation than other organs; some only very late.

Moreover, to limit this benefit to "foetal organs" in this paragraph serves simply to stay within the mandate of the Inquiry. No reason can be given that I can see for wasting this benefit by stopping at the foetal stage.

I have rehearsed the above from the informational paper simply to conclude that there is here – from the beginning and not in the end only – absolutely no regard for embryonic life; respect for that novel research subject exerts on experimentation no influence whatsoever; it is already and altogether tissue only, not its later organs only, whatever the therapeutic intention may be. And I also conclude that, from the beginning and not in the end only, this is already the manufacturing of our children – in this instance, by the use of identicals that have been arbitrarily *deemed* to count for nothing, for a favoured one, who counts for all. In my considered opinion, there is already the odour of totalitarianism in such use of a unique individual human research subject, and in the multiplication of more for like purposes.

3. **Freezing embryos** to be unfrozen later for transfer to enable women to establish a pregnancy "years after" they or their partners have been sterilized or "even after" their husband's death (par. 16(a)). Post-sterilization and even posthumous use of an embryo puts a nearby time limit upon the transfer, bearing and birthing of a child, providing progeny – I assume – for wife and husband. I suggest that while there is here a therapeutic intent, once we learn to do this, and do it, the primary effect and consequence will show those *time* or *marriage* limits to be ostensible only. Of the latter I have said enough. The posthumous transfer, as described, assumed the *husband's* death. But if the *wife* dies first, from the same motivations of love or childlessness – if that justifies – the husband may

secure the blessings of a child "with" his deceased wife only by searching for a surrogate "mother". Of that, too, I have said enough.

And, of course, that is not the end of the posthumous transfer of frozen embryos. For Nobel laureates to deposit semen in a bank in the backyard of a California millionaire is, after all, a very primitive method of improving the intelligence of human offspring to come. When both egg and sperm can be chosen, i.e., both genetic componenents, and then when embryos of two brilliant people can be frozen to await surrogates, married or unmarried, who want such a child, these ways of improving our progeny will offer some measure of greater chance of brilliance than from the frozen semen of (self-) selected man. Such a voluntary programme of genetic improvement would surely be advocated by the late H. J. Muller, if he were alive today. And a Hitler – if not quite mad – would relinquish his "natural" method of producing supposedly superior children for a voluntary or involuntary programme – if quite mad in another sense – of using frozen embryos, perhaps posthumously if their genetic fathers were killed in battle.

For Nobel laureates to deposit semen in a bank in the backyard of a California millionaire is, after all, a very primitive method of improving the intelligence of human offspring to come.

4. Par. 27 gives *drug tests* on human embryos cultured in vitro as an example of their experimental use. There are an unknowable number of other sorts of experimentation with the human embryo, beneficial to others, counting the embryo for nothing but means. This paragraph also states the reason there will be increasing, almost relentless pressure to keep this novel, "intervening" human subject classed as a mere means for research use (or, what is subject to the same ethical analysis, a mere means to therapeutic goals):

> "The protagonists of the use of human embryos for experimental purposes argue that the best species for human experiment is *man*, and claim that many uncertainties of human embryology and genetics could be resolved by experiments of this kind" (emphasis added).

To pass from "animal work" to human trials is always a move that has *unknown* and *unknowable* risks – no matter how thorough, prolonged, complete and successful are the trials in animal models. So, we are told we *must* not waste this opportunity to use *man* to benefit man. That's the significance of what I have called this "intervening" human research subject.

Now, the risks of passing from animal trials to human trials are to be stressed, if we foolishly fail to use this best of all subjects to fill in the gap.

But *before* this new experimental subject became available in great numbers (whose numbers can be deliberately increased by procedures that will be the same if we continue on to the entire manufactury of our progeny), these same risks of passing from animal to human experimentation are *now* frequently said to be so minimal as to be negligible.

My comment consists in some observations upon this paradox. *Now*, we must use the human embryo and foetus to avoid the risks. Before, we had to proceed at those same risks. The obviousness of these "necessities" before and after the embryo and foetus fell into our hands – calls for some discrimination to be made.

Of course, it was both necessary and right for medical science and the human community to place innumerable children at unknown and unknowable risks in widespread field trials of polio vaccine. I need not stay to mention other cases that will occur to any reader of this document.

Another class of cases is worth pondering. The first use of frozen human semen in AID (in the US, I believe) placed the children some women wanted by that means (if, indeed, they were informed that fresh semen was not to be used) at unknown and unknowable risk. This must have been so, if I understand what is involved in moving from animal trials to human. This, despite the fact that good calves had been produced from bull semen frozen for thirty years; the animal work, in this instance, was thorough and complete. But *one could not get to know* whether frozen semen would not, uniquely in the human, be seriously damaging to the children-to-be. That, I say, was an immoral, and unnecessary, experiment upon them. No scientist should have done that; nor any woman have consented to it.

The same reasoning applies to freezing and unfreezing the human embryos planned for transfer, or the cloned one planned to be entered into the same sequence of freezing and transfer. No matter how complete and successful in the case of animal embryos, to move to the human puts future human beings at serious risk. If freezing, or cloning and freezing (for a short time, while medical tests are done on identicals), followed by transfer *succeeds*, that will not show that the human trial was moral *when done*. A human experiment must be moral *in its inception*, not in its outcome (I believe I quote the late Dr Henry K. Beecher correctly). The same can be said of *long-term storage* of frozen embryos for subsequent "treatment" of the childlessness death may bring on a husband or wife. Genetic surgery and gene-splicing may also be listed here – to raise, at least, the same question about their first human trials. Finally, the physician in the doctor-lawyer team who advertizes for surrogate "mothers" in newspapers all over the US says that *one reason* he is doing this[7] is that he wants to "study" over years of time the effects, psychological or otherwise, upon the surrogates from bearing children for another couple. *That* information he cannot obtain without putting women at risks he might discover are actualized, and now hopes are not there in what he is doing. Others may draw attention that he has set up no good *scientific* test to get that knowledge. I say, the experiment is immoral in its inception, and would still be to do *wrong* with that knowledge may come of it, even if his was good social science testing.

So I conclude that if we listen to *the reason* now given for using *disposable* human embryos we ought to know that a number of procedures proposed today ought not to be used upon *favoured* human embryos, because the first human trial must necessarily be immoral in its inception, regardless of the outcome. We will have brought upon a child-to-be unknown and unknowable risks, unnecessarily and on balance without sufficient over-riding reason.

This was my view of the Edwards-Steptoe undertaking to prove that in vitro fertilization and transfer was possible: and would have remained my ethical analysis if the "animal work" with primates was completed before passing to the human.[8].

I do not put this judgment of mine "up front", simply because that is a bridge already under the water – to coin a phrase. I am not the expert to judge whether Dr Michael

Thomas is correct in holding that there is as yet insufficient grounds for a scientific judgment that IVF-transfer babies are not damaged. I do not need to know the scientific requirement to be "about 3000 test babies before we could be sure the risk isn't there".[9] No one needs to know that the figure is 50 or 3000 or 30,000 successful test babies, to sustain the argument I put forward.

One has only to listen to what scientists tell us is the gap between "animal work" and human trials (and what is *now* said about not wasting the opportunity afforded by *human* embryos as research subjects) in order to know (take any figure as sufficient for a procedure to be classed as no longer "experimental") that *up to that point on a descending curve* the procedure was subjecting children-to-be (not just "the potentiality of life") to unknown and unknowable risks of unknown and unknowable damage. This is the case almost *analytically*, if science is believed. To repeat this commentary refers to artificial insemination with frozen-unfrozen semen, to amniocentesis to select foetuses to be given birth[10] over those genetically indicated for abortion, *or* to IVF-transfer babies *only* to illustrate how the morality of "setting up a pre-natal adoption service using banks of eggs and embryos" (*The Guardian*, Feb. 8, 1982) should be *analysed*, and other future possible ways of producing children or altering them in utero.

Note well, I have *not* been speaking of embryos planned for research, and so planned for *discard*. The *favoured* embryos have also to count for next to nothing, when thought of as children-to-be. They, too, must be *disposable* mishaps, if mishaps come upon them in the course of the genesis chosen for them; replaceable by another pregnancy induced by yet another trial of the same procedure.

The other moral standards I suggest be used also apply. Does the goal of providing fertility by these procedures, when successful, open a wider path toward the manufactury of human progeny, and further threaten the foundations of the marriage relation? I judge no one can read the informational paper and fail to answer these questions in the affirmative.

In no essential respect should proposals for the manipulated *genesis* of a human embryo be compared with placing young lives, for example, at unknown risks of unknown damage in field trials of polio vaccine. Those lives were already members of a population at severe risk: each individually bore the risk and stood to benefit. Nor is the new genesis to be compared with venturing gene-splicing to learn to perfect genetic treatment of Tay-Sachs babies. This will be "surgery" (not "engineering" new beginnings); no new medical moral landscape will be brought into view: the life at risk is already a life and already at graver risk. In new forms of human genesis, however, the life placed at risk is *not* the same as those whose desires may be satisfied by thus overcoming infertility – posthumously, even – or by those risks brought upon another life so manufactured in order to make scientific progress.

I cannot conclude these comments without expressly addressing the matter of abortion. If it is said only that abortion stands ready to take care of any mishaps before they are children I might ask whether early infanticide – delayed birth certificates, as some have proposed – also stand ready? And ask, why not? The more fundamental response, however, is to say that this recourse demonstrates that *now* – not by some "slippery slope" into the future – we would already in principle be manufacturing our progeny. By primitive methods at first, of course. General Motors has sometimes to recall 500,000 automobiles to replace defective parts. The analogy to using abortion as an escape from producing defective children would be recalling those automobiles and destroying them.

But a more basic objection to the foregoing moral reasoning appeals not to the *fact* of the availability of abortion but to persons' views on the *morality* of abortion. It will be said that ethical objection to the new genesis of human beings depends on one's view that abortion itself is always or nearly always immoral. This mis-association must be answered.

Of course, any individual who believes that abortion as such is a moral wrong will also *for that reason* oppose the new proposals for human genesis, because in order to get to know how to do any of the proposed procedures we must be prepared to use abortion for a longer or shorter series of trials. Grant that. Still I want to suggest that people who wholly approve of the British Abortion Act, and of its execution, may nevertheless and should nevertheless disapprove of the abortions here necessarily contemplated. This I have wanted, in the above, to isolate – to bracket – from any general moral objection to abortion. So, while I do not know Dr Michael Thomas' opinion of abortion as currently legal and practised in Great Britain, I must say that the *Guardian Weekly's* editorial, February 2, 1982, was flawed. That editorial linked Dr Thomas's objection to the new gensis to his views on abortion in general (I do not deny that this may be so in his case) and went on to say among other things:

> If our society accepts that abortions are permissible until a life is considered to be viable on its own, at 28 weeks gestation, then logically it would seem possible to devise a code of practice under which test-tube embryos could be experimented upon up to 28 weeks.

I suppose it is possible to devise such a code, but it in no way *logically* follows from current British abortion practice.

For in the latter case (in prinicple) we are balancing *existent* life against other existent lives. Suppose we agree that the mother's life and health broadly interpreted, that the family's economic and other welfare, that the welfare of children already born may be deprived by another child born into the family, and that these are countervailing considerations that *are* over-riding and that justify therapeutic abortion – in the broadest possible meaning of "therapeutic" – *all that* in no degree justifies *creating* a new human life at risks that *foreseeably* may require subsequent abortion.

So I suggest that people who wholly approve the British Abortion Act and its practice have *good reason* to oppose recourse to abortion necessary in developing new forms of human genesis. However rapid and extensive the developments in contemporary abortion practice, these are extensions of the concept of "necessity" in conflict-of-life situations. To continue on the way of the new genesis of human lives involves no such "necessity" – not in the genesis itself. Appeals to the morality or the practice of abortion must rather be viewed as demonstration that modern society means to proceed, under that guise, to the making of its children.

A final objection will be that the analysis and moral reasoning I propose would *stop* medical and scientific progress. Indeed it would, because I refer to experiments immoral in their inception. To this ostensible objection I can only refer to what I said about a *serious moral conscience* in these matters. The question is whether we

have the ability to say "Never". It will be something, at least, if in Great Britain it says "Never" to surrogate motherhood, not to be expected in the United States. The argument holds as firmly for saying "Never" to any human genesis that entails first creating human life that then may be destroyed if not the desired "product".

5. I ought, responsibly, to comment on one further, distinct item in the informational document. This is also most complex, and incorrigible to certain analysis. On the *genetic* manipulation of embryos, the instance given (par. 29) is identifying and replacing the gene for cystic fibrosis in an IVF embryo. Other *single gene* diseases are mentioned. The limitation to IVF embryos can, I think, be ignored; and the supposition be that this could be done in embryo, foetus, child or adult, the course of future possible genetic treatment ("surgery") of suffering individuals. That surely would be a consummation desirably to be wished, if the relief of specific illness were the only consequence to be considered. If only the afflicted individual needs to be considered, one should ask only – but one *should* ask, as in all surgery – whether the genetic treatment of cystic fibrosis is likely or not to produce less or more debility than the illness iteself. This is a question all major surgery faces.

Sadly, one must add to the above statement of ordinary *treatment*-ethics that the elimination of *one gene* (defective) requires its replacement by another gene (nuetral, or *improving* of that individual). So even in the case of genetic treatment of an individual we face the fact that *negative genetics* cannot be separated from electing *positive genetics* of one sort or another. So far good – except to say that a facile conclusion to that effect without US Nobel laureate Marshall Nirenberg's sombre pondering of the awesomeness of our ever learning to move one gene around (involving another in its place) shows inadequate understanding of the gravity of the step taken.

The measure of risks to be accepted in proceeding with genetic treatment is the balance of the seriousness of the illness to be relieved against possible debilitating outcomes of the treatment itself.

To proceed against Tay-Sachs, for which there is no known cure, Yes. Against cystic fibrosis, for which there is some relief, less certainly. To proceed to gene change in the case of diabetes, however, would surely be an immoral trial. The aim of medicine is to make a patient well, or at least *less ill* than before.

The simple medical situation, however, is further complicated if we ask what happens to the gametes of the afflicted individual. If his or her reproductive cells are unaffected, or if the sperm or ova are in turn deprived of the transmission of cystic fibrosis to offspring, that would be addtional defense of the original genetic treatment. But what if the effect of that genetic treatment of individual sufferers may have unpredictable effects upon their gametes? Then instead of eliminating a deleterious gene from the human gene pool, we shall have thoughtlessly begun to "engineer" their progeny in unknown and unknowable ways. Shall our policy be that those benefiting from genetic therapy shall accept sterilization to prevent these outcomes?

This would seem to be sufficient cautionary "go slow" signs facing the medical application of genetic knowledge to human beings. Still these signs are not negative. (All said above about creating or cloning embryonic human research subjects for the purpose of carrying out such tests remains in place.) The treatments proposed for trials, properly limited by the usual medical estimates of costs and benefits *to the patient*, are sound. Modified only, but significantly, by the effects upon the patient's progeny.

Today DNA research, gene-splicing, whole chromosomes replaced by others, have leapt light-years ahead of the foregoing situation, however simple; even its complexities seem simple by comparison. Under the production of inter-species embryos, the informational document speaks of hamster-human hybrids; and, one might say if this were an evaluative document, with some regret that such hybrids can now be maintained only to the two-cell stage (par. 26). In the United States we have Mighty Mouse, a creature produced by gene-splitting, that from small mice produces very large rats.

What future does this hold for genetic engineering of the human race? It remains the case, I suppose, that a splice of genes eliminated must be replaced by another splice of genes. That, therefore, negative energies cannot be separated from positive eugenics. The apology – in the best sense of that word – in the United States for DNA research and application is that we are learning about cell development, and specifically that we may learn how to cure "cancer" – a code word that instantly gains approval. But surely more is involved than that, in the primary consequences to be expected from DNA, whatever the subjective intentions of the researchers.

Some discrimination should be attempted by public authorities, such as medical associations and the British Government Inquiry. I note that I have already reasoned that no such research is ever justified on an unconsenting research subject, a human embryo obtained or cloned for that purpose, who was not before its creation subject to any risks at all. Beyond that, and I suppose on consenting subjects, or unconsenting subjects already existent and in serious need of radical treatment, I can only endorse the recommendations of the (US) President's Commission that all DNA research and applications be *monitored* in future.[11]

This means, I take it, monitored in each and every specific use of DNA knowledge in the human – monitored in every particular case, not simply checking the accord between research and general guidelines laid down for it to follow.

I hope that the British Government Inquiry will endorse this proposal, and go further. No hope should be placed in merely national governmental or medical association regulations. Already, in Australia experiments in freezing embryos have gone beyond what the British Inquiry may approve. So, if there is point in national monitoring of specific applications of DNA, this must be *international*. So I urge that the Inquiry take the lead in pressing upon the European Parliament, the United Nations, or other international bodies, the need to monitor and control the use of the knowledge of human genetics that DNA has opened to us.

Why I am so concerned that the British Inquiry not parochially limit itself to monitoring DNA research in Great Britain alone can best be expressed by recounting certain personal episodes. Since I became concerned about measures for *Fabricating Man* in the late 1960s, on many a panel in American universities on the subject of the new genetics I was astonished to hear scientists on the panel (those were the "cold war" days), nay, even stupefied and nonplussed to hear these academic scholars suggest that even now certain powers (Red China was meant) were producing physically superior soldiers, and intimated that we had to do this also. Then the pseudo-question was competition in producing superior men. Now surely the

competition is as intense in the furtherance of scientific possiblities. So I say there must be not only national monitoring but international monitoring of DNA research and its specific application. If not, results will outrun all moral and civilized control. So I urge the British Inquiry to take the lead in the international control of these new powers human hands have now obtained.

To conclude: a fellow townsman of mine in Princeton, New Jersey, Freeman Dyson, a member of Princeton's Institute for Advanced Studies, a British citizen and a member of your war department in some capacity in World War II, recently published a book entitled, *Disturbing the Creation,* concerning the course of past nuclear decisions. This was a very melancholy book; the combination of *technology* and *bureaucracy* seemed to him inevitably fateful and erroneous; their momentum beyond human control.

I refer to Dyson's book to say that we are in the midst of another "disturbance of the creation" as a result of the biological revolution. In the revolution of nuclear physics we had not even the foresight to provide for the disposal of nuclear waste before we went for the peaceful use of nuclear energy! Now the Western world is alerted by various movements concerning nuclear arms policy to what may have been flawed decisions past. The public concentrates upon *past Faustian bargains* made with nuclear power and its sequelae.

Are we unable to concentrate on the *Faustian bargain now being made* with powers released to human control by the biological revolution? Does the momentum of biological technology rule our future? I myself believe that this may not be so. But if one reads the newspapers the conclusion must be that we the people seem able to try to contain Faustian bargains previously made by past generations, neglecting those currently being firmly enacted, without much notice, by the momentum of biological technology. So I conclude with some words from C. S. Lewis:

> . . . All long-term exercises of power, especially in breeding, must mean the power of earlier generations over later ones . . . If any age really attains, by eugenics and scientific education, the power to make its descendants what it pleases, all men who live after it are the patients of that power . . . The last men, far from being the heirs of power will be of all men most subject to the dead hand of the great planners and conditioners and will themselves exercise least power upon the future . . . There neither is nor can be any simple increase of power on Man's side. Each new power won *by* man is a power *over* man as well. Each advance leaves him weaker as well as stronger. In every victory, besides being the general who triumphs, he is also the prisoner who follows the triumphal car . . . The man-moulders of the new age . . . we shall get at last a race of conditioners who really can cut all posterity in what shape they please . . . Nature will be troubled no more by the restive species that rose in revolt against her so many millions of years ago, will be vexed no longer by its chatter of truth and mercy and beauty and happiness. *Ferum victorem capit:* and if the eugenics are efficient enough there will be no second revolt, but all snug beneath the Conditioners and the Conditioners beneath her, till the moon falls or the sun grows cold . . . (We should) not do to minerals and vegetables what modern science threatens to do to man himself.[12]

Notes

1. *Fabricated Man: the Ethics of Genetic Control.* New Haven and London: Yale University Press, 1970, pp.122-123 (emphasis added).
2. This is the title of C. S. Lewis' prose essay that should be read as a companion piece to his fictional *This Hideous Strength.*
3. *British Medical Journal,* Vol. 285 (1982), p.1480ff.
4. The Council's statement gives the aim or possible benefit of creating such novel research subjects. There will be citizens of Great Britain who will invoke Leviticus as basis of their religious and moral objection to it. Lev. 19:19 is the verse. A fresh interpretation was offered by Benjamin Freedman, "Leviticus and DNA: A Very Old Look at a Very Old Problem", *Journal of Religious Ethics.*
5. Official Report of the Proceedings, House of Lords, November 30, 1982.
6. The reference I am familiar with is Paul Ramsey, *The Patient As Person,* New Haven and London: Yale University Press, 1970, pp.204-206.
7. The lawyer has stated that he wants to clarify our muddled law – which, being interpreted by this layman, means that he wants to bring about widespread social acceptance of the practice before our laggard law can do anything about it.
8. See Paul Ramsey, "Shall We 'Reproduce'?" I. The Medical Ethics of In Vitro Fertilization. II. Rejoinders and Future Forecast", *Journal of the American Medical Association,* Vol. 220, nos. 10 and 11 (June 5 and 12, 1972), pp. 1346-1350, 1480-1485; and Paul Ramsay, *On In Vitro Fertilization,* which was my testimony before the Ethics Advisory Board of the US Department of Health, Education and Welfare shortly after Louise Brown was born in England, published in the *Law and Medicine* pamphlet series of Americans United For Life, Inc., 230 North Michigan Avenue, Chicago, Illinois 60601. See also two articles by Professor Leon Kass, M.D., Ph.D., the Henry Luce Professor of the Liberal Arts of Biology at the University of Chicago: "Making Babies Revisited", *Public Interest,* No. 54 (Winter 1979) pp. 32-60: and "Making Babies – The new Biology and the 'Old' Morality", *Public Interest,* No. 26 (Winter 1972). Professor Kass' articles were published at about the same time as my two listed above, and were also; roughly eight years apart in time. His first article and my first, were written in preparation for an international conference on our medical technical futures sponsored by the Joseph P. Kennedy, Jr., Foundation in Washington DC., for a panel on which Dr Robert G. Edwards was also a participant. Subsequently Dr Edwards published his article, "Fertilization of Human Eggs in Vitro: Morals, Ethics and the Law", *The Quarterly Review of Biology,* Vol. 49, No. 1 (March 1974), pp. 3-26 (Stoney Brook Foundation, Inc.). The second roughly contemporary articles by Kass and myself were occasioned by the apparent success of the Edwards-Steptoe experiment. Both of us – I venture to say, the two, persons in the US who have given the most sustained attention to the moral and public policy issues of IVF – had occasion to comment in these articles on Dr Edwards' 1974 analysis of such implications of his work. A shorter and revised version of my *On In Vitro Fertilization* was published in Great Britain in *Crucible,* London: Board of Social Responsibilities, Church of England, Oct.-Dec., 1981, pp.175-181.
9. Dr Michael Thomas' figure, as reported by Peter Williams and Gordon Stevens, "What Now For Test Tube Babies?", *New Scientist,* Feb. 4, 1982.
10. Concerning *amniocentesis* Dr Henry Nadler, Children's Memorial Hospital, Chicago, wrote (in an article written in 1970, published in 1972) that *only* defects established before amniocentesis was performed could be excluded from its possible adverse effects. "There is no way with present studies", he wrote "of establishing ten or fifteen years from now if these children lose 5 or 10 IQ points. We might be able to get an approximation during the first years of life if their rate of growth is significantly different. However, *more subtle damage will be difficult to evaluate",* in M. Harris, ed. *Early Diagnosis of Human Genetic Defects: Scientific and Ethical Considerations* (Symposium, May 18-19, 1970) US Government Printing Office, 1972, p.182 (my emphasis). This suggests that to declare a procedure manipulating human genesis to be no longer experimental needs more than any number of grossly successful trials. *Longitudinal* psychological tests over many years against an equally numerous "control" group seem also to be required.
11. *Splicing Life: A Report On The Social And Ethical Issues of Genetic Engineering With Human Beings.* Nov. 1982, p.87. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research. US Government Printing Office, Washington DC 20402. The "President's Commission" was the chronological successor of the Ethics Advisory Board within the Department of Health, Education & Walfare. The latter was short-lived, reporting to the Secretary only on IVF research. It was successor to our temporary National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research.
12. C. S. Lewis, *The Abolition of Man,* New York: MacMillan Co., 1947, p.48.

Ethical conflicts in long-term care of aged patients

An ontological model of the care situation

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Abstract

The care of the patients is analysed by means of an ontological model of ethics developed by Lögstrup. The analysis is based on experience from the care of aged patients with dementia. The patient and the caretaker are linked by a mutual dependence, the interdependence. The interdependence provides a state of mutual power. The caretaker influences the patient. The patient influences the caretaker. The interdependence thus produces an ethical demand and a responsibility of both patient and caretaker. The ethical demand introduces a tension between spontaneity and role (routines, professionalism) in the caretakers. Care work is distinguished by a dynamic interaction between patient and caretaker. The nature of this interaction makes it reasonable to regard care work as a vocation. When an aged patient with dementia enters the terminal phase and becomes difficult to spoon-feed, all caretakers should discuss and share the decision of "tube-feeding" or "no tube-feeding". If the decision is reserved for the medical chief, the other caretakers are deprived of their human ethical competence.

Introduction

There is a common view that moral ideas are expressions of pure feelings or subjective and individual opinions. Applied to the care situation, this view means that it is only an expression of a feeling or a subjective opinion among the caretakers that the patient has to be taken care of.

The experience of a caretaker is contrary to the above-mentioned view. Man's acting is decided by more concrete realities than only subjective opinions and passing emotions. One such fact is that the patient is there, independent of the feelings of the caretaker.

The aim of the present paper is to provide an ethical view, which is not an emotive or subjective theory. This view is that the opinions of how the care ought to be performed emanate from the real phenomena of the care situation. This view is also that the care situation is only a special case of what is called a "broadly human situation of life".

The first task is to describe some fundamental characteristics of this broadly human situation, which are of ethical relevance. For this purpose we use the ethical model developed by the Danish ethicist K. E. Lögstrup[1]. We call his model a type of ontological ethics, because it is based on an analysis and a view of the human life, of "that which is" (= "ta onta" in Greek).

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The ethics of Lögstrup[1]

First, there is a given structure in the human situation, which is not only a result of the cultural work of man. The task is to understand this structure. In a strict scientific sense, it is not possible to verify, that reality is structured just like this. There is always added a human interpretation of the "reality". The reference to the elements of the human situation is, nevertheless, a good argument for the view of this ethics; there is a feed-back between reality and the ethical model.

Second, one man is always dependent on other men to be able to live and develop. In a situation with many individuals involved, one individual cannot withdraw to a neutral position. He or she is always intermingled with the other individuals in a way that requests a decision. This structure of dependence between people is called the *interdependence.*

Third, one consequence of the interdependence is that *power* is a central phenomenon in ethics. The moral question is how this power is executed. It can be used constructively or destructively.

Fourth, the individual experiences an *ethical demand* in every situation to make a decision and use his power over the other individuals in such way that the other's abilities to live is constructively promoted. The individual has to decide what ought to be done in the concrete situation. This belongs to the *responsibility.*

Fifth, another consequence of the interdependence is that *trust* is a fundamental quality of human life. It competes, however, always with *mistrust.* Yet trust is thought to be more fundamental than mistrust.

Sixth, *the spontaneous utterances of life* such as mercy, love and forgiveness demonstrate that the constructive elements are fundamental in the existence of man. The individual is first moved by them and does not decide to move. It is impossible to value them as something bad and at the same time promote and protect life. This is a sign that the broadly human situation – and the care situation – is primarily moral, not moral by the valuation of man[2].

The care situation

The ethics of Lögstrup described above provides the tool for an analysis of the care situation in the present paper. The central concept *interdependence* means that there is a mutual dependence between patient and caretaker. There is also a mutual dependence between caretakers. This mutual dependence has to be interpreted and formed concretely.

The interdependence between caretaker and patient provides a special kind of emotional energy[3]. It is desirable

that the organization of the care promotes the positive canalization of this energy.

The patient is dependent on the caretakers to get a good care, but the caretaker is also partly dependent on the co-operation of the patient. The forming of the inter-dependence is therefore decisive for the success or the non-success of the care. At first, this may seem a bit trivial. By experience, the dependence of the caretaker on the patient is, however, nor clear to all caretakers. The interdependence bears great consequences for the performance and interpretation of care.

The interdependence does not exclude the need of the decision and the subjectivity of the individual. On the contrary, the need of the *integrity* of the individual will be accentuated by the interdependence.

Both patient and caretaker have *power* over each other. The ethical question is, if both of them use the power in a constructive or in a destructive way. There are great possibilities in a care situation to be passive or consciously/unconsciously interfere with the constructive interaction. The caretaker usually has more positive power than the patient. It is, however, an ethical task to describe if and how the seemingly powerless patient yet has some kind of power.

Both caretaker and patient experience an *ethical demand* to use the given power in such a way that the situation develops positively and to the best of the other. The caretaker often has more power and will experience the demand more and more pressing. There are many ways to escape from this problem.

No other person or instance than the caretaker, the patient and other persons involved are able to decide how to answer the ethical demand. If another person decides, the involved persons are deprived of their *responsibility*, which is a central element of the human situation. No one can run away from the demand of decision. Even the passivity will form the situation. The individual caretaker certainly can hide behind the professional role without personal engagement. But at length this will be experienced as a kind of perverted answer to the ethical demand. Perverted answers produce guilt and anxiety.

In his deprivation and dependence of the caretakers, the patient is a demonstration of the function of *trust*, if the care has not been perverted to a destructive power game. The patient expects in spontaneous trust to be well treated. He supposes that the best of the patient is the goal of the whole care system. Mistrust is, however, a reality to take into account.

The ethical demand is expressed in severe illness. Human life is defenceless and deprived of dissimulation in the situation of a severely ill patient. The caretaker has a great possibility to be grasped by the spontaneous utterance of life, such as mercy and love. This happens because of the existence of a patient. It is not due to a decision of the caretaker to follow a certain ethical rule or the existence of some feelings only. It happens to her or him. At the same time, there is an obligation to valuate for example mercy as nothing but morally good. The individual caretaker has to make up his mind how to answer the ethical demand. Nobody else in the care system can make this decision in her or his case.

We have now given some characterstics of a general care ethics. The first point was that this care ethics is to be understood only in connexion with an analysis of the total care situation. The second point was that the care situation is only a concrete example of a broadly human situation of life. We can apply this general care ethics to more and more concrete problems. In this paper we have chosen three ethical problems of importance for everyone in the care system.

Spontaneity and role

The ethical demand is often experienced intensely in care work. When the individual is grasped by spontaneity, she(he) experiences that her living is in accordance with the ethical demand and in accordance with true humanity. It is an ideal to organize the care so that possibilities of spontaneity are not prevented.

Nobody lives, however, in direct spontaneity. The caretaker becomes tired and exhausted and cannot manage to meet other people directly in every moment. The ethical ideal and demand are therefore transformed in to socially and culturally formed care conventions and care routines. It is desirable that the care routines express the purpose of the care.

The ethical point in this connexion is that there is a reciprocity between routine and more spontaneous commitment. It is essential that this feed-back between routines and spontaneity is stimulated, not inhibited.

The routines – and the professionalism – of the caretaker express at best an organized and not a spontaneous answer to the ethical demand. When spontaneity has vanished, the caretaker can fall back on the care routine and know, that these routines aim at the best of the patient.

One ethical task of great importance is to keep the question of the purpose of the care and of the care routines alive among all caretakers. This is one of the best possibilities to prevent that care routines get another purpose than that of good care.

It is essential that all involved persons get knowledge of current routines. The patient meets in the care system new kinds of social conventions and new demands. The patient also needs routines to support him in his communication with the staff.

Care work as a vocation

Care has earlier been described as a "vocation" for special persons. The term "vocation" has been negatively used in three different ways.

1. There has been an economic exploitation of care workers, who were expected to produce more work cheaper than comparable professionals.
2. There is a psychological view that only special persons, sometimes called helping personalities, are suitable for care work.
3. There is a view that care work demands total unselfishness and some kind of self-denial. The demand of total unselfishness seems to come into collision with the demand of self-realization of the care worker.

The term "vocation" has also been positively used in at least two ways:

1. There is a demand in care to give something of oneself.
2. The term "vocation" emphasizes that there is a special important task in care work.

The question is if there is something to rediscover in the positive use of the term "vocation". Care work can be

organized and performed so that the demand of the interdependence will be clearly experienced and possible to answer. The power can be used to the best of the patient. If the caretaker gives something of himself in that way, the best of the patient is promoted, but at the same time the caretaker gets back a kind of "reward" from the patient, a satisfaction from successful care.

The reasoning above shows that the caretaker and the patient give of themselves in some kind of unselfishness, but the result will be reward and satisfaction. The caretaker experiences some kind of self-realization through the work. If self-realization is promoted on the conditions of the interdependence, it brings satisfaction to both parts. The rigid alternative of selfishness or unselfishness is overcome.

If the care situation on the other hand is interpreted so that the caretaker tries to get self-realization without the condition of interdependence, there will soon be a destructive use of power and no positive rewards. The result will be guilt and a need of defence against the patient[4,5].

We are now in the position to evaluate the negative use of the term "vocation" and the positive use of "vocation" as regards care work.

The negative meaning of economic exploitation can be rejected by arguments of economic justice. The view that only special persons can be good care workers can be rejected – all persons can be grasped by spontaneity because of the structure of the care situation. The third meaning of self-denial can also be rejected. We have shown that self-realization can be achieved in another dimension than the alternative selfishness-unselfishness. We have given a more dynamic view with possibilities for both the patient and the caretaker.

The positive meaning of giving something of oneself we can accept. The positive meaning that care work is a special kind of work can also be accepted. In this work, one can give oneself more than in other works, and there is the possibility of reward and self-realization. The caretaker also has to give a personal answer to the question of how to perform the care.

One consequence is that problems on the broadly human level do not need to be reserved for experts. On the contrary, in our expert society all caretakers need to hear that they have a human ethical competence to act in accordance with the demand of the situation.

Another consequence is that all persons involved should participate in decisions about the care and in the responsibility of the care. There is a tendency that experts on the level of facts decide all difficult problems, even problems from the level of ethical valuation. The caretakers, who are not experts on the level of special facts, are deprived of their possibilities to answer the ethical demand from the care situation, in which they are involved. They thus cannot achieve self-realization. One basic condition of the care is threatened.

One example of deprivation of responsibility is provided in nutritional problems of patients with dementia in the terminal phase: should the patient be allowed to die from water deficiency, or should the decision be to feed him by a gastric tube with increasing distress for many years? The nurse, who often has a more personal relation to the patient than the physician, comes into a conflict. She wishes to promote the life of the patient. She does not wish to give the patient more and more suffering. In this situation, the nurse often pushes the decision to the physician. The tube-feeding decision is a typical problem with dimensions of both medical facts and ethical valuation[6]. The nurse deprives herself of the possibility to answer the demand of the situation. The physician has, however, the legal responsibility of the decision in Sweden.

Professional knowledge: valuation and responsibility

There is a general human ethical insight which emanates from the broadly human situation. All caretakers consequently have ethical insight to decide what to do and what is a good care and the right action on the level of valuation. This is an ethical competence.

There is another kind of competence with reference to special facts in different dimensions, e.g. medical facts. On the fact level, experts are needed. It is important to understand, that there are a common ethical competence and a fact competence. The organization of the care work should take this into consideration. One great problem is that the two levels often are so involved in each other that it is difficult to separate them.

It is perhaps already a routine that all problems of the tube-feeding type are decided by the medical chief without contact with other caretakers. This authoritative decision is, however, not in accordance with the type of ethics, which we have described in this paper. The other caretakers are deprived of ethical decision-making, of responsibility and self-realization through the care work. The patient becomes a great problem instead of a person. It is desirable that the decision "tube-feeding" or "no tube-feeding" is shared by all caretakers of the patient. By experience and by ethical analysis, we refrain from tube-feeding in the case of aged patients in the terminal phase of dementia.

Conclusion

It is evident from the present study of the care situation that the ontological model of ethics provides an appropriate tool for the analysis of complex problems of care work.

Acknowledgements

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References

[1]Lögstrup, K E (1971), *The Ethical Demand*. Philadelphia. Fortress Press.

[2]Armgard, L-O (1971), *Antropology. Problems in K E Lögstrup's Writings* (Swe). Dissertation, University of Lund. Lund. Gleerups.

[3]Svalander, P-A (1979), *On Renewing Hospital Organization – Organizational Learning and the Demands of the Curative Process* (Swe). Dissertation, University of Lund. Lund. Liber.

[4]Norberg, A, Norberg, B, Gippert, H and Bexell, G (1980). Ethical conflicts in long-term care of the aged: nutritional problems and the patient-care worker relationship. *Brit Med J 280*, 377-378.

[5]Norberg, A, Norberg B, Bexell G (1980), Ethical problems in feeding patients with advanced dementia. *Brit Med J 281*, 847-849.

[6]Bexell, G, Norberg, A and Norberg, B (1980), Ethical conflicts in long-term care of aged patients: Analysis of the tube-feeding decision by means of a teleological ethical model. *Ethics Sci Med 7*, 141-145.

Why I changed my mind

A Christian Gynaecologist explains his reasons for saying 'no' to abortions

PETER ARMON

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I decided to take up Gynaecology as a speciality while working abroad in Africa. It was 1967 and I had little idea of the impact that a certain bill, which was at that time passing through parliament, would have on my chosen speciality. I held a conservative view of abortion, being prepared to do it when I could see that the mother's life or health was at risk. I was a little unsure of my ground but faced with some of the problems patients presented, I could often see no alternative. There are very few medical indications for abortions and patients were mostly presenting with social, economic or marital problems.

I completed my training and went abroad again as a specialist in a Mission Hospital in East Africa, returning to this country in 1978 to take up a consultant post. My views on abortion hadn't changed in the intervening period and did not affect my chances of getting such a post. A more absolutist position on abortion would make it most unlikely for that person to obtain a consultant post in this country now. There are always likely to be good reasons why the other applicants are better suited for the job, or the exigencies of the service demand a pro-abortion candidate!

It was during the next 2-3 years that I began to modify my views. There were three threads in my reasoning. I became increasingly aware that in carrying out the abortion I was not really meeting the basic problem that my patient faced, but I continued to be amazed at the complicated lives some folk live and I could often see no alternative to the request. I found that in many ways I was acting like Pontius Pilate, unable to face the realities of the situation and the demands it would make upon me, I washed my hands and took up the suction currette. The patient was left to go back to her problems, I could forget them and walk away.

I found that in many ways I was acting like Pontius Pilate, unable to face the realities of the situation and the demands it would make on me, I washed my hands and took up the suction currette.

Secondly, I was becoming concerned about the effects of an abortion upon subsequent pregnancy. The short term complications of abortion are well known. I had carried out a survey of 350 patients undergoing abortion in a 'Centre of excellence' while I was undergoing my post graduate training. Contrary to some reports, I found that as many as 30% of these patients suffered one or more short term complications. These included excessive bleeding during the procedure or later, infection and damage to the womb. These problems were more common in single girls in their first pregancy who were more than 10 weeks pregnant at the time of the abortion. They were also related to the method of termination used and the skill of the operator.

Turning to the Scriptures, I looked to see if God was interested in the life of the unborn and to see whether they had anything to say about the personhood of the unborn. Psalm 139 semed a good place to start. Here I saw David talking about the Lord seeing his unformed substance. God – interested in David at the blastocyst stage even before his various organs had differentiated. He talks of God's involvement in the formation of his inward parts. It was interesting to note the use of the personal pronoun throughout this narrative. I found that in Psalm 51, David refers to himself as having been "sinful from the time that my mother conceived me" (NIV). Only a person can be described as sinful, I thought. David attributes personhood to himself from the moment of conception.

God seems to specialise in resolving the problems of elderly infertile females in the Bible. He is specifically involved in bringing about the conceptions of Sarah, Rebbecah, Rachel, Leah, Ruth and Hannah. I also found numerous descriptions of God's involvement in the lives of his people within the womb. Job talks of God fashioning him within his mother's womb (10 v 8-12). Isaiah talks of God forming, naming and choosing him while within the womb (44 v 2 and 24;49 v 1). Jeremiah talks in a similar fashion and so does Paul (Gal. 1 v 15). The Bible also records God's involvement in the intra-uterine lives of Esau, Jacob and Samson.

Luke, the beloved physician, gives some of the deepest insights into this situation. He uses the same Greek word to describe the fetus, the newborn child and the infants brought to Jesus for His blessing. A beautiful illustration of life as a continuum from conception. He records too God's involvement in Elizabeth's conception of John and something of his intra-uterine life. We see the fetal John recognising the embryo Jesus as his Lord and leaping for joy as he did so (not the quickening of the fetus, which would have occurred some six weeks earlier, but the expression of a very human emotion of a person meeting our Lord for the first time).

Thus I found that I had to change my mind. God's word confirmed for me the fact that I was dealing with another person from the moment of conception, and His interest and involvement in the life of the unborn confirmed their value in His sight. There was framework laid down within which I had to work out my approach to the need of my patients, both the mother and her child and it could not involve the killing of one of them. Abortion was not an option.

This change of mind immediately brought a new set of problems.

These problems are seriously under reported by the DHSS who only require a doctor to report complications arising within the first seven days following an abortion which he has carried out. Most patients will have left hospital by the time a problem arises and will then see their GP who may, or may not, refer them back to hospital. Quite likely it will be a different place from that where the abortion was carried out and the doctor seeing the patient will be under no obligation to report the complication.

I now began to look at the problems these patients developed in a subsequent pregnancy. I have examined the

records of 322 patients who have had 526 pregnancies since an abortion. There is a small but definite increase in the incidence of bleeding both during and immediately following the pregnancy. There is also evidence of problems associated with damage having been done to the neck of the womb by the abortion. It was particularly interesting to compare the pregnancies of patients who had been pregnant both prior to and subsequent upon an abortion. There was a ninefold increase in problems associated with damage to the neck of the womb.

My series, to date, is small and my findings would not be regarded as being statistically significant, as yet. It does, however, substantiate the findings of other published surveys that abortion does cause harm to the physical wellbeing of the mother and her ability to bear children. It may also be doing her some psychological harm. So I came to the conclusion that I was not only not meeting the real needs of my patients, I was actually causing harm to some by terminating their pregnancies.

The third thread in the chain were the writings of Francis Schaeffer. I saw the films "Whatever happened to the human race" and read his book. I began to see that it wasn't really a question as to whether I was helping or harming my patients, it was a matter of whether it was right or wrong to perform an abortion. Was I destroying a clump of cells or a human being? Was the embryo just a potential human being or a human being with potential?

It was at this point that I had to step outside of my Christian belief and practice and look at the issue from a humanitarian and scientific point of view. Biologically there was then no escaping the fact that when a human sperm fertilises a human egg, a new human being comes into existence. A new life which is different in both nature and being from the egg and the sperm. I could never say that I was an egg or a sperm but I can say that I was an embryo or a fetus.

Biologically there was then no escaping the fact that when a human sperm fertilises a human egg, a new human being comes into existence. A new life which is different in both nature and being from the egg and the sperm.

I discussed the problem, from the embryo's point of view, with other Christians. We seemed to argue round in circles about when the soul enters the body and about what made the embryo "truly" human. When we looked at the mother's problems, the approach suggested was often to judge each situation on its merits and try and do that which would most express Christ's love and concern for her. It seemed to me that even Evangelical Christians were advocating an approach more akin to that of situational ethics than Biblical thinking. I was confused.

1. I couldn't, in all fairness, go on seeing patients requesting abortion when I knew that I would have to say no to their request. This made me sad and, for a while, caused me to postpone my decision. I knew that, while I continued to see these patients, there were a number who, with an attitude of love, care and explanation, I could dissuade from going on with the abortion. I would lose this opportunity.

2. My decision would have implications for my colleague and our relationship. Fortunately he was willing to accept my decision and we have since been able to work out a way of equalling out our workload again. Others were less understanding.

3. I was also very aware that I had still to show that I cared about these patients and their problems and was both ready and able to provide a viable and acceptable alternative to abortion. This has been difficult to do, as an individual. I found very little support in the local churches and had to turn to a secular organisation, LIFE. I was impressed by the caring work that they were doing and gladly identified with it. Now CARE trust has entered the field and I would urge all Christians to support and to get involved with the initiative being taken by Dr. Anne Townsend.

I was also very aware that I had still to show that I cared about these patients and their problems and was both ready and able to provide a viable and acceptable alternative to abortion.

4. I have come to see that as Christians we need to get involved in the political arena too and do all that we can to see the law on abortion changed.

5. I saw that the Lord had given me a unique opportunity to open the shutters of the womb and to teach and educate those who seem so blind to the marvels of creation that are occurring during the early weeks of pregnancy. Such education is essential if public opinion is to be changed.

I pray that the Lord will open the eyes of His blinded people to the holocaust that is going on around them. Something in excess of 160,000 abortions a year are being performed. Less than a thousand are done for anything like a medical reason. How God must sit in Heaven and weep. Are there not more who will stand in the breach and hold back the judgement that must inevitably fall on such a land as this. Where are those who will promote righteousness and justice in this land. God needs those who will 'open their mouths for the dumb and for the rights of the unfortunate' (Proverbs 31 v 8). We need to speak out for the rights of the fetus and for the needs of the mother. We need to show respect for both. It will mean examining our whole lifestyle. It is so often the 'have-nots' who seek abortion, while the 'haves' are the ones saying 'no'. We must ensure that we are seen to practically express our care and concern by helping where we can and by calling upon the government to improve, not cut back, on the social services and support which will enable the pregnant mother to think again and find that she can cope with another youngster in the family.

Something in excess of 160,000 abortions a year are being performed. Less than a thousand are done for anything like a medical reason.

'You have come into the Kingdom for such a time as this', Queen Esther was told. Perhaps those words apply to me and my reader too. God wants us to think again, to face up to the implications of His word; to pray above all but also to act and to get involved; to show the world that we care and that within God's family there are the resources to provide for all in need; that there need be no such one as an unwanted baby.

Reviews

Abortion and the Christian. What every believer should know
John Jefferson Davis
Presbyterian and Reformed Publishing Co.
Evangelical Press £4.60

This book by an American Professor of Theology deals with the Abortion issue as seen from the North American perspective. As such, the historical and legal aspects may, at first sight, seem to have little to say to us in the U.K. To conclude this would, however, miss the major contribution which the book makes to the Christian discussion of this extremely important moral, ethical and social problem.

The first chapter deals specifically with "The American Dilemma" and sets the background with startling figures for the abortion rate in the U.S.–1,533,000 in 1980, and more abortions than live births in Washington D.C.!

Chapter 2 discusses the leading ethical positions as represented by the medical ethicist Joseph Fletcher (author of Situation Ethics: The New Morality) who is a leading advocate of abortion on demand; by the theologian Norman Geisler who supports the view that the fetus is a potential person and therefore of lesser value than the mother, and accepts abortion on indications; and by Harold Brown who supports abortion only to save the life of the mother, on the grounds that the fetus is from the moment of conception a human being and cannot be anything other.

The next chapter presents a lucid account of intra-uterine development followed by a description of the various abortion techniques and their potential complications. This may seem rather simplistic to medical readers but should be easily understood by the layman.

The Biblical position is set out in the next chapter. First the sanctity of human life is established on the basis that man is made in the image of God, and this thread is traced through both Old and New Testament. Then the personhood of the unborn child is established on five grounds; the use of personal pronouns to refer to the unborn, personal relationships between God and the unborn, Mosaic law, the psycho-physical unity of man in the imago Dei and the incarnation of Christ. A final section deals with some of the objections raised to the fetus being a person.

The fifth chapter deals with decision making in the context of the difficult cases such as rape, anticipated birth defect, unwanted pregnancy and economic hardship. The position is affirmed that if the fetus is a full and not a potential person then abortion cannot be justified in any of these circumstances. This is an extremely conservative view, and many would plead for exceptions to allow for rape and severe congenital anomaly. The only acceptable position is that of abortion to save the life of the mother – a position which this reviewer would support.

Chapter 6 illustrates specifically American case law. An appendix, notes and bibliography conclude this valuable book.

Ian Brown
Glasgow

Let them live!
Huw Morgan
Evangelical Press 60p

This small booklet by a General Practitioner covers the topics of the sanctity of life, the beginning of life, the end of life and the defence of life.

The position taken by the author is firmly Biblical, the first chapter setting the Scriptural basis for the sanctity of life. Creation, the Fall, Exodus, the Prophets, the Psalms and the Gospel are all briefly cited to maintain the Christian belief that human life is sacred. Chapter 2 deals with the techniques available for interference at the beginning of life. Post-coital contraception (the "morning-after pill", for example) is condemned on the grounds that it may act after fertilisation has occurred. A more detailed discussion of this technique would have been useful. The coil is discussed and a similar conclusion reached. Many Christian couples use this technique, and again an expanded discussion would have been helpful. Artificial insemination, "test-tube babies" and antenatal screening are briefly discussed.

In the third chapter abortion, infanticide and euthanasia are considered in the light of the current situation in the United Kingdom. The final chapter describes some ways in which Christians may respond: proclaiming and obeying God's truth, practical care and concern, campaigning for God-honouring legislation. This is a very good booklet: its limited size means that it can only stand as an introduction to these topics. Every reader of this Journal should ensure its availability on the church bookstalls of our nation!

Ian Brown
Glasgow

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continued from p 36

These are some thoughts about the new ethical climate in which we live – Consider them, and then, if you will, please write to "Ethics and Medicine." about them, or about anything else which stimulates you to do so, and I shall try to draw together the threads of the arguments and opinions.

We should very much like to have a real "Student Forum" in which we may look at real and relevant issues in a real and relevant way, but this can only happen if you make it happen by writing.

I look forward to hearing from some of you within the next month or so, so that this monologue may become at least a dialogue if not a "multilogue" in future issues.

GEORGE L. CHALMERS

Rutherford House
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