ETHICS & MEDICINE

A Christian Perspective

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New Medicine for Old

For a generation and more the year 1984 has been symbolic, symbolic of a vision of society done to death by a combination of technological advance and the erosion of human dignity. It is therefore deeply ironic that Mary Warnock should have completed her work in that year. For the report that bears her name is addressed to this same, twin, problem; the problem that has haunted science fiction and futurology alike. And the settlement which it advocates, while intended as a compromise, will surely have the effect of gradually ushering in the worst of all possible worlds, or something very like it. Unless, of course, it is effectively resisted.

The individual elements within the Warnock Report, like the individual elements in the technology to which the report seeks to accommodate us, must be seen within the context of the whole. Some, of course, are a good deal worse than others. Some are mild and well-nigh acceptable, in the light of such a comparison. But, taken together, they form a charter for the kind of society about which far-seeing men and women have been warning us for many a year. The seeming reasonableness of the Warnock compromises – which boil down to everything in moderation – must not deceive us, since it is by such means that social and moral change of a fundamental kind is accomplished. The report, like the medical scientists and moralists who stand behind it, has striven hard to avoid the posing of plain moral choices, just in case we should decide to say No. The door, as it were, must be opened a little at a time, or someone might notice.

The seeming reasonableness of the Warnock compromises – which boil down to everything in moderation – must not deceive us.

That is to say, the new world to which Warnock seeks to play midwife is the world against which we have always been warned; and, in that sense, there is nothing new about it. Its novelty lies in that it is now with us in fact – cold, technological fact – and not merely in fiction and fantasy. All the panoply of the futurologist (baby farms, organ farms, humans raised or made over for experimental use, all the rest) has become the subject of serious discussion in the journals, because the techniques which make these things not simply possible but also desirable are now available or soon will be. That is how close we have come to *Brave New World* and all that.

And a key element in the new world that is dawning is the new medicine. it is playing a leading role, drawing together the latest technology and the necessary de-humanisation and presenting the resultant package to us as the latest product of medical advance, the blessings of an ancient tradition in our generation.

And yet this presentation is an act of fraud. What we are offered is not a product of the old medicine at all. Unknown to most of its practitioners and most of their patients, the birthright of the old medicine has been sold. In its place is a new tradition, startling in its implications, in which the ancient values that have governed humane medical practice in western society have been set upon their head.

In the old medical tradition, the tradition of Hippocrates infused with new ethical blood by the Judaeo-Christian inheritance of the west, the role of the physician was carefuly defined. He is to relieve suffering, but he is never to do harm. The relief of suffering is not to be brought about by the doing of harm. The high calling of the physician will not permit him to abuse the dignity of human life, for any reason – however good it may seem. His task of alleviating suffering is, as it were, set within a circle, and the circle represents the sanctity of human life.

Unknown to most of its practitioners and most of their patients, the birthright of the old medicine has been sold.

There is no question of competition between the task of the physician and the context in which he is to carry it out. His calling is to work within the circle, and for many hundreds of years the ideals of civilised medicine have remained the same. It is only in our generation that we have witnessed a systematic attempt to erase the circle from the page, and thereby to admit the 'doing of harm' as what clinicians are pleased to call a 'management option'. The alleviation of suffering has become the unqualified task and goal of the physician. Suffering is to be relieved *at all costs.*

At the same time, other forces have been at work. The notion of what constitutes 'suffering' has been greatly extended from any definition that our grandfathers would have recognised. By a route that goes via loose concepts of mental illness and mental health we have come to a position in which not only discomfort, but misfortune and simple inconvenience can all come under the heading of 'suffering' that has to be 'relieved'. This is, of course, how many would justify abortion. The pregnancy will interfere with a career, or an income, or the annual holiday. 'Suffering' must be 'relieved'.

The chief effect of this change in the values of medicine has been to legitimate the concept of medical killing, though always by another name. The link between such apparently diverse phenomena as active or passive euthanasia of the elderly, the infanticide (active or passive) of neo-nates, and abortion itself is one that has often been pointed out.

The notion of what constitutes 'suffering' has been greatly extended from any definition that our grandfathers would have recognised.

It has been said that one leads to another. But what needs to be noted is that these diverse medical practices are not *related* but – at the point of real importance in each of them – *identical.* The medical killing of the unborn may lead to the medical killing of the new-born, the handicapped and the aged. But the act is the same, and it has become an option in many instances for one reason: the physician now has the 'doing of harm', to hark back to the Hippocratic phrase, as an option in the management of suffering. This is the new medicine.

Yet whose is the 'suffering'? Granted (as many freely will) that in a day when our capacity to relieve suffering is so much greater than it has ever been before we have seen fit to rub out the boundary line around human life, and raise the question of its sanctity in individual cases, whose is the suffering we seek to relieve, and at the expense of the sanctity of whose life? It may seem simple, but it is not. There are at least three kinds of case.

The first is the one we expect, where the suffering of an individual can be ended by the taking of his or her life. Yet even when this seems to be the case there are usually complications. What of the suffering of the relatives? Perhaps without realising it, the physician will take that into account. What of his own suffering? What of the frustration and distress of the doctor who finds he cannot cure? And what of the suffering of others, whose contact with this case is remote, but whose claims on medical or other resources may be real, and may (either crassly or unconsciously) influence clinical decisions? It is rarely simple, but there must be allowed to be situations where, in principle, the suffering of John Smith is held to justify the taking of John Smith's life. This can be true of the elderly, it can be true of the baby whose suffering is largely prospective (but the suffering of whose parents, present and prospective, may be acute). It can be true also, by extension, in cases of abortion where it is argued that the good of the child (whether handicapped or unwanted) will justify the taking of his or her life.

The medical killing of the unborn may lead to the medical killing of the new-born, the handicapped and the aged.

In the second case we find ourselves in different territory, since the death of John Smith is required not to end *his* suffering, but to end that of (let us say) Jane Smith. In actual fact it is, as we have hinted, this situation which lies behind so many which at first sight look like examples of the first kind. Yet it is explicitly the case with the great majority of abortions. John must die so that Jane's suffering will end. To state it in these stark terms may or may not be shocking, but it exposes the fact that we face here an ethical dilemma of an altogether different kind from that which confronts us in euthanasia (broadly understood) which can be held to be in the interests of the patient himself.

But a new and third possibility has now arisen, in which the conflict of the sanctity of life and the relief of suffering is held to require the sacrifice of one life not for the sake of *any* particular person (himself or another), but, rather, for the sake of others-in-general; as we would say, for the sake of science, for research, to increase the sum of human knowledge so that, presumably, the sufferings of individuals whose names we do not know will be alleviated. This takes us directly into the Warnock debate, with which we began, and on which we may feel that this discussion casts a chilling light. For by a majority of only 9-7 the Warnock Committee recommended the approval of deleterious research upon human embryos created for the purpose, research which (as, indeed, is insisted) must lead to or otherwise end in their death.

We do not know how these debates will end. It may well be that public and Parliamentary concern in Britain will make itself felt, and the Warnock settlement derailed despite its momentum. What needs to be underlined is that these proposals are integrally related to other changes going on round about us in society and, specifically, in medicine. They are all part of the new medicine which is striving to wrest the initiative (and control of the medical-scientific establishment) from those who represent the authentic tradition. In his characteristic fashion the journalist and historian Paul Johnson drew dramatic attention to this process in a recent article in *The Times*. We are grateful to him and to Times Newspapers for permission to reprint it in this issue of *Ethics & Medicine*.

N. M. DE S. CAMERON

Withdraw this licence to kill

PAUL JOHNSON
Formerly Editor of *The Spectator*

We are grateful to ***The Times*** *for their permission to reprint this article in which Paul Johnson finds a link between holocaust, abortion and embryology.*

The 20th century has been unique in its destruction of human life. Since 1900 more people have been violently done to death by state action than in the whole of history before that date. The Second World War killed 50 million even before nuclear weapons were used. Since 1945 conventional wars have disposed of 35 million more. The scale of civil slaughter by the state has been almost as prodigious. Hitler's death factories swallowed up six million defenceless souls. Stalin's killer system, of which the Gulag was only one element, engulfed 20 million, who were shot, beaten, starved or frozen to death.

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Mao Tse-Tung carried out human culling on a similar scale. The practice of state holocausts has spread to many smaller nations. Witness poor Uganda: 350,000 murdered by Amin, as many – perhaps more – by his successor. A million have died in the war between Iraq and Iran. Life is cheap in 1985.

We in the West, living under legal and parliamentary traditions, believe we are immune to this 20th century plague. Is not the benevolent state, with its caring, compassionate agencies, the guardian of life in a way it has never been before in all history?

This is a dangerous illusion. We too are catching the killing plague. It may exhibit different symptoms among us, but we are beginning to subscribe to its essential precondition – the acceptance of moral relativism as state doctrine. Western civilization has never been as strong as we like to think it. But such strength as it does possess springs essentially from the core of moral absolutism which it derives from its Judaeo-Christian tradition.

Western civilization has never been as strong as we like to think it. But such strength as it does possess springs essentially from the core of moral absolutism which it derives from its Judaeo-Christian tradition.

Moral absolutism is the assumption that there are certain laws governing the conduct of individuals and societies which are permanent and universal, not man-made but God-given, and the necessary foundation of any human system of law. By accepting moral absolutes we concede the limitations of our human wisdom. We admit that no human society can be wholly sovereign and that all our legal notions must be based on natural law. We can interpret natural law, we cannot change its fundamentals.

In Britain this is implicity accepted when Parliament begins each day with prayers, genuflecting to a higher law. The function of Parliament, indeed, might be defined as making the necessary adjustments between the system of fundamental law and the changing needs of society. Its primary role is therefore as a revising body. It is a law-making body only in a secondary sense. It cannot make marriage a crime, murder a duty or false hood meritorious.

The US constitution and Congress are based upon exactly the same assumption, the Declaration of Independence, in its first paragraph, invoking "the laws of nature and of nature's God". Both the great Anglo-Saxon democracies are, or at any rate were, morally absolutist in this profound constitutional sense.

The devaluation of life in the 20th century reflects the retreat from moral absolutism and the slide into the abyss where law and morality are wholly man-made in accordance with what he perceives to be his needs. Until 1914 most of the great powers subscribed to some system of moral absolutes, however shaky, and imposed it on their overseas territories as well. That consensus went for good in the Great War.

As absolute morality falls, the mountains of corpses rise, ever higher.

Leninism came first, replacing the Judaeo-Christian framework with what he called "the revolutionary conscience", a euphemism for the unrestrained will of the ruling group. Then came Hitler with his "higher law of the party, and in due course Mao with his Little Red Book. The Gulag, Auschwitz, the millions slain in the Cultural Revolution – all were the result of moral relativism.

The major mass murderers have been followed by scores of minor ones, the phoenix flock of evil emerging from the dying embers of empire. Most of them have affixed a bloody thumb-print to some relativistic code of totalitarian morals, revolving round the central proposition of the 20th century: the state shall kill when it wishes. As absolute morality falls, the mountains of corpses rise, ever higher.

We are not yet among the summits of death but we are moving fast through the foothills. It is now fashionable among the progressive establishment to advance the arguments of moral relativism as justification for extinguishing life. Lady Warnock, at present the height of intellectual fashion in Whitehall, uses them to defend the state-supervised creation, experiment upon and extinction of human embryos. She is enthusiastically supported by the Archbishop of York, who warns of "the danger of moral absolutism" and thinks that differences between "right and wrong, good and evil" are "largely a question of degree".

It is the essence of moral relativism to devalue life, to counterfeit the moral currency of creation. Giving and taking life is a divine prerogative. Absolute or nature law revolves round this principle and teaches that the taking of life can be delegated to human societies (under God) only in the gravest circumstances to defend the principle of life itself. Consider how the erosion of moral relativism has undermined this principle in three areas: murder, abortion and embryonic destruction.

Societies under natural law regard murder as a crime of unique atrocity. Paradoxically, this public abhorrence has always been expressed by capital punishment. This is an awesome , even horrifying institution, the supreme exercise of state power, the point at which it comes closest to usurping divine authority. It can be justified only on the grounds that, by its intrinsic but wholesome terror, it makes manifest the magnitude of the crime it penalises.

For purely social reasons perfectly healthy women are now aborted of normal foetuses 28 weeks old and virtually capable of independent life.

By removing the judicial right of society to kill we have removed the singularity of murder and so devalued life. This is a point the anti-hangers, like Roy Jenkins and Lord Gardiner, could not or would not see. But in consequence of their victory, murder is now a crime like many others, punished like many others. It may indeed be lightly punished. When capital punishment was abolished, the public was repeatedly assured by the reformers that its substitute, life imprisonment, would indeed mean imprisonment for life. This guarantee has proved worthless. Few killers now serve more than seven years. Many serve much less because of the growing tendency to downgrade acts of homicide from murder to manslaughter.

It is not unusual for a man who has killed his wife, or a woman her husband, to receive a suspended sentence and leave the court free, the judge considering the time spent in custody awaiting trial to be adequate punishment. The moral character and personal behaviour of the victim is taken into consideration, both in deciding the charge and calculating the punishment.

The most fruitful line of defence is thus to portray the dead person as a monster, so that the victim undergoes a second assassination, of character, while the state as prosecutor stays silent. The law and the courts are thus transforming our whole attitude to killing and so undermining our veneration for life.

The legalization of abortion is in some respects more serious because of the enormous number of creatures now killed in the womb and the multiplicity of people involved. The evil of the Hitlerian holocaust was immensely magnified by the fact that many thousands were needed to man the gruesome production lines, produce the fatal chemicals, operate the trains which fed the slaughter, and take away the soap, the fertilizer and the other industrial by-products of mass murder. All knew what they were doing – how could they not know? But some at least might claim that they worked in a climate of fear and in the absence of moral debate and advice. No such extenuation of guilt is open to those who serve in our abortion clinics or our public hospitals which run abortion wards little better than slaughter houses.

They know that the morality of abortion is under active debate, and that, since it was made legal, the whole thrust of medical research has been in the direction of emphasizing the humanity and even the personality of the foetus, whose sex and physical characteristics can now be ascertained long before birth. Meanwhile, as a result of the David Steel Act the practice of abortion has been moving in quite the opposite direction, killing, closer and closer to birth, living creatures who in all essentials are human beings, who can undoubtedly feel pain and even express their anguish.

Here again, the glib assurances given by reformers when the principle protecting the life of the unborn was first breached have proved worthless. For purely social reasons, perfectly healthy women are now aborted of normal foetuses 28 weeks old and virtually capable of independent life. All the qualifications and safeguards written into the legislation have been disregarded in practice.

We have abortion on demand, often of living, breathing, crying creatures, who are left to die or strangled before being hurried shamefully to the incinerator. Some hospital nurses refuse to participate in these acts and have foregone promotion in consequence. All honour to them. The rest know exactly what they are doing, just as the men who stoked Hitler's furnaces knew.

However, if the moral relativism which increasingly governs our official attitudes towards murder and abortion-infanticide is still concealed by a shroud of hypocrisy, it has come into the open on the issue of embryoicide. In its efforts to deal with this new threat to the sanctity of life, our public system has not so far covered itself with honour. The House of Commons has voted overwhelmingly against the practice but has been prevented from making it illegal by a procedural filibuster devised by its leading hooligan, Dennis Skinner. Meanwhile, an official committee has produced a report whose chief begetter declares herself a relativist, accepts the end as justifying the means and says we must balance the needs of research against the sanctity of life. So far as I can follow her reasoning, both are "principles" or "values". Well, I daresay Dr Mengele would have gone along with that, as also with her view that research into human embryos should continue "subject to strict control and monitoring". Who would have predicted the monster vindicated just as he was pronounced officially dead?

Murder and infanticide are important enough issues in themselves. But the creation of life for laboratory destruction opens up a new chamber of horrors.

Lady Warnock and her allies in high places think that those of us who stick up for absolute values, and seek to protect life against the encroachments of ruthless utilitarians, are dangerous. She finds us guilty of "dogmatism, intolerance and fanaticism"; we are not merely "objectionable" but "terrifying". The abuse and threats rained on Mrs Victoria Gillick and her family, for her crime of upholding the right of parents to protect the moral welfare of their children, have prepared us for this kind of vilification. Those who reject absolute morality are unlikely to be scrupulous in debate.

Murder and infanticide are important enough issues in themselves. But the creation of life for laboratory destruction opens up a new chamber of horrors. I do not believe assurances that the permit to experiment will expire after 14 days. The guarantee will prove as worthless as those we received on life imprisonment and abortion.

We are approaching the point in Britain when the world of natural law and the world of social engineering are coming into direct conflict. The relativists and social engineers have carried the day in many countries. But they have not yet finally triumphed here. These issues should become paramount at the next election, with every candidate obliged to declare exactly where he or she stands on them.

O'Donovan's dilemma

STEPHEN N. WILLIAMS
Professor of Christian Doctrine and Philosophy of Religion, United Presbyterian Theological College, Aberystwyth

In a book of haunting power, Oliver O'Donovan examines some key contemporary bioethical issues under the rubric of a distinction announced in the title: *Begotten or Made?* (Clarendon, 1984). His analysis of Western technological culture, which appositely provides the framework for the whole discussion, locates its relevant genius not in what it does but how it thinks. When it progressively subsumes human activity under the concept of 'making' it comes up against the fact that, in the case of child 'production', we are dealing with what is, naturally, begotten, not made. What is begotten is like ourselves and determined only by what we are. What is made is unlike ourselves, a product of our own free determination in a way that renders it alien from and unequal to our humanity.

O'Donovan shows the relevance of the distinction, and what is implied in its terms, by considering, first, transsexual surgery and, then, procreation by donor. In both cases the ethical issues and difficulties attendant upon such practices have root in the implicit or explicit conceptual framework of technologically creative culture. In a further chapter, the Christian concept of personhood is explored and its bearing on embryo-experimentation clarified. If we exercise an experimental transcendence over the embryo, we bestow upon it an ambiguous humanity and outlaw that love by which we alone can truly discern persons. 'The practice of producing embryos by IVF with the intention of exploiting their special status for use in research is the clearest possible demonstration of the principle that when we start making human beings we necessarily stop loving them; that that which is made rather than begotten becomes something that we have at our disposal, not someone with whom we can engage in brotherly fellowship'. (p. 65).

What is begotten is like ourselves and determined only by what we are. What is made is unlike ourselves, a product of our own free determination in a way that renders it alien from and unequal to our humanity.

The climax of the author's argument, however, comes in the discussion of *in vitro* fertilization in the last chapter. It is not the principle of IVF, more than the principle of AIH as an unwarranted separation of coital from procreative activities in marriage, that troubles O'Donovan. It is, rather, the logic of IVF as a 'making'. By means of a fable which, all in all, leaves Edgar Allan Poe idling, O'Donovan shows how the logic of IVF practice seems to turn its practitioner into the creator of its product. Revulsion at such a conclusion does not give the lie to its logicality.

Yet this is how the discussion, and the book, is concluded.

> For myself, I do not *believe* that the doctor has become the child's creator. I do not believe it, though, as I have admitted, I do not know how to reconcile my unbelief with the obvious significance of *in vitro* fertilization.

Such disbelief arises from the Christian confession that God is the unique Creator 'who will not relinquish to others his place as the maker and preserver of mankind' and such confession calls forth the hope that His created humanity will 'vindicate its maker, and his creatures, against every false claim to lordship' (p. 86).

What we have, then, in conclusion, is an antinomy. One proposition affirms that the IVF child is not created, on the ground that God is, uniquely, Creator. Another proposition affirms that the IVF child is the practitioner's creature, on the ground that the child is made. In one way, some such conclusion is not surprising. When ethical enquiry combines sober analysis with a human sense of the dimensions of a theme that is awesome by any standards, the frank antimony better conveys the mood of the conclusion than the trumpetings of a confident resolution. In another way, the outcome is quite surprising. One has not been entirely prepared for it. Surely, antinomy it is and, surely, antinomies must normally be removed to attain coherent conclusions.

IVF children are, sub specie Dei, our equals and our fellows, in the sense that God finds us all guilty, in need of redemption, potential or actual objects of regeneration, susceptible to communicant fellowship in the Body of His Son.

I aim here to propose a summary resolution of what with faint presumption, in the service of a still fainter alliteration, I have described as O'Donovan's dilemma. It is proposed from within the theological framework adopted (to my mind, with justice) by the author. For these purposes, I shall differ from the book under discussion by formulating the issue, as I understand it, with prosaic baldness.

Let us ask first; what is problematic about the proposition that affirms that the doctor is creator of the child and the child the creature of the doctor? Is it that the child is termed a creature of the doctor in any sense whatsoever, or that the child is termed such a creature in a way incompatible with the ascription of Creatorhood to God? At the end of the book, O'Donovan says:

> I confess that I do not know how to think of an IVF child except (*in some unclear but inescapable sense*) as the *creature* of the doctors who assisted at her conception — which means, also, of the society to which the doctor belongs and for whom he acts. (p. 85; italics in brackets mine).

Such a confession undoubtedly encourages us to look for *some* sense in which a child could be said both to be a creature of the doctor and to be a creature of God. And undoubtedly, again, there is some such sense, when we attend both to the 'creature' regarded, perhaps, as the product of wayward experimentation and to that same creature regarded in terms of immanent characteristics of personhood. For there are such characteristics, independent of the method or context of production. IVF children are, *sub specie Dei,* our equals and our fellows, in the sense that God finds us all guilty, in need of redemption, potential or actual objects of regeneration, susceptible to communicant fellowship in the Body of His Son. To say this is to

affirm that God is the unique Creator in the strongest of ways, for it is to say that however or whyever a child comes into the world, he is dependent on and accountable to God.

At the same time, there is no need to affirm that the good will of the Creator is, in undifferentiated form, present unconditionally wherever life is created. It is not the same when the Spirit overshadows the consenting Virgin as when the savage overpowers the dissenting victim in respective acts of grace and rape. (The differences between the modes of creative presence entailed in the miraculous conception of the Saviour are not to the point here).

The child in the one case is conceived when the human will is instrumental in the divine purpose in its availability for the good; the child in the other case is conceived when the human will is intrusive in the divine world in its propensity for the evil. So, that a doctor, somewhere, should never have enabled a given life to come into being as it did, permits us to speak of the child as a human project and an alien creature of the doctor. Whether or not this is the best way to speak of the matter, it is a legitimate way, in conformity with the vocabulary and, perhaps, usage, of O'Donovan himself.

However, while he speaks of an unclear sense in which the IVF child may be said to be created, we are led by the whole of the foregoing argument of the book to see what that sense might be, and it is *not* the sense I have just presented, which presents O'Donovan with no antimonies. What it is for an entity to be made by us is explained at the beginning of the first chapter.

> . . . . That which we make is *unlike* ourselves . . . We have stamped the decision of our will upon the material which the world has offered us, to form it in this way and not in that. What we 'make', then, is alien from our humanity. In that it has a human maker, it has come into existence as a human project, its being at the disposal of mankind. It is not fit to take its place alongside man in fellowship . . . . man's will is the law of its being. (p. 1).

All this is in contrast to that which is begotten. Now clearly, if all this characterizes what is made by us, and the IVF child is made by us, the proposition which affirms this is, indeed, incompatible with the proposition which affirms God as Creator. For the first proposition predicates of the creature an inequality and disposability with regard to other creatures incompatible with the status assigned to all creatures indiscriminately by the confession that God is, uniquely, Creator.

One might, indeed, propose to resolve the antinomy by suggesting that the concept of 'making' in general, delineated without taking initial account of what may be involved when the child is 'made', thus fails to characterize properly what it is for an entity to be made. Thus, with reference to O'Donovan's prefatory remark about the 'essential characteristics of human existence' (p. *v.*) it might be claimed that where 'essential characteristics' have to do with equality and disposability in creatures, technology has no abilities to determine them. Neither the origin, nor the way the child is thought of, in this analysis, has anything to do with the essential characteristics.

But this fails to resolve the issue because it fails to grasp it properly. For O' Donovan's antinomy seems to arise precisely from considerations entailed by the fable he tells at the close of the book. To reduce, again, to bare prose, what is presented with an imagination that enables, not prevents, conceptual exactness, the following is the scenario. Jack and Jill are both disabled from birth; Jack was born 'naturally', Jill as a result of *in vitro* fertilization. Jack sues his parents for wrongful life — i.e., the precautions of amniocentesis and abortion were omitted. The judge who hears Jack's case dismisses it on the grounds that a wrong can only be done to someone who has life — 'wrongful life' is a self-contradictory notion. Strictly, 'the ultimate author of human life was not a parent, but a person or force that could not be made a defendant in court'.

Such are the enormities to which modern technology may lead us that the ability of a doctor to become a child's creator, in the sense that he stands in legal relation to her in the same way as does God, seems to me to be altogether conceivable.

The judge who hears Jill's case now seizes on this judgement to issue a consistent verdict in her case. Jill sues not her parents but the doctors responsible for her fertilization, on the grounds that the defects (in her particular case) were due to IVF. This judge likewise dismisses the case brought by Jill. For the previous judge had demonstrated that the author of life cannot be a defendant in court. In Jill's case, the doctors, because she was an IVF child, occupied the position of author of life. They are thus above the law, in the relevant respect.

O'Donovan then poses the crucial question: is this line of reasoning resistible? It seems not, but, if not, the consequences are shattering. For if the child cannot hold responsible the practitioner more than it can hold parents or God,

> Can we deny . . . that the IVF practitioner, who takes these risks, not as a parent does, in renunciation to divine providence, but in calculation relating to his technical project, places himself in a quite unparalleled position vis-a-vis another human being? (p. 85).

That is, the doctor's calculation and unaccountability together, really assign the project to the class of making, producing the creator-creature relation therein involved. There is now a central paradox: we have a singular case of the ability of someone to pursue a scheme which results in an injury for which the practitioner cannot be held responsible. This paradox is generated by the fact that 'the beginning of a human being has come to be at the same time a making'. This is why O'Donovan needs to think of the IVF child as somehow the doctor's creature . . . . yet (and this, of course, leads to the antinomy under consideration) O'Donovan does not believe it.

Now the more one ponders the decision of the second judge in the fable re suing for *peculiar* risks attendant upon IVF, the more, I think, the force of O'Donovan's point emerges. If one accepts the validity of the reasoning of the first judge, then perhaps — perhaps, I do not know — the second verdict is consistent with it. But, if this is the case, what *is* entailed about the status of the child? Only, as far as I can tell, that the doctor *legally* occupies the position of the author of life in relation to the creature. Such are the enormities to which modern technology may lead us that the ability of a doctor to become a child's creator, in the sense that he stands in legal relation to her in the same way as does God, seems to me to be altogether conceivable.

But, surely, the objection of those who hold that to speak of the doctor as creator and the child as unequal is 'grotesque and self-evidently wrong' (p. 86) is not, if it is to have force, an objection to the proposition that the position is *legally* thus. The Christian doctrine of God as Creator is scarcely compromised by the ability of the doctor to acquire such a legal standing, incredible as it may be. Those who affirm, in the name of God, the radical equality of the child are not compelled to deny the sad limitations of legal structures which can, with perfect consistency, permit the doctor to play the role of Creator. It is of accountabilities and equalities and thus creaturely realities outside the realm which a culture, technology or legal structure may determine that the Christian doctrine of the unique Creator speaks. His role and reality are not touched by His inability thus to function in a self-consistent legal system, even of the best kind.

Those who affirm, in the name of God, the radical equality of the child are not compelled to deny the sad limitations of legal structures which can, with perfect consistency, permit the doctor to play the role of Creator.

It may be objected that this is not the point. The point, it may be argued, is that there are no *moral* grounds, it appears, for impugning the decision of the second judge, if that of the first is valid. *That* is what leads to the antinomy.

But consideration of *this* antinomy leads us inevitably, if understandably, to consider the ethics of law, in a broad sense, as if the dilemma is concerned with legal implications, not with moral realities.[1] Hence there is no need to pursue it in this context.

I have sought to show, thus far, that the antinomy which generates the dilemma is apparently soluuble within O'Donovan's own theological framework. However, it may be argued that the dilemma is not entirely accurately described. That is, O'Donovan may not be affirming that we are faced with a strictly formal logical antinomy which he finds himself bound to assert. The foregoing 'resolution' would thus be valid but beside the point. The point is, rather, that we are faced with a monstrous 'moral' contradiction whereby in this world, created by a sovereign personal Lord of all, doctors have apparently attained the incredible status of creators in the specified sense with the specified implications. *That* is the awesome reality which faces us as Christians, challenging us in the spiritual depths about our convictions on divine omnipotence, the sinister labyrinths of evil and how the Christian picture of God, man and the world is to be presented, even if our logical sense at least keeps us from affirming inconsistent propositions.

If this is the root of the 'dilemma' then the advantage of our discussion so far is to show how at least it does not involve us in perilous hesitations about affirming either that God is, ever, the unique Creator or that medical technology has, indeed, taken an awesome turn in its creative abilities. This, in turn, enables us to sorrow properly at the device hidden under the cloak of progress as it enables us to rejoice freely at the Eternal One from whom nothing is hid. And this, again, leads us to tremble before the scene that now hoves into sight.

And what is the Christian to do as a generation of children, created under conditions he believes to be fundamentally wrong, grows up amongst us?

For a dilemma now arises concerning our own humanity to man. Christian objection to the practices of AID or IVF, as outlined by O'Donovan, has the most cruel of logical entailments: we must affirm of many persons that they should never have been born.[2] That might ever have been said of some, considering the circumstances of the liaison that led to their existence. But it happened through Nature and it is in the intimacy of knowing the immanent ways of God in the natural world and the transcendent way of God with His creatures that a person may come to terms with the circumstances of his or her own existence. Now what happens happens not through nature, in the previous way, but through a personal intermediary, or entire society, whose very identification in that role displays the reality of the alienation. And what is the Christian to do as a generation of children, created under conditions he believes to be fundamentally wrong, grows up amongst us? Are we to persist in calling, in the name of God, for an end to certain techniques, or their wrongful use, for the creation of those whom we meet, befriend, succour, nurture in the Church?[3] Or are we to refrain, in the name of compassion, from any such protest that would injure the deepest vulnerable sensibilities of the innocent creature? O'Donovan's dilemma ultimately points us in the direction of such particular dilemmas which minimize the comforts given by a logical mind to a sensitive soul.

For a long time, philosophers of religion who do not, finally, take kindly to Christian belief, have surveyed the world around them and asked what on earth, or in heaven, would constitute a state of affairs incompatible with belief in the Christian God? The force of the question is, of course, that there is too much evil around to permit God to be around, in any venerable form, as well. For the Christian, indeed, there are reasons for saying that there are some states of affairs which God just will not, in reality, allow to come about. O'Donovan's presentation reminds us with grim poignancy that we seldom, however, can know what those states of affairs are. It may be that, for the sake of those deep sensibilities which alike inform us of the intractability of man and impel us to spare no attempt in his rescue, *this* dilemma is one we must be prepared to live with awhile.

Notes

1. My discussion from this point on derives from some comments kindly made by Professor O'Donovan in a personal communication relating to an earlier draft of this article.
2. This statement is of course, subject to an all important qualification: it is God, in His sovereignty, who wills who is to be born. But in the context of the general issue of relating divine to human wills, and in the context of the present discussion, to protest against the *process* employed to bring about new life is to say that those born of such processes should not have been so born. I do not, of course, deny that God can bless the life of one born from the wrong mechanism; which is why, ultimately, we dare not treat as "unequal" any born of such processes.
3. This way of putting it seems to suggest its own inequality: we should speak also of those who meet, befriend, succour and nurture *us*.

Screening for Spina Bifida

EDWIN PUGH,
Registrar in Community Medicine, Co. Durham

Spina bifida is one of the commonest congenital abnormalities in the U.K. having an incidence of 1-8/1000 births in different geographical locations. Nearly half of these are due to anencephaly. Anencephalic and a substantial proportion of "open" spina bifida babies will die due to the lesion being incompatable with life. Much debate has ensued over the threshold for operating on the more severe lesions.

Following the discovery of the association between raised A.F.P. levels in the amniotic fluid and spina bifida by Brock and Sutcliffe (1972) antenatal diagnosis of "open" spina bifida has become a reality.

Screening: A simple proceedure?

The philosophy and proceedure for screening for neural tube defects as outlined in many medical texts seems remarkably uncomplicated at face value. Initial testing of blood for A.F.P. levels identifies those women likely to have a N.T.D. affected fetus. After ultrasound and amniocentesis an abortion is offered to those women with abnormal levels. Spina bifida is therefore prevented.

Screening: Not so simple!

Each step of the screening programme, overlooking the question of whether screening should occur in the first place, raises a complex practical and moral issue.

Blood testing to be accurate must be performed between 16-18 weeks gestation. In many cases the gestational age of the foetus is not precisely known; for example the woman may have irregular periods, may have conceived on the pillor had a period when pregnant. Ultrasound, remarkably accurate in experienced hands is of poor value for gestational age after 20 weeks.

It would seem that the issue of a community N.T.D. screening programme raises more questions than it answers. Are we playing the eugenics game? Is it acceptable to abort normally formed foetuses as the cost of preventing spina bifida? Should screening be allowed at all?

The next proceedure of amniocentesis is not without risk. The M.R.C. trial[1] found that the proceedure was associated with a 1% chance of abortion of the foetus as well as nearly 1% chance of significant morbidity. Results suggested that infants born to mothers who had undergone the investigation were at greater risk of respiratory difficulties or postural deformities. Normal foetuses are therefore put at risk.

The result of the tests are not foolproof. As the sensitivity (ability of the test to diagnose disease) and the specificity (ability to diagnose non-disease) are both less than 100%, false positive and false negative results do occur.

Women may be told they have an affected foetus when they do not and that they do not have an affected foetus when they do. Once again a normal foetus may be aborted if a false positive result is obtained.

Induced abortions may be occurring at 20 weeks or more. The viability of a foetus is a theoretical possibility in cases of late termination given the recent advances in neonatal medicine. At present in the U.K. in the arbitrary legal age at which a foetus becomes a potentially viable baby is 28 weeks. In some states of the U.S.A. the limit is 22 weeks.

Professional self-congratulation at diagnosing spina bifida should be tempered by the realisation that all anencephalics and some open spina bifida babies would have died if the pregnancy had proceeded to term. Also normal foetuses are sacrificed to prevent the birth of a N.T.D. child.

The epidemiological approach

Chamberlain[2] undertook a cost-benefit look at the screening proceedure. Making assumptions from her experience of the test having a false positive rate of 2.5% and a false negative rate of 36% (over 1/3 cases missed on screening) she calculated the number of N.T.D. births averted in relation to the number of normal foetuses aborted or damaged. From a cohort of 100,000 births approximately 187 N.T.D. births would be averted. As about half would be anencephalic and others would have a lesion incompatable with life, a handicap survivor would be prevented in 36 cases. The cost side of the equation reads 10 normal foetuses being aborted with an equal number of damaged infants.

The economic approach

Hagard, Carter and Milne[3] calculated a "Benefit Cost Index, B.C.I." for N.T.D. screening which was derived by "dividing the total economic benefits . . . . by its total costs". It was found that owing to regional variations in spina bifida the B.C.I. was less than 1 for some areas. By the use of a mathematical model, feeding in test sensitivity and N.T.D. incidence an index is deduced to indicate whether screening is "beneficial".

The Christian approach

It would seem that the issue of a community N.T.D. screening programme raises more questions than it answers. Are we playing the eugenics game? Is it acceptable to abort normally formed foetuses as the cost of preventing spina bifida? Should screening be allowed at all?

One thing is certain – the screening proceedure is operating in some districts, the value-judgement having been made that the "benefits" made from preventing the birth of a N.T.D. baby exceed the "costs" of the loss and damage to normal foetuses.

On a personal note I would like to see the objective of the spina bifida screening programme, as is usually stated, the '*prevention* of a spina bifida child', to be changed to the '*termination* of a spina bifida foetus'. The affected child is already present, not prevented by the screening.

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Ethical Conflicts in the long term Care of Aged Patients A Response

GEORGE L. CHALMERS

Consultant in Administrative Charge, East District Geriatrics Service, Glasgow

I was interested to read the paper by Bexell, Norberg and Norberg in the last issue of Ethics and Medicine,[1] as I have been similarly interested to read the authors' previous communications on a similar subject in the British Medical Journal.[2,3]

As a Physician in Geriatric Medicine I am not unfamiliar with the principles, nor indeed, with the problems associated with the care of aged patients with dementia. I was, however, a little surprised to find that I was not completely comfortable with the concepts which are expressed in this article. It is not so much that I disagree with what is being said, but rather, that it seems to be dealing with the familiar problems in a somewhat unfamiliar manner and context.

It is readily apparent that subjective and individual opinion is an inadequate basis for ethics, or for "moral ideas", and the idea that it might be otherwise may be expected to give rise to a situational ethic of the worst kind, in that it would be capable of variation according to the fluctuations in feeling and opinion of the individual. Such an ethic would be particularly open to conflict, not only where two strongly held feelings or opinions are in confrontation, but even where there has been a "change of mind" on the part of the same individual.

There must, of course, be a direct relationship to the practical, pragmatic or perhaps "ontological" model, but there must, surely, be, also, some reference to an ethic which is beyond either pragmatism or subjectivism, and I found it difficult to define such an ethic in these papers.

The care given to the individual in need, within a culture or community, may be legitimately seen as a reflection of the values of that community.

Humans beings as a group have not consistently defined "a broadly human situation of life" and the variation in what is considered as ethically obligatory in terms of care is not at all universal in practice. Some cultures or even subcultures can relatively easily take aboard the abandonment of the disabled or disadvantaged, or even the elimination of such people, and recent history reminds us that such phenomena are not confined to so-called, "primitive" or "undeveloped" societies.

The carer, (I prefer the term "carer" to "caretaker") must have more than feelings or emotions, and, I believe, more than the situational or ontological model, on which to base recognisably ethical behaviour. Furthermore, the carer, whether medical, nursing, para-medical or even a family member, will have less difficulty in defining their ethical position and acting upon it, if they have thought through the ethical principles before facing them, as problems, in the individual case in clinical practice.

I would readily subscribe to the concept of a mutual dependence or interdependence between carer and the subject of care, each gaining something from the other and each contributing something to the other; such inter-dependence is, indeed, implied in most inter-personal relationships. It is equally readily acceptable that there is an ethical demand in such relationships which must evoke a responsible response. The basis of this transaction must be one of trust, and where the "spontaneous utterances of life", defined as mercy, love and forgiveness are involved, the practical standard of care as well as its ethical basis are well established and safeguarded.

There is no need for the patient to become "a great problem, rather than a person" if we lay value upon the personhood of our patients.

Even where these last qualities are not part of the carer's recognised response, however, the ethical demand remains no less valid, and must stand upon an objective view of responsibility, as defined by convention or even by legal obligation.

I believe, however, that this is more than a mere recognition of the care conventions and routines which mark the professional approach to caring. It involves also the acceptance and expression of the human, cultural, and even religious expectations of the community, in the context of which care is being given. The care given to the individual in need, within a culture or community, may be legitimately seen as a reflection of the values of that community.

For this reason, I believe it is of major importance for the Christian Physician, Nurse, Para-medical, or other professional carer, to witness constantly to the relevance of Christian faith and ethics in the maintenance of professional standards. This is important particularly for those whose "ethical demand" must be implied rather than expressed, by reason of their disability and more especially where it includes cognitive as well as communicative difficulties.

It was interesting to have the nature of care work as a vocation defined in specific terms, and the economic terms of the first of these interpretations may ring familiar in the ears of those who have felt for some time that the idea of vocation may sometimes be an excuse for exploitation.

The Authors make it clear, however, that there is a good deal more to vocation than this, and the recognition of altruism is not inappropriate.

The reward of altruism, the satisfaction deriving from good care well given, does not, however, depend as fully upon the recognition of interdependence, as the authors seem to be suggesting. Especially in the context of the aged dement, such an interdependence is not at all readily apparent, and, without the carer in any sense seeking a sense of "power", as suggested, they may well be placed in a situation in which there is no "self-realisation" except in meeting the patient's "best interests", as perceived by the carer, without either agreement or interaction.

The example quoted, of the "tube-feeding" or "no tube-feeding" conflict, is, perhaps, an unfortunate one since it is a situation in which the clinical issues are not always clear-cut.

If the assessment of the patient as being in the terminal phase of dementia is accurate, there is no question of "being fed by a gastric tube with increasing distress for years". The use of the term "terminal" implies a prognosis which is, of necessity, short. If there is this possibility, whether by the use of a gastric tube or other means, the condition is not in the most accurate sense "terminal".

In such a situation, the normal practice in most units for the care of the elderly, or of the elderly mentally disabled would be in fact to "share" such a decision, in the sense that it would be discussed openly with staff and relatives involved. Very few physicians would currently accept that "all problems of the tube-feeding type are decided by the medical chief without contact with other caretakers"; indeed, very few would get off with it even if they did!

Our clinical decisions must be ethical because our ethical decisions are based on something less variable than the clinical situation.

Such sharing, however, cannot neccessarily imply automatic compliance with the majority opinion, or with strongly held views. Such a decision is a clinical one which must be made in the light of the clinical facts by those qualified to make it, and legally as well as professionally, ethically, and morally obliged to do so.

Frankly, I have not met ethical conflict over this particular issue and, indeed, I have seldom found it relevant to the care of patients in whom it is neccessary to opt for comfort rather than cure because cure is not a possibility. It is usually practicable to maintain a sufficient level of hydration of the mucosae without intubation, and in the event, the tolerance of such a tube is often poor.

I do, as a matter of course, involve nursing and other staff in discussion of such issues when they do arise, but I recognise the ethical responsibility of making a decision, rather than agreeing to make none. There is no need for the patient to become "a great problem, rather than a person" if we lay value upon the personhood of our patients.

I thought it particularly interesting that, "by experience and by ethical analysis" the authors had reached the same conclusion as is often reached in a more pragmatic way, but I do think we need to be careful lest, in our ethical zeal, we exclude from the use of a particular procedure the occasional patient who, clinically, has something to gain.

Our clinical decisions must be ethical because our ethical decisions are based on something less variable than the clinical situation.

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An Introduction to the History and Present State of the Law relating to Abortion in England

C. R. FRADD M.A., LL.B. (Cantab)
Solicitor

We are grateful to Paternoster Press for their permission to reprint this piece from their recent ***Abortion and the Sanctity of Human Life.*** *The material first appeared in a pamphlet published by the Association of Lawyers for the Defence of the Unborn.*

Under English law abortion has always been a crime. Originally the common law seems to have treated it as a form of homicide. The greatest of our medieval jurists Henry de Bracton, one of King Henry III's judges, in his immense and authoritative treatise "De Legibus et Consuetudinibus Angliae" compiled in about the year 1250, wrote, "Si sit aliquis qui mulierem pregnantem percusserit vel ei venenum dederit, per quod fecerit abortivum, si puerperium iam formatum vel animatum fuerit, et maxime si animatum, facit homicidium".[1] (If one strikes a pregnant woman or gives her poison in order to procure an abortion, if the fetus is already formed or quickened, especially if it is quickened, he commits homicide.) The word "homicidium" at that period covered both murder and manslaughter, the word murder (murdrum) being confined to a killing carried out in secret (clam perpetratur).

Exactly when abortion ceased to be treated by the common law as a variety of homicide is not clear. By the early seventeenth century Sir Edward Coke (Attorney-General under Elizabeth I and successively Chief Justice of the Court of Common Pleas and of the Court of King's Bench under James I) whose writings on English law have traditionally been regarded as highly authoritative, wrote, "If a woman be quick with child and by a potion or otherwise killeth it in her womb; or if a man beat her whereby the child dieth in her body and she is delivered of a dead child, this is a great misprision and no murder."[2] Misprision, in this sense, means a high misdemeanour. Other authors, after the Restoration, such as Hale and Hawkins, wrote similarly of the matter.

Sir William Blackstone, the first Vinerian Professor of English Law, one of the judges of the Court of Common Pleas in George III's reign, a renowned jurist whose "Commentaries on the Laws of England" published in 1765 were the most distinguished (indeed almost the only) attempt since Bracton to present the whole compass of English law in an elementary and orderly manner comprehensible to non-lawyers, summarized the history and current state of the law on the subject thus: "Life is the immediate gift of God, a right inherent by nature in every individual; and it begins in contemplation of law as soon as an infant is able to stir in the mother's womb. For if a woman is quick with child, and, by a potion or otherwise, killeth it in her womb; or if any one beat her, whereby the child dieth in her body, and she is delivered of a dead child; this, though not murder, was by the antient law homicide or manslaughter. But the modern law doth not look upon this offence in quite so atrocious a light, but merely as a heinous misdemeanor."[3] Elsewhere he says, "To kill a child in its mother's womb, is now no murder, but a great misprision."[4]

This is the last word we hear of the common law crime, though it may perhaps still exist, for soon afterwards statutes on the subject begin to appear. The important point to note is that abortion was always criminal at common law. The analysis of the nature of the crime changed over the centuries, but under one head or another abortion has always been illegal.

The first statute on the subject was that known as Lord Ellenborough's Act passed in 1803. This Act, passed partly in response to pressure from the medical profession, strengthened the law. Previously, as has been seen, abortion was a misdemeanor, but by this Act it was made a felony without benefit of clergy, and thus punishable by death. (Professor Edward Christian, the first Downing Professor of the Laws of England, in his edition of Blackstone's Commentaries published in 1809, draws a parallel between this and the Jewish law on the subject.[5]) The Act applied when any noxious or destructive substance was wilfully and maliciously administered to any woman quick with child. The same Act provided that where any medicine should be so administered or any instrument or other means used to cause an abortion and the woman should not be or should not be proved to be quick with child then the offenders should be guilty of felony and liable to be fined, imprisoned, set in the pillory, whipped or transported for up to 14 years. The Act stiffened the law. It may also have been intended to clarify it, but if so it failed. The distinction between women who were quick and those who were not or were not proved to be quick was found awkward in practice and was abandoned when the law was recast in 1839.

Abortion was always criminal at common law. The analysis of the nature of the crime changed over the centuries, but under one head or another abortion has always been illegal.

The Offences against the Person Act, 1839 established the law in substantially its modern form. It was re-enacted with only slight alterations in the Offences against the Person Act, 1861 which is the statute which governs the matter today. It provides by s.58 as follows:

> Every Woman, being with Child, who, with Intent to procure her own Miscarriage, shall unlawfully administer to herself any Poison or other noxious Thing, or shall unlawfully use any Instrument or other Means whatsoever with the like Intent, and whosoever, with Intent

> to procure the Miscarriage of any Woman, whether she be or be not with Child, shall unlawfully administer to her or cause to be taken by her any Poison or other noxious Thing, or shall unlawfully use any Instrument or other Means whatsoever with the like Intent, shall be guilty of Felony, and being convicted thereof shall be liable, at the Discretion of the Court, to be kept in Penal Servitude for Life ...

The distinction between felonies and misdemeanours has in recent years been abolished, but the punishment for this crime remains anything up to life imprisonment.

By s.59 of the 1861 Act it is an offence punishable by up to three years' imprisonment to supply or procure poisons or instruments knowingly for the purpose of abortion.

An oddity of the English common law was that while it was murder to kill anyone who had been born and a misdemeanour to kill a child while still in the womb, it was no crime at all to kill a child while in the actual process of being born. To remedy this defect the Infant Life (Preservation) Act, 1929 was passed. The first section reads as follows:-

> 1. (1) Subject as hereinafter in this subsection provided, any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to penal servitude for life:
> Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.
> (2) For the purposes of this Act, evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be prima facie proof that she was at that time pregnant of a child capable of being born alive.

The crucial moral distinction between deliberate killing and inevitable death from natural causes came to be obscured or ignored.

It will be seen that this does not deal only with the child while in the process of being born. Bills on this subject introduced in 1908 and 1927 had used the phrase "during the birth thereof", but the final version now enacted extends to any time before the child "has an existence independent of its mother". Furthermore it gives protection to any child "capable of being born alive". Obviously this stage is reached a long time before the child starts being delivered and therefore this statute overlaps the field covered by the 1861 Act.

Thus the result of the legislation so far was that by 1839 at the latest all deliberate abortion was felonious and by 1929 so also was killing a child in the process of being born unless to preserve the mother's life.

This state of affairs was resented by many in the changed moral climate after the Great War. Partly from a desire to make the welfare of the mother the paramount consideration regardless of the life of the child, but largely from motives of pure personal convenience, pressure developed for the relaxation of the abortion laws. The mode of attack upon the old view was by an insistent clamour upon the theme of the awful choice which sometimes arose, or was thought to arise, between saving the life of the mother and the life of the child. The crucial moral distinction between deliberate killing and inevitable death from natural causes came to be obscured or ignored. It is possible to see the proviso (set out above) to s. 1(1) of the 1929 Act as the first fruit of the new view, although that was not the object of the statute.

There was no majority in Parliament for a relaxation of the law, but the Courts proved amenable to "progressive" opinion. In the case of *R. v. Bourne* [1939] 1 K.B. 687 the evidence given was that a girl of 14 years had become pregnant after being violently raped by a number of soldiers. Dr Bourne, a leading obstetrician, who later regretted his part in the affair, carried out an abortion with the consent of the girl's parents, on the grounds that the continuance of the pregnancy might cause the girl serious injury. The doctor was prosecuted for carrying out an illegal abortion contrary to s. 58 of the Offences against the Person Act, 1861. At the trial Mr Justice MacNaughten seemed determined not only to encourage the jury to acquit Dr Bourne but also to make a statement of the law which would permit many abortions in the future notwithstanding the clear statutes to the contrary. In his direction to the jury he stated, without any authority, that the proviso (quoted above) to s. 1(1) of the 1929 Act (permitting an abortion to save the mother's life) must be read into the 1861 Act, and then went on to indicate that in his view there was no essential difference between a danger to the life of a mother and a danger to her health. By this means he led the jury to believe that conduct which was acknowledged to be in contravention of the clear words of a criminal statute was, nevertheless, not illegal.

The legal analysis that this direction to the jury has received has represented it as an example of the defence of necessity, which is one of the general defences to crime, but ordinarily a highly restricted one. It rests upon an implied assumption of an omission by Parliament to provide a defence. "Circumstances occurred which rendered it necessary to break the law. If Parliament had thought of these particular circumstances it would not have made the conduct criminal", is what the accused relying on such a defence is effectively driven to say. Obviously it would quickly undermine the authority of Parliament and obedience to the law, not just with regard to abortion but in respect of all crimes, if the defence of necessity were generally accepted. It was, therefore, highly unsatisfactory that the Rule in *R. v. Bourne* should ever have formed part of the law of England, both because it placed the law relating to abortion upon a highly dubious footing and because it constituted a dangerous extension of the doctrine of necessity.

Unfortunately the repeal of the Rule in *Bourne's* case came only with the Abortion Act 1967 which replaced the evil of that Rule with the much worse evil of permitting doctors to carry out abortions in a wide range of cases. The Rule is repealed by s. 5(2) of the Act which states, "For the purposes of the law relating to abortion, anything done with intent to procure the miscarriage of a woman is unlawfully done unless authorised by section 1 of this Act." Section 1 of the Act reads as follows:-

> 1. (1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to

abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith—
(a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or
(b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.
(2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) of subsection (1) of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.
(3) Except as provided by subsection (4) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of State under the National Health Service Acts, or in a place for the time being approved for the purposes of this section by the said Minister or the Secretary of State.
(4) Subsection (3) of this section, and so much of subsection (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

Sections 2 and 4 will be mentioned later and section 3 is irrelevant to this essay. Section 5 not only by subsection (2) repeals the Rule in *Bourne's* case but also by subsection (1) expressly preserves the Infant Life (Preservation) Act, 1929. Sections 6 and 7 deal with certain definitions and formalities.

It will be seen that the Act does not replace the law which preceded it. It does not codify the law on the subject of abortion. It does not even repeal or amend a single word of the earlier statutory provisions—sections 58 and 59 of the Offences against the Person Act, 1861 and the Infant Life (Preservation) Act, 1929—which remain in force. The Abortion Act is grafted on to the old law and has to be read as one with it. For example, s. 5(2) (quoted above) tells us that an abortion is illegal unless authorized by s. 1. It does not specify the nature of the illegality. To ascertain what crime has been committed if an abortion is not authorized by s. 1 it is necessary to refer back to the 1861 and 1929 Acts which create the relevant crimes and remain the governing statutes.

As the Abortion Act has not replaced the previous law on the subject, neither has it legalized abortion. It does not say that an abortion shall be legal in such and such circumstances. It is wholly negative in form. It exonerates participants in an abortion operation from prosecution in certain circumstances. Abortion remains illegal, but those people in those circumstances are exculpated. This is not accidental. It springs from the second of the two motives which lay behind the Act—not just to facilitate abortion but also to drive out "back street abortionists". The most effective way of accomplishing this was to re-assert that all abortion was to remain illegal unless authorized. The result is that all abortions are *prima facie* illegal.

The other important point to note about the general scheme of the Act is that it is purely permissive. It permits a doctor to carry out an abortion if the conditions mentioned in s.1 are fulfilled, but it does not oblige a doctor to carry out an abortion even if those conditions are fulfilled. There is a logical corollary to this. This is that no-one has a right to an abortion, for if a woman had such a right it would have to be matched by a corresponding duty on the part of a doctor to provide that to which she had a right, and, as has been seen, the Act imposes no such duty. When people speak, as some are prone to do, of "a woman's right to choose" to have an abortion, they are voicing their own theoretical opinions and are not stating the law of England as it actually stands.

The position, therefore, is that abortion is very far from being lawful in every case. This is not always appreciated. It is commonly assumed, for example, that if qualified doctors give their certificate and the abortion takes place in a hospital or an approved clinic then the abortion is legal. This is very far from being necessarily the case. The nett result of the 1861, 1929 and 1967 Acts is that an abortion is permissible only if:

(a) The child is not capable of being born alive (for otherwise the killing would be an illegal act of child destruction contrary to the 1929 Act) and
(b) It is carried out by a registered medical practitioner; and
(c) It is carried out in a National Health Service hospital or other establishment approved by the Secretary of State for Health and Social Security for the purpose; and
(d) Two registered medical practitioners have formed the opinion in good faith,
Either, that the balance of risk to the woman or her existing children as between termination and continuance of the pregnancy favours termination,
Or, that there is a substantial risk that the child would be born seriously handicapped.

As the Abortion Act has not replaced the previous law on the subject, neither has it legalized abortion. It does not say that an abortion shall be legal in such and such circumstances. It is wholly negative in form.

If the doctor carrying out the operation believes that the abortion is immediately necessary to save the mother's life or to prevent grave permanent injury to her health then a second opinion is not required and it does not have to be carried out in a hospital or other approved place. Such cases are, of course, extremely rare.

Abortions have, notoriously, become very common indeed in recent years. This is not because they are all legal, but because it is difficult to prove them to be illegal. There are several reasons for this. First, there is a conspiracy of silence. The woman has wanted the abortion; the doctor has been willing, and often well paid, to carry it out; and the baby, the chief sufferer, does not survive to complain about it. Secondly, a doctor is a respected professional person and it is not easy to convince a jury that he has formed his opinion other than in good faith. Thirdly, the risks as to which an opinion has to be formed are unquantifiable and thus essentially matters of judgment. It is only in the most blatant of cases that the doctor who actually saw the woman at the time can be shewn to have erred in his judgment. For these reasons few prosecutions are brought.

Let it be quite clearly understood, though, that this is not because most abortions are legal, but because it is difficult to prove them to be illegal. It is a problem of evidence.

When the conspiracy of silence breaks down then there can indeed be the evidence to support a prosecution. Such a case was *R. v. Smith* [1974] 1 All E.R. 376. The doctor had bungled the abortion and the woman became very ill. As a result she was willing to give evidence against him. Her evidence was to the effect that there had been no second opinion, that he had not assessed the risks, and that he had really been interested only in getting the money for his fee—evidence which the jury believed and which led them to convict. In how many countless thousands of other cases must the same essential illegality also be present—no interest whatever in the relative risks, and abortion on request provided the money is forthcoming? Yet because all goes smoothly no evidence of illegality is given, so therefore there are no prosecutions and thus no convictions. The vicious result of this is that the impression builds up in the public mind, and perhaps even in some judicial minds, that a legal abortion is always available if desired. Yet the law says nothing of the sort.

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For an abortion to be legal under s. 1(1) (a) of the 1967 Act the balance of risk must favour termination. The relevant risks are (i) a risk to the life of the pregnant woman, (ii) a risk to her physical or mental health, and (iii) a risk to the physical or mental health of the existing children of her family. The two doctors must assess the risks honestly according to proper medical practice. They are required to examine the particular woman before them and assess her personal health (or her children's, as the case may be) and not just statistical averages. They must take account of her age and the length of time the pregnancy has already continued. Lord Justice Scarman (as he then was) has pointed out that in forming these opinions "a great social responsibility is firmly placed by the law on the shoulders of the medical profession".[6] The opinions must be formed in good faith and in a trial the question whether or not they have been formed in good faith "is essentially one for the jury to determine on the totality of the evidence ... By leaving the ultimate question to a jury the law retains its ability to protect society from an abuse of the Act."[7] It is beyond the scope of an essay on the law to give detailed attention to all the medical considerations which should be taken into account when doctors form their opinions, but, to take an example, Lord Justice Scarman quoted with approval the evidence of a doctor in *R. v. Smith* that where risk to the mental health of the pregnant woman is relied on (as it was in that case and is in 85% of cases) "... one would want to know as much as one could about the patient's general background and so on ... Then there is the girl's own history, her past medical history, has there been mental illness in the family, one would expect to check that."[8] The contrast between what the law requires and what commonly occurs these days is too glaring to call for further comment.

The circumstances in which an abortion may be legal have been enumerated already. It is sometimes said that an abortion in the first 13 weeks of pregnancy must always be legal (provided the formalities are observed) because there is always some risk to life or health from a pregnancy and almost no risk from an early abortion. As a statement, this is simply untrue, because there is generally little or no risk from pregnancy to a young mother in good health, while an abortion, even in the first few months, can cause haemorrhage and can lead to subsequent sterility quite apart from the possible emotional disturbance and other mental effects. As an argument, it is fallacious as it does not compare like with like. It compares statistics for maternal mortality among mothers of all ages and in all states of health with those for maternal mortality from first trimester abortions. Almost all such abortions are carried out on young women in good health. There is practically no mortality from pregnancy among young mothers in good health. Deaths from pregnancy, barring accidents, occur only among older women or those with high blood pressure or otherwise in poor health. Thus, if a true comparison is made, statistics do not prove that abortion is safer and therefore do not make early abortions automatically legal. In any case, it is the individual patient whom the doctors must examine and about whom they must form their opinions, not the generality of pregnant women gauged by reference to statistics.

In recent years, since the invention of the post-coital pill sometimes called the "morning after pill", it has been argued that s. 58 of the Offences against the Person Act, 1861 does not apply to the fertilized ovum before it becomes implanted in the womb and that therefore the administration of this drug (which is thought to work by preventing implantation) is not an illegal abortion. The present Attorney-General has himself adopted this view on the grounds that "Whatever the state of medical knowledge in the 19th century, the ordinary use of the word 'miscarriage' related to interference at a stage of prenatal development later than implantation."[9] This is, in fact, wrong. All the leading Victorian medico-legal textbooks state that the law against abortion applies from the moment of conception. A good example is Charles Tidy's "Legal Medicine" (London, 1883) in which at p.154 appears the following passage:

> The ovum as really lives from the moment of conception, as does the child or the man. Criminal abortion, therefore, is as criminal at the instant of conception, if we could tell it, as at any other point of pregnancy. The life may be feeble and the embryo incomplete, but neither feebleness of life, nor incompleteness of embryo constitute the slightest argument against the existence and perfection of the vital principle.

It would seem, therefore, that s. 58 of the Offences against the Person Act, 1861 does forbid abortion from the very moment of fertilization, as indeed Professor Glanville Williams (when criticizing the law) always maintained that it did.[10] As two doctors cannot possibly give an opinion in good faith that the balance of risk from the continuance of a pregnancy favours termination when they do not even know whether a pregnancy exists to continue, it follows that the act of administering to a woman a post-coital pill or causing her to take such a pill is an illegal procuring of abortion and that the Attorney-General is wrong in his opinion on this point. The view of the law presented here is, after all, what first principles would suggest because the post-coital pill (so far as is known) works not by preventing conception but by preventing the embryonic child already

conceived from surviving.

Fertilization in vitro has started to occur in recent years and so-called "test tube babies" have been born. There have been no decided cases on this subject, neither is there any statute governing the matter, and it is thus not known whether the practice of fertilizing in vitro is legal or not.

The contrast between what the law requires and what commonly occurs these days is too glaring to call for further comment.

The position of those who conscientiously object to abortion is dealt with in section 4 of the Abortion Act. By sub-section (1) it is provided that "no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection." By the word 'treatment' it means, of course, abortions. This provision applies not only to doctors but also to nurses, anaesthetists, radiologists, hospital ancillary workers and indeed everyone concerned. The onus of proof of conscientious objection rests upon the person claiming it, so it is as well for those who do object to abortion to make this clear to their employers from the outset. The exemption is paramount and no contract of employment or disciplinary regulation can validly detract from it.

The only possible qualification to this is in the case of emergency operations to save the mother's life or to prevent grave permanent injury to her health. It is improbable these days that any such case would occur. If one were to happen, though, subsection (2) provides that conscientious objection is not to affect any duty to participate in an abortion in such circumstances. It is highly doubtful, however, that there is any such duty. Abortion remains *prima facie* an illegal operation. From the earliest times until 1938, far from there being any duty upon anyone to participate in abortion operations, there was a duty upon everyone not to do so. The idea that there might be at times a duty to abort was invented by Mr Justice MacNaughten in *R. v Bourne,* being a logically inevitable corollary of the defence of necessity enunciated by him in his direction to the jury to secure Dr Bourne's acquittal. With the repeal of the Rule in Bourne's case by s. 5(2) of the Abortion Act itself any duty there might ever have been to abort in any circumstances whatsoever must have gone too. Thus s. 4(2) attempting to restrict the scope of conscientious objection must, because of the way it is phrased, consist of words empty of meaning.

The Abortion Act shews that it is a true creature of the modern age not just in its permissiveness but also in its bureaucracy. By virtue of s. 2 of the Act no abortion may take place without the completion of two forms—first, a certificate that the two doctors have formed the required opinion as to the risk if the pregnancy continues, and second, a notification by the doctor performing the abortion that he has done so. Failure to comply with the Abortion Regulations (which prescribe these forms) is itself a criminal offence involving a fine of up to £1,000. More importantly, an incomplete or carelessly completed form may itself be evidence of an illegal abortion e.g. if the reasons given for the abortion are not such that any honest doctor could have held the opinion in good faith that the balance of risk favoured an abortion. Sometimes an accurately completed form can be evidence that an abortion which has taken place amounted to an illegal act of child destruction because the pregnancy had lasted long enough for the child to have been capable of being born alive. These forms, however, are not generally available to the police as they are required to be kept confidential by the Department of Health and Social Security.

The Abortion Act shews that it is a true creature of the modern age not just in its permissiveness but also in its bureaucracy.

The law of Wales is the same as the law of England. Nothing in this essay must be assumed to apply to Scotland or Northern Ireland where the law is in many respects different.

Notes

1 Selden Society edition, 1968, Vol.II, p.341
2 3 *Institutes* p.50
3 Book I, p.129
4 Book IV, p.198
5 Exodus 21:22
6 *R. v. Smith,* supra at p.378
7 *Ibid.* at p.381
8 *Ibid.* at p.382
9 *Hansard,* 10 May 1983, col.239
10 *The Sanctity of Life and the Criminal Law* (London, 1958), p.141

The law is stated as at May 1984.

News

Conferences

Caring Professions Concern have arranged the following conferences for early part of 1986:

The Primary Care Team and the Local Church

January 18th - 20th 1986.
An exploration of general practice today in the context of developing the vision and outreach of the local church.

CHAIRED BY: Dr. Tony Dale.

VENUE: Lamplugh House, Thwing, Driffield, East Yorkshire.

DURATION: Friday lunchtime through to Sunday lunchtime.

FEE: £50.00

Whole Person Counselling

February 6th - 8th 1986
SPEAKERS: Tony Dale
Trevor Martin

VENUE: Ashburton

Student Days

February 14th - 16th 1986
A training weekend to provide a foundation for a biblically based professional life. This time is for those recently qualified, medical students, nurses, physios etc., to explore how they combine their knowledge of God with their forthcoming professional lives.

LED BY: Tony Dale.

VENUE: Sunbury Court Conference Centre, Sunbury-on-Thames, Middlesex.

DURATION: Friday evening to Sunday lunchtime.

FEE: £30.00

Healing and Medicine - Complementary

March 14th - 16th 1986
A weekend for Christian professionals to examine the relationship between the natural and supernatural means of achieving healing and health. The interplay between the present active power of God and the need for using ordinary natural means will be examined through Bible Study and discussions. An attempt will be made for providing a framework to truly treat the whole person.

LED BY: Revd Trevor Martin.

VENUE: Lamplugh House, Thwing, Driffield, East Yorkshire.
For information contact CPC office.

Those wishing further details about these events should contact, *Caring Professions Concern, The King's Centre, High Street, Aldershot, Hants, GU11 1DJ. Tel: 0252 333767*

Study Day

There is to be a study day on 13 February 1986 on the subject "Ethical Issues in Paediatric Nursing". The meeting will be chaired by Professor Christine Chapman, Director of Advanced Nursing Studies, Welsh National School of Nursing.

Topics to be covered are:–
- Resource allocation
- Media presentation of information
- Nursing's contribution to inadequate care of handicapped children
- Community responsibilities
- Research application and interpretation
- Rights of a child

Application forms and further information are available from:

Miss S. Barlow
Director of Nurse Education
Charles West School of Nursing
24 Great Ormond Street
London WC1N 3JH

News Page

ETHICS & MEDICINE is to carry a regular *News* page in future issues. The editorial team will be glad to hear of any conferences, seminars or other events relating to issues in Medical Ethics. If you would like a news item to appear on the *News* page please contact Mrs Ruth Michell at the editorial address.