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A Christian Perspective

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Rutherford House Medical Ethics Project

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Ethics and Ethics

We have all been done a great service by the burgeoning public debate on medical ethical issues, since it has become clear once and for all what medical ethics is not. Time was when the silent deliberations of 'ethical committees' of one kind and another were seen as some sort of insurance against medicine and medics gone wrong, confidently fielding any ball that came their way. From the grave disciplinary proceedings of the GMC down to a watchful eye on hospital research programmes, ethics had the final say. The constant re-iterations of the IVF pioneers that they seek to operate ethically has been to similar effect. We can all sleep safely in our beds, even hospital beds, because ethical concerns are paramount and all's right with the world.

If only it were true. It is remarkable (as we shall see again below) how significant vocabulary can be in moulding people's thinking. We naturally assume that one word denotes one thing, and while we are used to the idea that several different words can denote one single thing, and that sometimes one word *connotes* several closely related things, it is a great surprise to discover that a single word, used by most of its users *as if* it spoke of a single thing, can actually refer to more than one fundamentally distinct entity. So it is, we have seen, with ethics.

Ethics I, of course, is really etiquette, the traditions of propriety which the profession holds dear. They may or may not have actual 'ethical' validity in any particular ethical tradition. They are the rules by which the game is being played, and they must be observed, if for no other, for that reason. It is 'unethical' for a doctor to have an affair with his patient *because she is his patient*, and not because the relationship is inherently improper (it may be and it may not be, in terms of general ethical principles). It is, or might be, an abuse of a professional relationship. Which is not to say that such rules as these are valueless. They have (as in this case) much intrinsic merit, and they are also derived from an altogether more substantial notion of ethics.

Ethics II is such a notion. It is Christian ethics, although many of the positions for which Christians contend are also defensible (some would say establishable) on natural ethical criteria. For our present discussion the point to note is that this is a concrete ethical system with definite values and moral imperatives. Things are right or they are wrong. This is of course what most people think 'ethics' must be, and is the ground of their (false) assurance as to the role of 'medical ethics' in the quality control of doctors and their decisions.

Ethics III is what is causing many of us concern. It is new, and essentially an attempt to subsume II under I, that is, to treat the interface of medical practice and general ethics as an area for the determination and application of 'professional' values. It has come about for many reasons. One of them is the fact that in the Hippocratic tradition there was a blending, or marriage, of I and II, since I (professional etiquette) was plainly the fruit of II (general ethical principle). So the Oath itself covers respect for medical teachers and confidentiality alongside the sanctity of human life, all arising out of a respect for human persons as the ground of medicine. This has led many to believe that in the tradition itself Ethics II arose out of Ethics I, as if the sanctity of human life, having once been decreed by doctors to be a good idea, could now be revoked by them.

A more recent factor is the growing consciousness of the break-up of the Judaeo-Christian ethical tradition in society at large, and in particular in the churches. The ethical vacuum elsewhere has allowed, almost required, the medical profession itself to take the ethical initiative. When the churches, and even a body like the (evangelical) Christian Medical Fellowship, have been divided in their approach to fundamental ethical issues, the medical profession itself could hardly be blamed if it concluded that there are no such things as objective Christian ethical principles. Ethics is doing what is right in your own eyes, and professional ethics doing what is right in the eyes of the profession. Which is another way of saying that it is doing what you like. Ethics is only beginning to bite when it starts making us do things we find distasteful. That is how we can be sure that someone is actually holding the reins.

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Another reason lies in the series of court cases which have been tried in recent years in the United Kingdom, in which doctors have found themselves on serious criminal charges on account of their doing things which some of their colleagues, at least, have regarded as well within the purview of 'ethical' (i.e. professionally permissible) practice. These cases have led to the cry that matters should not be resolved by lawyers and judges, but by the doctors themselves. The startling implication of that would be akin to the 'political' defence against extradition which complicates the international pursuit of terrorists. That is, it would imply that a physician had an absolute defence against any criminal charge if he could claim he was acting in a professional rather than a private capacity, in (say) bringing about the death of a handicapped child. It might be remarked that this whole development is an interesting comment on the *hubris* which afflicts medicine.

For these and other reasons, *Ethics III* is upon us, the notion that, far from being required to conform to the general ethical standards of society (which happen shakily still to be generally Christian ones) medicine can make its own rules and enforce them upon its members, deciding for itself both where medical practice impinges upon general ethical standards, and how doctors are to behave where it does.

But the bringing of this out into the open has aroused deep concern on the part of the wider public, including many doctors and members of other professions who find the tendency of the medical profession to arrogate to itself all ethical wisdom deeply distasteful; and who believe that the kind of fashionable stances being increasingly taken up by medical bodies on ethical issues show nothing other than the general incompetence of doctors to pronounce on questions outside of their clinical expertise.

There is a simple way of discovering how well fitted the medical profession is to pronounce on issues of medical ethics other than our Ethics I (the merely professional): find some medical students and ask them how their training

in this area (if there is any at all) compares with their scientific and clinical preparation. Perhaps some would like to write in to our *Student Forum*, and tell us.

Embryos and Pre-embryos

It is never a pleasant experience to discover that someone is trying their hand at fraud, but the attempted coinage of the term 'pre-embryo', to describe the human embryo up to fourteen days from fertilisation, is just such an occasion. It is disgraceful, and (in the light of what has already been said) an ethical indicator of some interest, that distinguished men and women should be attempting to win the game by moving the posts midway through the second half. Much to their credit, many journalists have insisted on using the term in quotation-marks, implying that its provenance is suspect. As Professor Ian Kennedy pointed out in an important letter to *The Times*, that this is a fabrication and not in any sense a scientific term is proved by the fact that it is not to be found in the Warnock Report. Since its definition so happily coincides with Warnock's own recommended fourteen-day limit on embryo research this observation is decisive.

Of course, it is well-known that many of those who favour the vivisection of the human embryo are privately or publicly in favour of a cut-off point well beyond an age of two weeks. No doubt, when the time comes, their vocabulary will keep pace. Will it be 'discovered' that, against all expectation, the pre-embryo actually continues until 21, or 28, or 35, or even 42 days? Will this be a simple discovery, or a series of consecutive discoveries? Of course there is a limit beyond which this programme could not go, since at around six weeks it becomes customary to talk not of an embryo but of a fetus. Will the embryo stage be altogether 'discovered' out of existence, with a swift move from pre-embryo to fetus?

It has already been remarked elsewhere that human embryologists are, unusually, leading the field. No doubt their animal colleagues will re-do their research and see if animals have pre-embryos too.

But the usefulness of the 'pre-' pre-fix has far from been exhausted, and whatever 'pre-' does surely 'post-' can do at least equally well. The possibility of pre-fetuses up to whatever happens to be the current abortion limit suggests an opportunity for a proper programme of experiments on live abortuses in place of the haphazard and embarrassed attempts which have been made from time to time, both in Scandinavia in the 1950's and, more recently, closer to home (including two examples published in the late 1960's by a member of the Warnock Committee).

Those of us who are concerned for a serious Christian approach to the treatment of the human embryo will be appalled by this attempt to give greater credibility to the cause of those who desire to use humans as experimental objects. But perhaps, at the same time as trying to make what they are doing more acceptable to the rest of us, they are secretly trying to make it more acceptable to their own consciences too. Perhaps the enormity is dawning on them of bringing human beings into existence to spend their entire short lives in the laboratory. More likely it is not, and what we see is simply a dishonest attempt to add a veneer of respectability to something which can never be anything other than sordid.

N. M. DE S. CAMERON

After the Embryo the Fetus?*

SIR JOHN PEEL
Former President of the Royal College of Obstetricians and Gynaecologists

When I began my medical career as a student over sixty years ago I was introduced to the subject of Embryology by the then Professor of Anatomy at Oxford. Embryology was his prime interest. In his lectures he took us through, with methodical precision, all the stages of development from the fertilised ovum, in the fallopian tube, to its ultimate expulsion from the uterus as a full-term child.

If there was one fact he used to impress on all his students time and time again, it was that a new life began at conception – that all the developmental changes that took place thereafter were part of a continuum that went on for the whole duration of the pregnancy. There are of course many landmarks, each denoting progression, which can be picked out during the course of intra-uterine life, which are significant – both subjectively and objectively; but their recognition does not alter the fundamental fact that it is at the moment of conception, when the sperm penetrates the ovum, that a new vital spark is given to the single-celled ovum which endows it with the potential to create a new human being. Some distinguished scientists have argued that after fertilisation, as the ovum begins to divide and multiply its cellular formation, it remains a simple mass of cells, a morula, which cannot be regarded as even a potential human being, because half of those cells are given to form merely the placenta and membranes, and it is only with the appearance of the primitive streak that the new embryo becomes recognisable. This I think is only a half truth because the other half of the cells really are destined to form the new fetus. After all, in these terms what are any of us, as adults, but a mass of millions of cells. The statement therefore that life begins at conception and not only after fourteen days or thereafter, is not simply an anti-abortionist moral stance, but is scientifically indisputable. Perhaps I could quote from a more modern embryologist, Dr David Woollam, who at the launching of the Helsinki Medical Group on May 1st this year said "The Warnock Committee appears to have reached the view on the allowability of experiment on the human embryo by starting with the fertilised ovum and then working forwards to a time when they felt that experimentation was no longer acceptable. I prefer to look backwards in time from the birth of a normal healthy child. As I travel back in the life history of the fetus and embryo to the point of formation of the zygote I find, as an embryologist, that there is no moment in time at which I can say 'yes' this must be the stage when it changed from a non-human being to a human being."

I find that the choice of fourteen days as a cut-off point before which anything by way of disposal on experimentation goes, whereas after that date nothing is to be allowed, is a choice that has no real scientific, moral or practical basis. We have lived through an era of thirty to forty years in which there has been a graduation, a progression by stealth, in most aspects of individual and social behaviour. What was unacceptable thirty years ago is taken as common-place today. Whether progression is always progress is a matter of opinion – in many areas I would regard it as deterioration. The erosion of discipline, not so much external discipline, but self-discipline, of responsibility for personal actions, and personal life-style, is clear for all to see. Within the context of what we are discussing today, I think it is naive in the extreme to imagine that fourteen days relating to experiments on human embryos will be adhered to for very long, whether carried out legally or illegally. Already a number of scientists working in this field have expressed the view that this date-line should be extended to twenty-eight days and beyond. And if you believe in experimenting on human embryos, you have logic on your side in taking this view. No-one can tell the end result of any research programme, and I have little doubt that when the time comes that the *in vitro* embryo can be kept alive and growing for fourteen days and beyond the experimenters will want to go on. And once you breach a fundamental principle of ethics, why shouldn't they? We have been through the era of sexual revolution, with abortion, originally for serious medical and social reasons, and now free for all, with contraception for married women with large families and now for pre-teenagers, etc. We are now beginning the era of the reproductive revolution, with veterinary principles entering into the field of human reproduction. Is this what society wants?

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In 1970, when considerable concern was finding expression in the public about the disposal of the thousands of fetuses that became suddenly available, as a result of the Abortion Act 1967, I was asked by the then Minister of Health to chair a working group to consider the ethical, medical, social and legal implications of using the fetus and fetal material for research. Much has, of course, happened since then. I.V.F. was, if I may so use the expression in this context, very much in an embryonic stage of development. Some of our conclusions might not be applicable today, but much of our report dealt with matters that are as relevant today as they were then. At the outset we found difficulty in regard to some of the definitions in general usage – embryo, fetus, previable and viable fetuses. After reviewing all the evidence we came to the conclusion that the "fetus" was the human embryo from conception to delivery – and nobody at that time questioned the validity of that definition. I think it is important. It concentrates the mind and clarifies the debate to appreciate that the embryo is simply the fetus in the earliest stages of its development, and not a separate entity to be disposed of at will. I make no apology therefore in discussing briefly ethics and fetuses, because they include embryos.

There are no ethical problems involved in making use of fetal material or the dead fetus expelled from the uterus by spontaneous or therapeutic abortion. There is a question about which opinions differ – whether there should or should not be any statutory obligation to seek the consent of the woman herself if it is intended to make use of the

material for research or therapeutic purposes – or indeed whether a woman who has consented to have the fetus she is carrying killed by abortion has any right to exercise any control over what is done with the fetus afterwards. (Refer to our Report, page 9, section 42.)

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For a great many years research has been conducted in the areas of virology, cancer research, immunology and in relation to congenital deformities, with very significant and beneficial results. At the other end of the scale it would be unethical and unacceptable to carry out research on the viable fetus after delivery, except in so far as any research consisted of the results of the application of any new technique or the exhibition of a new therapy designed to treat a condition for which the neonate was suffering, with a view to assisting its recovery or prolonging its life. The real ethical problems arise in regard to what is spoken of as a pre-viable fetus. Enshrined in the Infant Life Preservation Act 1929 is the definition of a viable fetus as one that is "capable of being born alive." That Act gives blanket protection to the fetus from deliberate injury from conception to delivery, save under the provisions of the Abortion Act 1967; and further that protection is not abrogated by the fact that it may be the intention at the time of the infliction of the injury that the fetus should be prevented by subsequent abortion from attaining life. So in law you can kill the fetus but you must not inflict any injury upon it. Hence there *is* a need for clarification of the law and some more precise definition of viability and what is meant by "capable of being born alive", which is a very imprecise phrase. During the past two decades such advances in neonatal paediatrics have been made that more and more fetuses born prematurely can now be kept alive by the application of new techniques, and the degree of prematurity is becoming earlier and earlier, but without the application of such medical care the fetus is no more "capable of being born alive" than it was previously. A fetus expelled at say sixteen to eighteen weeks will, unless it has already died, have a detectable heart-beat and make respiratory gasps. There is no possibility of it surviving even with all that scientific medicine has to offer at present, but its basic life process can be kept going for a brief period, perhaps an hour or more. It is here that the scientist argues that if such a fetus is certain to die in such a short time, why not keep it going as long as possible so that we can do useful experiments. Alternatively prior to the abortion why not give to the mother drugs, chemical substances, etc. which will not damage the mother but may pass through the placenta to affect the fetus. In that way it might help to know just how and why different fetal organs become affected. The Abortion Act has unhappily lowered the status of the fetus in the eyes of both doctors and the public and to many it seems totally illogical that society allows in this country alone upwards of 150,000 fetuses to be killed every year, and raises serious and fierce debate about the fate of an embryonic fetus during the first fourteen days of its life. It is indeed illogical. But it is an issue that raises such fundamental questions on all aspects of human experimentation. I make no apology for having spoken at some length about the problems of experimentation on the fetus conceived *in vivo* both before and after it leaves the mother's uterus, because these problems are closely related to those of experimentation on the human fetus (embryo) conceived *in vitro*. To raise the spectre of ectogenesis runs the risk of being accused of scare-mongering in the realms of science fiction. But as research progresses into the creation of the artificial womb, what purpose can there be in it if not to take the first steps towards the ultimate of ectogenesis? Scientific, technological and clinical developments are proceeding at such a rapid rate that clearly once fertilisation *in vitro* has been accomplished, efforts will be made to prolong the life span of the embryo – while at the other end of the scale fetuses delivered prematurely at earlier and earlier stages of development will survive. Will a time come when the two extremes may meet? There is developing a whole new field of fetal medicine which is not only exciting scientifically but is of great practical clinical value. The new techniques of monitoring the fetus throughout its period of intra-uterine life are no longer confined to diagnosis, but are being extended to beneficial therapy. Intra-uterine blood transfusion was the first in this field, but now a variety of operative as well as diagnostic procedures are possible. My only anxiety is that the opportunities for experimentation must occur and it would be tragic if such a beneficial development should become at risk of being abused. And make no mistake it will be abused if the standards of human experimentation are relaxed.

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Since the Warnock Report was published so much has been written and spoken about it, both for and against, that it becomes difficult to find issues that have not been debated very fully already. However there are three or four aspects that I should like to speak about now. Let us take one problem of infertility. It is frequently stated that it is only by means of *in vitro* fertilisation and research on embryos that infertility can be cured. Infertility has always been with us and most couples unfortunate enough to find themselves in this situation have learned to live with it. In my experience the absence of children has seldom led to the break-up of a marriage (a relationship to use the current phraseology) if that has been firmly based in marital love and devotion. And seldom has a rocky marriage been secured by pregnancy. But with the advent of *in vitro* fertilisation, it has become, in a sense, glamorised. Many women having won the right to discard the fetus at will have then had expectations to have their infertility cured at will. The whole subject has, so to speak, hit the headlines. I.V.F. was of course first popularised as the best means of relieving the infertility in a very special and restricted group of women – those whose fallopian tubes had become obstructed due to previous infection. It was indeed a tremendous technological medical achievement and full recognition of this fact is freely acknowledged by us all. Unhappily due to the current climate of sexual mores there has been a considerable increase in sexually transmitted diseases and so more women, otherwise fertile, have become infertile by reason of tubal blockage compounded

by early sterilisation.

However I.V.F. remains a technique at present complicated and not highly efficient albeit the best even if not the only way of alleviating the infertility in these cases. A recent report from Australia records a series of 244 pregnancies established after *in vitro* fertilisation – in which 27 per cent ended in spontaneous abortion, 22 per cent in multiple births, 5 per cent in tubal pregnancies and a three times higher incidence of pre-term births than in the general population. Both premature births and multiple births greatly increase the physical and mental risks in those babies that survive as they progress into childhood and adolescence. It is often alleged that those of us who are expressing grave concern at the new technology of artificial reproduction are callous about the plight of infertile couples anxious to have a child, and further it is argued that only by I.V.F. can a cure for infertility be found. Both allegations are totaly untrue, and my concern is not with the application of *in vitro* fertilisation to suitably selected infertile couples, but to its extension and possible abuse outside this narrow field of application. We should not confine our attention too strictly to the question of embryo research, but see it in the context of this whole new field of artificial reproduction – A.I.D., egg donation, surrogacy, as well as *in vitro* fertilisation. These techniques can be and are being extended outside marriage – even to single women with no male partner, who are anxious to have a child, but who wish to avoid involvement with any member of the opposite sex, moral, emotional or legal. Are the wishes of the individual woman always to be paramount? It is not for doctors to provide answers to such a question, but I believe society should give far more serious consideration to the direction in which we are moving and consider whether it is not laying the foundations of problems to come. Those problems concern something so far largely ignored and scant concern has been expressed about products of these procedures – namely the child. How will many children as they grow into adolescence, conceived in these artificial circumstances, regard the dignity of their origins? In the days when there were many babies available for adoption prior to the Abortion Act, it was commonly accepted that at the age of 18 it was right for every adopted child to know the details of its birth. The Houghton Committee in 1972, set up to consider adoption, stated that the interests of the child should always take precedence over the requirements of the adopting couple. How is this principle to be applied, for example, in the case of children artificially conceived outside the normal family situation? And because when I.V.F. is employed, it is necessary to implant more than a single embryo, the risks of multiple pregnancy are greatly increased. I find the production of six babies, instead of one, as occurred in one case, positively obscene. Instead of being regarded as a medical failure, it was glamorised as a triumph with pictures in the newspapers of a whole army of doctors, nurses and paramedical staff who had been employed in the whole procedure. What is to be the future of those six babies? One cannot help wondering – not to mention the reactions of the parents as time passes.

Reverting to the problem of infertility, it is important to remember that the causes of infertility are many and varied and that the whole range of these new techniques of artificial reproduction are aimed at alleviating the condition and are not directed in any way to elucidating the causes. I think therefore that there is a great danger that if they are adopted too widely and too easily, they may inhibit alternative research and the development of treatments likely to cure rather than alleviate. There are a whole range of conditions responsible for infertility, which it would be inappropriate to discuss within the context of this conference, but great strides have been made in many conditions and it would be wrong to imagine that artificial means are the only ones likely to benefit the infertile couple. The second claim that is often repeated is that it is only by experimentation on the embryo that the results of I.V.F. can be improved and abnormalities in the fetus prevented.

I believe society should give far more serious consideration to the direction in which we are moving and consider whether it is not laying the foundations of problems to come.

It is, of course, the word experimentation on the human embryo (fetus) that creates so much emotion and moral indignation; and quite rightly, because experimentation on the human is by common consent, only to be undertaken if designed to help the subject, but not simply to increase knowledge or benefit science and society. It is important to recognise that observation is an integral part of research, and it would not be right to criticise the observation of the embryo created *in vitro*, up to the time when it is judged optimum for implantation into the uterus. That is not experimentation, and it seems to me perfectly ethical to observe the embryo fertilised *in vitro* and to make every effort to improve the medium in which the embryo develops prior to insertion into the uterus. But the biggest problem is not so much the fertilisation of the ovum *in vitro*, but the embedding in the uterus. There is only a 15 per cent success and that is why it is necessary to implant several embryos, and why the causes of failure are maternal rather then fetal – and experimentation on the embryo seems unlikely to make the procedure more successful. But much more is contemplated by the scientific researchers. No-one can foretell the ultimate outcome of any research programme, and that is why it is impossible to prove or disprove the validity of any claim that may be made about the potential benefits likely to come from any particular piece of research. In the matter of embryo research the experts disagree. Even if those experts who argue that it is research on the gametes prior to fertilisation that is more necessary than research on the embryo, appear to be in a minority, it is not to say they are wrong, and I for one agree with them on general principles and on my clinical experience. We all want the elimination of genetic diseases, but not I hope at any price. Maternal and environmental factors are more important causes of handicap and disability in children than are genetic diseases, but that does not mean that every effort should be made to eliminate hereditary factors. It is a question of the most likely avenue for research and I do not believe that experimentation on the embryo is the most profitable line to be pursued.

If embryo research is to be permitted, albeit only for fourteen days, will not very large numbers be required? Spare embryos from infertile couples will never satisfy the needs and so we face the practice, in my view entirely unethical, of inducing multiple ovulation in the ovaries of volunteer women due to have some gynaecological operation – collecting them by laparoscopy or other techniques and fertilising them with sperm from any source available. I find this procedure repugnant and so I think will the vast majority of women.

It is claimed that amongst other benefits likely to emerge from research on human embryos is the reduction in the incidence of early embryonic death and spontaneous abortion. The Medical Research Council in its response to the Warnock Report was reported as saying that one million conceptions are lost every year before pregnancy is established and 100,000 spontaneous abortions occur due to chromosomal abnormality. Both these figures, especially the first, seem to have been plucked out of the air. Surely there must be millions of sperms, near exhaustion towards the end of their journey to the female genital tract after seven or eight days meeting up with the ova beginning to disintegrate, and small wonder if conception occurs it is unlikely to progress. How could such an event be prevented, except by confining sexual intercourse to the optimum period of 12 to 24 hours in the life of the ovum, to the whole human race? And even if it could, there would be either an unthinkable explosion in the population or a vast increase in the demand for abortion. In my experience I would argue that maternal and environmental factors are more important causes of spontaneous abortion than chromosomal abnormalities, and if they are the cause, is it not better that the conception be aborted spontaneously? The potential benefits from embryo research are, I think, exaggerated, but not being a scientist but a simple clinician I cannot prove it – nor can anyone else.

One final point – if embryo research is so vital and so necessary, why is it necessary to create such an elaborate means for monitoring and controlling it? Obviously to try to reduce the risk of abuse. And if opinion is so divided, what sort of licensing body can ever be created that would be truly impartial? And how could it possibly carry out its responsibilities in every detail? The controlling mechanism established after the 1967 Abortion Act failed almost completely to function in the way originally intended, and I fear that the same fate would befall any licensing body set up to try to control this whole new field of reproductive techniques.

No-one can foretell the ultimate outcome of any research programme, and that is why it is impossible to prove or disprove the validity of any claim that may be made about the potential benefits likely to come from any particular piece of research.

I am aware that the objective of this conference is to produce a Christian view of all the issues covered by the Warnock Report. For that reason I have deliberately strayed away from the narrow field of ethics and embryos. I am no theologian but do profess Christian convictions relating to this whole field of artificial reproduction. I find the oft repeated statement that it is only those of the Catholic faith who are opposed to the recommendations of the Warnock Report, not only grossly inaccurate but offensive to those of us who, though not of the Catholic faith, hold strong convictions and who are profoundly worried by the deterioration of moral standards in so many aspects of contemporary life. Do we really believe that the introduction of some of the principles and practices applicable to the veterinary world, if introduced widely in the area of human reproduction, will enhance the dignity and status of the human race? Let us have by all means compassion for the infertile couple, but let us not become obsessed with physical perfection as the only goal to be aimed at. Human sperm, ova, embryos, are frozen, banked and stored in so many places – if this is allowed to continue how will the dignity of human reproduction be maintained? How will the Christian marriage survive and the family remain a pivotal entity in our society? How will some of the children, who having been deliberately deceived about the mode of their origin, react when they learn the truth? Is this Pandora's box when opened not liable to lead to such a confusion of moral, social and legal problems that will not be capable of resolution? If the tide is to be turned it will be on a moral and not a scientific stance.

How will some of the children, who have been deliberately deceived about the mode of their origin, react when they learn the truth?

I would like to conclude by reading a letter which I and a number of other gynaecologists wrote to *The Times*, which epitomises my views better than I can do in any other way.

> Sir,
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> As Fellows of the Royal College of Obstetricians and Gynaecologists, we consider that those recommendations of the Warnock Committee relating to embryo research reduce the status of the human embryo to that of an experimental animal, contravene the code of medical ethics and must be rejected.
>
> The rejection of experimentation on human embryos is implicit in the code of professional ethics, relating to all human experimentation, which has from time immemorial been endorsed by the medical profession and repeatedly confirmed by the World Medical Association and other professional bodies. The central principle of this code is that concern for the interests of the subject, namely the patient, must always prevail over the interests of science or society. The human embryo conceived by *in vitro* fertilisation is the subject of the doctor's concern, and as with an adult patient, may not be put at risk for any reason other than to enhance his or her own well-being.
>
> The effective investigation of pathological conditions developing during pre-natal life should not require the killing of human embryos. Indeed primary prevention of many such conditions, as opposed to their secondary prevention by killing those who suffer them, is more likely to be achieved by applying new techniques of research to human gametes and not to human embryos.

* *A version of this paper was read at the* Embryos and Ethics Conference, *Edinburgh, 23 November, 1985.*

Some Theological Perspectives on the Human Embryo (Part 2)*

Generalising from Psalm 139

We return now to Psalm 139, and to the theological significance of the poet's affirmation of a continuity of his personal identity from his adult life back to the time of his conception. This is, it might well be pointed out, the history line of a mature adult which he can trace back to his personal beginnings. Because of this some writers reject the suggestion that from this psalm we can draw general conclusions concerning the personal identity of every other human conceptus. Thus, in his article 'The beginnings of Personal Life' (*Journal* of the Christian Medical Fellowship Volume 30:2; April 1984), Donald MacKay makes a distinction between those fertilised ova which are spontaneously aborted 'at too early a stage for any of the minimal structures for recognisably personal life (not just human life) to have developed'. He calls these X's. Those that develop into normal infants and eventually adults, he calls N's. Among the N's he finds the writer of Psalm 139. 'But', says MacKay. 'Where, O where, does Psalm 139 say anything whatever about the X's of this world?' He goes on: 'People seem to be arguing that because in Case N (where the evidence comes from those who have 'made it' as persons), God's concern for their whole world line was personal, therefore in Case X God must view the fertilised egg as a person (with the rights of a person). I don't know any canons of logic by which this follows! In the case of the N's, of course, there is direct continuity of personal identity. But in the case of the X's, on what grounds could it be claimed that there ever was a person with personal identity?' He continues later: 'In the case of the X's, then, it seems entirely consistent with the biblical data to take the view that there never has been a person there: that in this case the 'person' is only a might-have-been, and not an existent to whom moral obligations are owed.'

Now, Mackay's distinction between X's and N's is made on the basis of physical structures which have or have not developed. He supports the view that the maturing nervous system goes through a sequence of stages in which qualitatively new modes of co-operative activity arise, some of which are known in later life to be essential for the maintenance of conscious personal agency 'so that even complete continuity of biological development would not rule out the possibility of a decisive moment, or at least a decisive stage, before which there is nobody there but after which there is someone who is 'he' or 'she' as a personal cognitive agent, however limited in capacities.'

Now of course there are real differences in the cognitive and agency capacities between a fertilised egg, and a more developed fetus. And if one accepts that personhood is defined in terms of capacities, and that only personal entities which have a sufficient level of cognitive capacity have rights of protection, then MacKay's argument is valid. If, however, as we have argued, it is species identity that in itself constitutes a moral claim, and if the moral status of a human entity is not defined in terms of its capacities but rather in terms of God's relationship to it, then MacKay's distinction betweem X's and N's needs to be questioned.

From the theological perspective which I outlined earlier, it seems clear that personhood – being in the divine image – needs to be understood relationally and teleologically, and not primarily ontologically. There are, to be sure, a whole series of discontinuities in the development from an embryo to an adult. On what *theological* grounds does MacKay single out cognitive capacity as the one significant discontinuity? From the earliest moments of life right through to death, the human organism is performing metabolic functions which characterise an organic whole. Through all the various discontinuities of development, there is this continuity of organic integration which marks the continuing identity of the conceptus, embryo, fetus, child and adult.

If Professor MacKay's distinction between X's and N's is not valid, what generalised conclusions may be drawn from, for example, Psalm 139?

First, the poetic power of the psalms depends on the generalisations which we make. We are involved in the psalms. Their words stand as testimonies very often not just to the truth about one individual, but about human life before God. The Lord is my Shepherd, not just David's. He keeps my going out and coming in, not just that of the author of Psalm 121. And, O Lord, thou has searched me and known me.

Second, and to put the argument at its weakest: even if we have to be agnostic about the appropriateness of calling every early conceptus a 'person' (and is not the destiny of naturally aborted fetuses God's question and not ours?), Psalm 139 makes clear that in some cases at least (such as this psalmist) there is a continuity of personal identity from conception to maturity. Given what we are clearly told about such cases, and the fact that we are not told anything at all about the others, we ought to steer well clear of utterly unjustifiably treating the cases we are not told about in an entirely opposite way from those in relevantly similar circumstances of which we have some knowledge. If the personal 'I' of this poet in embryo is an innocent human being with an inviolable right to life, we should beware of presuming to know that other embryonic life is definitely not. And in any case, *we* are not, of course, in a position to know which embryos will have an on-going personal history, and which will not.

The infancy narratives

There are a number of features of the opening chapters of the Gospels, particularly Luke, and the doctrine of the Incarnation which they imply, which cast some further light on the status of the human embryo.

The Virginal Conception of Jesus – As T. F. Torrance and others have argued, indeed the seeds are present in Calvin, one of the crucially significant corrolaries to be found in the doctrine of the virginal conception of Jesus is that the divine Son of God has joined himself with human flesh precisely at the point of conception. The word has become flesh, so to speak, right down to the level of our

genes. In his role as Mediator, Christ has taken our humanity, our human flesh from conception onwards, into relationship with God in a decisively new way. This confers on the human embryo a sacred and inviolable status. 'The Lord Jesus assumed our human nature, gathering up all its stages and healing them in his own human life, including conception.' (Torrance). There is a human continuity through all these stages from conceptus to mature adult.

Brephos – There are two sets of biblical texts which support this line of argument. The first is the continuity implied by the use of the Greek *'Brephos'*, particularly by St Luke.

In classical usage, brephos can mean both 'embryo' and 'child'. There is a passage in Homer (I1.23.266) which talks about some games in which the first prize offered is 'a woman with a tripod', and the second prize is of a 'mare pregnant with the *brephos* of a mule'. The lexicons translate *brephos* in this instance 'embryo'. In St Luke the references are all human, but there is a variety of contexts. In 1:41 the 'babe' leaped in Elizabeth's womb on hearing Mary's news; in 2:12,16 Luke writes of a 'babe' lying in a manger. In Luke 18:25: 'Now they were bringing 'infants' to him that he might touch them.' (cf. Acts 7:19). Some sort of continuity is implied linking embryo, child in the womb, new-born baby, and infant.

The Visitation – The other support comes from the narrative of Mary's visit to Elizabeth recorded in Luke 1.39f. Within at most a few days after the Angel's visit to Mary, she was on the road. Elizabeth's house could not have been more than ten day's donkey ride away, so it is the natural reading of this passage that Mary arrives at Elizabeth's house with a ten day old fetus (to be called Jesus when he is born) in her womb. The greeting by Elizabeth is full of significance: she calls Mary 'the mother of my Lord'. Elizabeth recognises Mary as already a mother, even though the fetus in her womb was no bigger than a pin-head. And then the fetal Messiah is recognised by the six-month old fetus, the still-to-be-born John the Baptist, jumping with joy in Elizabeth's womb!

Thus the American Benedictine Stanley Jaki comments: 'A lucky John, whom our Supreme Court (though not the widespread medical practice) would have protected. As to the Messiah, only a two-week old fetus, he would not have been granted any protection by that august Court.'

Parenthood

Taking our cue from Elizabeth's greeting to Mary, we may suggest that, rather than asking 'When does human life begin?' a more biblical way of posing the question might well be 'When does parenthood begin?' What is the significance of parenthood under God?

The creation story implies that procreation is a divine command (Be fruitful and multiply); and the psalmist tells us that children are a blessing. (cf Ps 127:5). Now lrt us put these themes alongside two other biblical paragraphs. At the opening of the Gospel of John, we read of God's creative Word, and that 'all things were made through him, and without him was not anything made that was made.' And in Ephesians 5, the love relationship between husband and wife is to be patterned on the love relationship which that same God in Christ has with his church. Because of our view of the unity of God, we can thus see that within the Godhead love and creativity belong together, and so the human procreative process in which love and creativity normatively (although, of course, not always in practice) belong together is a sharing in the loving creativity of God through whom all things were made.

A 'product' is subject to human will and human disposal; a 'neighbour' exercises a moral claim.

The child conceived is thus begotten through the human relationship, though brought into being by God. As such he or she is to be welcomed as a neighbour within the human family. His or her life is a gift of God's love. Parents do not, then, 'make' children as products; they share in God's creativity by begetting. As another psalmist has put it: 'It is he that has made us and not we ourselves.' (Ps 100:3)

This view is supported by the notion that conception is a 'gift' (cf. Ruth 4:13: 'the Lord gave conception'; cf. also Gen.1:25; 21:1,2; 25:21; 29:31-35; 30:17-24; 33:5; Dt. 7:13; Jud.13:2-7; 1 Sam 1:1-20; Ps 113:9; 127:3-5; 128:1-6; Isa 54:1; Lk 1:24). It is supported also by the view of some biblical writers that an 'untimely birth' expresses something unnatural and inappropriate, and sometimes under divine displeasure (Ps 58:8; Job 3:10-16; Eccles.6:3; cf. 1 Cor 15:8)

To be a parent, then (we are talking normatively, not descriptively), is to have a calling under God to share in his creative love. This must count against any view which sees the conceptus merely as a product. The conceptus, rather, must be seen and welcomed as a neighbour. A 'product' is subject to human will and human disposal; a 'neighbour' exercises a moral claim. If the 'product of conception' is in any sense a sign of God's loving creativity, then the claim it exercises on me is a claim not to be treated as a product, and so as a means only, but as a neighbour, and so as an end also.

I do not believe that to insist that the loving and procreative aspects of human sexual relationship belong normatively together rules out all contraception. But it is an altogether different question, when faced with the fact that one *has become* a parent, whether the rejection of that life can be compatible with the nature of God in whom love and creativity are joined, and before whom parenthood has the status of a calling.

'Souls'

The argument is sometimes heard that God is not really concerned with biological life at all, but rather with our 'souls', and that it is by no means clear that the 'soul' is 'added' at fertilisation. This sort of language misunder-' stands the Hebraic ways of speaking of human beings. You do not 'have' a soul, in a sense you are a soul; likewise you do not 'have' a body, in a different sense you are a body. The various aspects to our make-up (heart, soul, body, flesh, spirit) are ways of speaking of the whole of us. Essentially we are psychophysical unities, embodied souls and ensouled bodies. There is no living human being without a body (whether a physical body, or the 'spiritual' body of the resurrection). When we are in the presence of a living human body, we are in the presence of a living human being.

It is of human beings that God said they are to reflect his image. It is of innocent human beings that God says they are not to be deliberately killed.

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Responses to Warnock : a Review*

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Other contributions to this Rutherford House Conference have brought specialist insight to our understanding of foetal life. My task in presenting a review of the various denominations' responses to Warnock is to consider how the churches have applied those insights within their role as witnesses and advocates of the Christian faith, and to consider what challenges remain.

(By way of preparation, I have studied the responses and, where possible, the submissions of the following bodies to the Report of the Warnock Committee: the Baptist Union of Scotland, the Catholic Bishops' Joint Committee on Bioethical Issues, the Church of England Board for Social Responsibility, the Church of Scotland Board of Social Responsibility, the Free Church of Scotland, the Free Church Federal Council, the Free Presbyterian Church of Scotland, the Methodist Church Division of Social Responsibility, the Royal College of General Practitioners, the Royal College of Nursing. Other denominations approached, for instance the Congregational Union and the United Free Church, were unable to supply copies of any responses. The focus of this paper will be mainly on the response of Scottish based denominations to the Warnock Report. The Report of the Catholic Bishops' Joint Committee straddles the border and the reference is made to the reports of the Church of England and Methodist Church as these will be recognised as significant contributions to the discussion of such issues within the Christian Church.[1]*)*

One's first impression on studying the responses to the recommendations of the Warnock Committee from the above range of denominations is of the extent of agreement to be found between the churches in Scotland. While there may be differences in the expression of points or subsidiary matters, there is agreement on the central issues raised in the Report, relating to the sanctity of human life and the exclusivity of the marriage relationship. Indeed, if anything, the differences in presentation, reflecting different traditions, tend to draw attention to different aspects of the Report, and to complement one another, adding to the quality of the combined response.

The central issue, on which there is common agreement among Scottish churches, concerns experimentation on human embryos. A misgiving shared by all the churches lies in the Report's side-stepping of moral questions leading to recommendations with which, in the words of the response of the Church of Scotland Board of Social Responsibility, 'It is impossible to sympathise. . . . without conceding issues of principle which the church believes to be of fundamental importance.' These issues are to do with the status of the human embryo and the marriage relationship as an institution ordained by God.

The basis of the moral arguments presented by the different denominations is summarised within the Church of Scotland response:

1. The Christian perspective starts from the position that human beings have been created by God and are loved by God. Made 'in the image of God and after his likeness', man is unique and has been endowed with faculties which enable him to enter into a personal relationship with his creator, and undertake responsibility for the creation on behalf of and alongside his creator. However, it is not just to the creative activity of God we must look, but to the Incarnation and his saving activity. God in Christ underlines not only the uniqueness of man, but the attitude of God, which is that his love does not depend on our achievements or abilities. The value of human life and the dignity of life, derive from how God regards and treats us, and not from any status which legal or moral codes and conventions may confer at particular ages and stages of development. Thus, human beings may never treat each other as means to ends, but only as ends, and as ends backed by the ultimate sanction of God's being and love incarnate in Jesus Christ. No human being at any stage in his or her development may be treated in a way that violates his/her distinctively human nature and status, or subjects him/her to being a means to an end, even when that end is the greater health and happiness of other beings.

2. From the moment of conception the human embryo is genetically complete. It is an 'organised, unique, living unity with intrinsic capacity for development, human in character from its beginning' (Dr Teresa Iglesias). The moral status of the embryo and its moral claim on us do not diminish the further back we go in the stages of its development. From the moment of fertilisation it has the right to be protected and treated as a human being. There is 'a serious ambiguity about an argument from the premise that the embryo is "potentially human", for the potentiality concerned is not that of becoming something else but of becoming what it essentially is', (Professor T. F. Torrance).

A major objection to experimentation on human embryos, stemming from a belief in their essential humanity, is the view put forward that it is not acceptable to use any human being simply as a means to an end.

With the exception of the Church of England and Methodist Church all the denominations listed above have put forward arguments based on the sanctity of human life to oppose experimentation on human embryos which is not intended for the good of the embryos involved.

A major objection to experimentation on human embryos, stemming from a belief in their essential humanity, is the view put forward that it is not acceptable to use any human being simply as a means to an end. The 1975 Declaration of Helsinki (WHO) is widely quoted: 'In research on man the interests of science and society should never take precedence over considerations related to the well-being of the subject.' Although the Warnock Report rejects the charge that it is based on a utilitarian ethic, its defence cuts little ice with the churches. The argument is developed most effectively by the Catholic Bishops' Committee, which sees in the priority given to the interests of infertile adults the use of children precisely as a means to an end. The result is, they say, a distortion of the human perspective.

> The Inquiry's terms of reference were 'to consider recent and potential developments in medicine and science related to human fertilisation and embryology', and 'to consider what policies and safeguards should be applied. . . .' The Chairman's letter to the Government, which introduces the Report, foreshadows a subtle but quite fundamental shift of perspective. In that letter, 'fertilisation' and 'embryology' disappear from view, to be replaced by 'the field of human assisted reproduction'. . . . In this shift of perspective, from the embryo to the infertile, the interests of embryo and child, i.e. of the new human being who is either being envisaged and planned for or who actually exists, are systematically subordinated to the interests of the adults who (very understandably) want a child. And those interests and rights of the newly generated are subordinated to the optimisation of a technique for fulfilling that adult want. . . . The moral rights of the embryo, and the moral rights and wrongs of IVF and artificial insemination, are issues submerged or at least distorted by the Inquiry's primary concern with techniques for meeting an adult need.

The churches' opposition to embryo research also relates to the deliberate wastage of human embryos and to a concern that IVF techniques may provide the opportunity for embryo selection and the discarding of unwanted or unacceptable embryos. A dilemma arising from current practice is demonstrated in the response of the Church of Scotland Board of Social Responsibility in commenting on superovulation resulting in the production of spare embryos. These, it is suggested, should be disposed of rather than put to alternative uses. The Free Presbyterian Church of Scotland and the Catholic Bishops have expressed their opposition to the promotion of IVF on the grounds that it is basically an experimental technique involving a significant risk of failure during implantation and the predictable wastage of embryos.

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When to the churches' opposition to experimentation is added the opposition of such groups as the Royal College of Nursing (totally against experimentation), and the Royal College of General Practitioners (opposed to experimentation in their submission, but more divided in their response), and the fact that three members of the Warnock Committee rejected experimentation in principle and another four rejected the production of embryos specifically for the purpose of research – it is clear that concern and opposition to experimentation on human embryos has to be taken seriously in any legislation following on the Warnock Report. The reactions of these various groups brings into question issues which strike at the heart of the Warnock Report itself.

The extent of agreement between the churches regarding their approach to the embryo is found also in their reaction to the Report's recommendations regarding the development of infertility treatment. Views differ as to whether AID is actually adulterous but there is unanimous rejection of third party donation on ethical grounds as an intrusion into the marriage relationship and an acute concern for the practical consequences of such techniques. The Warnock Committee is supported by the churches in its concern over surrogacy and its recommendation that organised surrogacy be made illegal, although in some responses social or psychological reasons are stressed while in others concern surrounds the fact that surrogacy strikes at the essence and dignity of the woman as created by God.

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The pragmatism of the Report – in seeking to provide the means by which now established practices may be continued – is also attacked by the churches. The point is made by the Baptist Union and the Free Church of Scotland, for instance, that it is concerned apparently only with the consequences of the procedures both in terms of research and developments in infertility treatment, not with the moral choices involved. In addition, it is pointed out, the Report lacks any discussion of relative priority in developments in health care. Isolation of its subjects from their wider context and the presentation of infertility as a basic human need mean that questions concerning the allocation of health services resources, and the development of alternative means of responding to infertility not involving donation, or even serious consideration of the underlying causes of infertility, are neglected.

As the Free Church of Scotland has argued:

> There is no doubt that the emotional, psychological and marital problems which can result from infertility, are very real and the development of techniques to overcome the problem is to be welcomed. If, however, a priority list of major world-wide medical problems were to be made, infertility would come relatively low down on such a list. In addition, in vitro fertilisation will only provide a solution to those cases of infertility due to tubal blockage. In these days of limited and declining financial resources, programmes for in vitro fertilisation must carry relatively low priority. We feel that there is a danger that the clinical importance of the problem has been exaggerated by medical scientists to allow them greater access to a potentially most exciting research tool.

The responses to the Warnock Report from the Anglican and Methodist Churches in England differ significantly from those of the Scottish churches. Within the Church of England discussion of issues arising from the Report has led to a long and contentious debate. The majority view in a report from the Board for Social Responsibility that experimentation on human embryos be permitted up to 14 days – but that embryos should not be produced for experimentation, in line with Note of Dissent C – was rejected by Synod in February 1985. Subsequent discussions in dioceses is focussing now on a further Social Responsibility report called *Personal Origins*. Given the strength of the debate within the Church of England, it would appear that opinion on this matter is fairly equally

divided with groups both convinced for and against experimentation and third party donation, but with a number in-between who may use the opportunity provided by the *Personal Origins* report to come to an understanding of the issues.

The Methodists have aligned themselves with the Anglicans, as reported in the *Methodist Recorder* of 10 January 1985:

> Each welcomed the insistence of Warnock that the human embryo must have some protection in law, but each, by majority vote, agreed with the recommendation that strictly controlled experimentation should be permitted within the first 14 days of conception. The Methodist response quoted the Statement on Abortion approved by the conference in 1976. 'All human life. . . should be reverenced. The foetus is undoubtedly part of the continuum of human existence, but the Christian will wish to study further the extent to which the foetus is a person.'

Underlying the recommendation that experimentation be permitted up to 14 days after conception, as proposed by Warnock, is a fundamentally different outlook on the embryo from that taken by the churches in Scotland. Whereas the Scottish churches have taken the view that the embryo be respected as a human person from the moment of conception, the Anglicans and Methodists have argued on the basis of a gradualist perspective that while the human embryo is very special, recognition of its humanness (and therefore the way in which it may be treated), is to be related to stages in its development as revealed in embryology.

> . . . until the embryo has reached the first 14 days of its existence, it is not yet entitled to the same respect and protection as an embryo implanted in the human womb and in which individuation has begun.

At what stage in its development, and according to what criteria, are we to decide that the developing embryo has become a person?

The most obvious difficulty in taking up this position is the arbitrariness that it involves. At what stage in its development, and according to what criteria, are we to decide that the developing embryo has become a person? If not from its earliest stages, does not this decision tend to reflect the purposes and requirements of a particular treatment programme? Foetuses at similar stages of development may, for instance, find themselves as the focus of urgent peri-natal care to ensure viability, or the subject of termination. Professor John Marshall, a member of the Warnock Committee, speaking at an earlier Rutherford House Conference, talked of the arbitrariness of the 14 day limit on experimentation. This was, he said, a pragmatic compromise worked out between members who opposed experimentation on ethical grounds and others who wished to unlock the knowledge which they believed experimentation would provide.

Humanity is not something to be conferred on the developing foetus depending on the availability of resources or relative to treatment or research priorities, or parental wishes. It is there in the foetus, though we may choose not to recognise it. Human personhood is conferred by God in the act of creating a new human life. His followers are called to act responsibly towards his creation recognising its status in his eyes[2]. Development is the mark of human growth, extending into mature adulthood. How, then, are we to justify attributing greater significance to some individuals rather than others according to the stage of their development? Similar questions are obviously arising towards the end of life, when decisions have to be made regarding treatment. This is an urgent question which our society must probe in recognition of the moral issues underlying developments in contemporary research and medicine.

It is to be hoped that in reflecting on responses received from the churches to the Warnock Report, those responsible for legislation will appreciate the need to look critically at the attitude towards foetal life on which is it based. It would be a mistake to overlook the strength of opposition within the Scottish churches to the practice of experimentation. This would be to also underestimate the seriousness of discussion continuing within the churches in England regarding the embryo's status. Following the Anglican Church's decision on this matter, the *Methodist Recorder* reflected on current debate.

Humanity is not something to be conferred on the developing foetus depending on the availability of resources or relative to treatment or research priorities, or parental wishes.

> Our own view is that the Church of Scotland is right to maintain that 'the status of the embryo' is the heart of the problem. On this we incline to the opinion that genetic research has provided a great deal of evidence for the further study envisaged by the Conference of 1976, and that the balance of the evidence tends to the judgment that the embryo is human. Our Scottish friends are better scientists and better theologians.

The widely held concern within the Christian community for developments in the area of embryo experimentation demonstrates the inadequacy of the Warnock Report in its reluctance 'to appear to dictate on matters of morals to the public at large', page 1, paragraph 2). The Report was concerned with issues which are inescapably of moral significance, and in seeking to pursue some perception of 'the common good', and in making concessions to a pluralistic society, the Committee has failed to address fundamental questions. The combined responses of the churches provide an important contribution to this discussion and it is to be hoped that their relevance will be appreciated in any consideration of the findings of this Committee.

Challenges Facing the Church

1. Every effort must be made to ensure that the views of Christians are represented clearly in future Parliamentary discussion of legislation on human fertilisation and embryology.

2. The opportunity should be taken within denominations to develop serious discussion amongst their members

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The Gillick Judgment: a Perspective

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The question at the heart of the *Gillick* case[1] was in its simplest form at what age does a parent lose rights over a child and in particular the right to be consulted and to give or withhold consent. Stated in such wide terms, the question is an ancient one to which legal systems have given different solutions.

English law and Scots law, seem, traditionally, to have adopted the age of twenty-one as the age of majority and English law has given parents considerable power until that age[2]. Scots law also accepted the age of twenty-one but drew a distinction at twelve, in the case of girls, and fourteen, in the case of boys. At twelve or fourteen, the child becomes a minor in Scotland and a parent's consent is, then, only required for dealings in property or contractual matters. At these early ages, in Scotland, a parent loses control over the person of the child. In 1969, the Age of Majority Act reduced the age of majority from twenty-one to eighteen.

It should be stressed that the brief summary of the laws of the United Kingdom on the question of parental control has only looked at the ages within which it may be exercised. There has been no discussion of the degree of control of children by parents and it is, surely, obvious that most parents and children relate to each other in complete ignorance of the law and that acceptance of a parent's authority will rarely depend on pronouncements of the House of Lords. Human behaviour is more often controlled by basic requirements and needs than by the words of judges and legislation.

Gillick, however, concerned the rights of parents over children under the age of sixteen – an age which does not appear in our brief statement of the law. In this respect, *Gillick* was reflecting the statute law of England which has no application to Scotland. The Family Law Reform Act 1969, Section 8 had declared that the consent of a minor aged at least sixteen to "any surgical, medical or dental treatment" is as effective in law as if the child were of full age and that the parent's consent is not necessary[3]. Section 8 limited Mrs Gillick's case to children under sixteen.

One other statutory provision which makes a division at sixteen years of age was under discussion. The Sexual Offences Act 1956[4] makes it an offence for a man to have unlawful sexual intercourse with a girl under sixteen years.

Although obviously important to the case, and, indeed, in the view of Lord Brandon of Oakbrook[5] largely the determining factor, the Sexual Offences Act 1956 was not regarded by most of the judges in the House of Lords as central to the debate. The problem with an argument based on the Sexual Offences Act 1956 was simply that such an argument would have given a result beyond that which Mrs Gillick sought. Lord Oakbrook was prepared to accept that result, namely, that the provision of contraceptive facilities to a girl under sixteen years of age is unlawful with or without parental consent. That was not the issue which Mrs Gillick brought before the courts. It is true, however, that in the Court of Appeal Lord Justice Parker[6] developed a less extreme argument based on the Sexual Offences Act 1956. He thought that the criminal law showed "that Parliament has taken the view that the consent of a girl under 16 in the matter of sexual intercourse is a nullity". In that form, counsel for Mrs Gillick had mounted an argument based on the Sexual Offences Act 1956.

Having attempted to understand the significance of age sixteen to the case, we now turn to the actual issues raised and the background to them. The Department of Health and Social Security issued in 1980 a revised memorandum of guidance on the family planning service. The memorandum explained that the service should be open to all ages and then specifically dealt with the problem of young people.

Regarding children under sixteen the relevant section began by stressing, what might broadly be termed, the need for family involvement. It stated,

> "Special care is needed not to undermine parental responsibility and family stability. The Department would therefore hope that in any case where a doctor or other professional member is approached by a person under the age of 16 for advice in these matters, the doctor, or other professional, will always seek to persuade the child to involve the parent or guardian (or other person in loco parentis) at the earliest stage of consultation, and will proceed from the assumption that it would be most unusual to provide advice about contraception without parental consent."

Clearly, the Department were encouraging consultation with parents and, furthermore, were asking doctors to refrain from giving advice without parental consent except in the most unusual cases. Although the emphasis was laid on parental responsibility and consent, the document did not regard such consent as an absolute requirement and envisaged possible exceptions.

Human behaviour is more often controlled by basic requirements and needs than by the words of judges and legislation.

The next part recognised the important principle of confidentiality and explained further the unusual cases in which a doctor or other person might not seek parental consent. The memorandum read as follows,

> "To abandon this principle for children under 16 might cause some not to seek professional advice at all. They could then be exposed to the immediate risk of pregnancy and of sexually-transmitted diseases, as well as other long term physical, psychological and emotional consequences which are equally a threat to stable life. This would apply particularly to young people whose parents are, for example, unconcerned, entirely unresponsive, or grossly disturbed. Some of these young people are away from their parents and in the care of local authorities or voluntary organisations standing in loco parentis."

Assuming for the moment that doctors or other persons should give contraceptive advice to under sixteens, we could not argue that the document attempted to undermine wholly parental responsibilities. We can, however, accept Lord Scarman's point in the House of Lords that "Though

it provides illustrations of exceptional cases, it offers no definition."

Finally, the relevant section concluded,

> "The Department realises that in such exceptional cases the nature of any counselling must be a matter for the doctor or other professional worker concerned and that the decision whether or not to provide contraception must be for the clinical judgment of a doctor."

Once more emphasis has been laid on "exceptional cases" and a new phrase has been introduced, namely, "clinical judgment". The phrase is rather ambiguous. It could mean that a doctor should arrive at the type of judgment at which a doctor should arrive; that is, it could refer to medical practice. Again, "clinical" can refer to that which is based on observation or fact. Two judges in the House of Lords looked at the expression. Lord Scarman contended,

> "And it gives no clue as to what is meant by 'clinical judgment' other than that it must at least include the professional judgment of a doctor as to what is the medically appropriate advice or treatment to be offered to his patient."

Lord Templeman[8] developed this point when he contended,

> "As the memorandum now stands, a 'clinical judgment' by the doctor may amount to no more than a belief that a parent will not consent to contraception and a fear that the girl may practice sex without contraception."

Certainly, the statement does not entitle a doctor to act according to his prejudices, liberal or otherwise. How much more it means remains far from clear.

Following the issue of the revised memorandum, Mrs Gillick wrote to her local health authority in terms which formally forbade any medical staff employed by them to give any "contraceptive or abortion advice or treatment" to her daughters without her consent. When the authority replied that the matter of treatment is one for the doctor's judgment and, thereby, refused to accede to her request, the way was set for court proceedings.

Mrs Gillick sought two declarations from the courts. The first declaration was that the local health authority and the DHSS had no authority in law to issue the memorandum and give advice which was unlawful and wrong and could adversely affect the welfare of her children, her rights as parent and custodian and her ability to discharge her duties as parent and custodian. The aim of the declaration was to render the relevant part of the memorandum ineffective. It was, at least partially, based on the idea that a parent has rights but also stressed was the welfare of the children and parental duties.

The second declaration was solely against the local health authority and demanded that no doctor or other professional person employed by them give advice or treatment to Mrs Gillick's family without the consent of the parent or guardian, while the first declaration sought to have the memorandum declared illegal, the second declaration looked for a positive statement of law and sought to establish an application of the law to her family.

In the courts, Mrs Gillick met with mixed success. She failed to obtain either declaration in the High Court before Mr Justice Woolf succeeded in the Court of Appeal before three judges and then lost in the House of Lords by a majority of three to two judges. Thus, of the nine judges who heard the case five favoured Mrs Gillick's contention and four did not. She lost finally because there was a majority against her contentions; but not a majority of all the judges, only of the judges in the highest court.

The statement that Mrs Gillick lost in the House of Lords is rather simplistic and requires clarification in the light of a technical point. The DHSS but not the local health authority appealed to the House of Lords. The second declaration was, of course, against the local health authority alone. The House of Lords reversed the first declaration, but left the second declaration standing. They did, however, overrule the second declaration, that is, they made it clear that it could not be followed in a future case. Thus, there is a legal declaration which protects Mrs Gillick and her family so long as they are dealing with the West Norfolk Area Health Authority. Such a declaration is not, however, available to any other family.

Society cannot have the benefits of parental responsibilities and yet deny the very basis of their exercise, namely, the knowledge and consent of parents.

It is impossible to analyse fully in a short article the reasoning of the judges at all stages. A few points mentioned by the majority in the House of Lords are metnioned because they provide the guidance for the future.

Mrs Gillick's case appears to have rested heavily on the idea of parental rights. Lord Fraser stressed that parental rights are not absolute but may be overriden in certain circumstances. He explained[9],

> "Once the rule of parents' absolute authority over minor children is abandoned, the solution to the problem in this appeal can no longer be found by referring to rigid parental rights at any particular age. The solution depends on a judgment of what is best for the welfare of the particular child."

Lord Scarman[10] also developed a similar approach. The third majority judge Lord Bridge of Harwich agreed. The reference to "what is best for the welfare of the particular child" is important. On the other hand, it excludes an argument based on the premise that it is generally in children's interests that girls under sixteen are not given contraceptives. On the other hand, it makes such an argument possible in a particular case.

The judges did, however, suggest that parents should be consulted. Both Lords Fraser and Scarman stressed this point. Lord Fraser stated[9],

> "Nobody doubts, certainly I do not doubt, that in the overwhelming majority of cases the best judges of a child's welfare are his or her parents. Nor do I doubt that any important medical treatment of a child under 16 will normally only be carried out with the parent's approval. That is why it would and should be 'most unusual' for a doctor to advise a child without the knowledge and consent of the parents in contraception matters."

Lord Scarman explained[11],

> "And it further follows that ordinarily the proper course will be for him, as the guidance lays down, first to seek to persuade the girl to bring her parents into consultation, and if she refuse, not to prescribe contraceptive treatment unless he is satisfied that her circumstances

are such that he ought to proceed without parental knowledge and consent."

The dictum of Lord Scarman is particularly interesting because it appears to accept that a doctor should refuse to provide contraceptives to a girl who will not allow her parents to be consulted unless certain conditions are met. The House of Lords did not intend either that all girls under 16 should be given contraceptives on request or that parental consent should be ignored.

The question arises what are the circumstances in which parental consent may be ignored. In two passages Lord Fraser[12] and Lord Scarman[13] set out what may be described as tests to be applied by the doctor in deciding whether or not to proceed without parental knowledge or consent. Lord Fraser explained,

"But there may well be cases, and I think there will be some cases, where the girl refuses either to tell the parents herself or to permit the doctor to do so in such cases the doctor will, in my opinion, be justified in proceeding without the parents' consent or even knowledge provided he is satisfied on the following matters: (1) that the girl (although under 16 years of age) will understand his advice; (2) that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice; (3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment; (4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; (5) that her best interests require him to give her contraceptive advice, treatment or both without the parental consent."

Lord Scarman stated,

"In the light of the foregoing I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances. Emergency, parental neglect, abandonment of the child or inability to find the parent are examples of exceptional situations justifying the doctor proceeding to treat the child without parental knowledge and consent; but there will arise, no doubt, other exceptional situations in which it will be reasonable for the doctor to proceed without the parent's consent.

When applying these conclusions to contraceptive advice and treatment it has to be borne in mind that there is much that has to be understood by a girl under the age of sixteen if she is to have legal capacity to consent to such treatment. It is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved. There are moral and family questions, especially her relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are the risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate. It follows that a doctor will have to satisfy himself that she is able to appraise these factors before he can safely proceed on the basis that she has at law capacity to consent to contraceptive treatment."

These quotations (or as lawyers would say *dicta*) emphasize that a doctor must proceed with care and only dispense with parental consent in rather limited circumstances.

Any thought that the judges were giving the doctors a free hand is further diminished by Lord Fraser's contention that doctors were not being given licence. He added that he would expect a doctor who failed to discharge his professional responsibilities to be disciplined by his professional body. Lord Scarman indicated that the decision to override parental rights was not wholly a matter of a doctor's discretion and warned that there could be possible criminal consequences for a doctor who did not exercise his judgment properly. He explained[12],

"Clearly a doctor who gives a girl contraceptive advice or treatment not because in his clinical judgment the treatment is medically indicated for the maintenance or restoration of her health but with the intention of facilitating her having unlawful sexual intercourse may well be guilty of a criminal offence. It would depend, as my noble and learned friend Lord Fraser observes, on the doctor's intention, a conclusion hardly to be wondered at in the field of the criminal law. The department's guidance avoids the trap of declaring that the decision to prescribe the treatment is wholly a matter of the doctor's discretion. He may prescribe only if she has the capacity to consent or if exceptional circumstances exist which justify him in exercising his clinical judgment without parental consent. The adjective 'clinical' emphasises that it must be a medical judgment based on what he honestly believes to be necessary for the physical, mental and emotional health of his patient. The bona fide exercise by a doctor of his clinical judgment must be a complete negation of the guilty mind which is an essential ingredient of the criminal offence of aiding and abetting the commission of unlawful sexual intercourse."

It is hard to believe that the treatment of a child does not affect parents with whom the child lives.

It is no easy matter to make a judgment in this area of medical practice. Liberal prejudices could lead to a criminal conviction.

Conclusion

This short look at the Gillick case has not attempted either a full legal analysis or a discussion of morals. The aim has been to show what the argument was about and to identify parts of the speeches in the House of Lords which provide guidance for the medical profession. Quotations have been extensive to enable readers to make up their minds on the significance of the case.

Underlying the arguments is the question of who should decide for the young. That question has not been fully discussed. If it is not parents who should make the decisions, why should it be doctors of medicine? What special skill or training do they possess which entitles them to this special responsibility? The Gillick case provides two answers. Firstly, parents should make the decision. In most cases it is not a matter for the doctor. Secondly, doctors may

sometimes shoulder the responsibility because they are members of responsible professional bodies and can be disciplined for failure to act properly. Some might, however, argue that if more and more social issues are to be left to doctors and their professional bodies, these bodies and, therefore, the doctors should become subject to more widespread social control. Even so, one cannot readily avoid the conclusion that a doctor is the person to exercise this responsibility because he is the person to whom the girl has gone for medical advice.

It might also be questioned whether there should be a requirement that in the case of girls living at home parents should be consulted. It is hard to believe that the treatment of a child does not affect parents with whom the child lives. Practically, it may be harmful for all concerned if the parents are ignored.

Furthermore, a worrying aspect of *Gillick* is the possibility that a doctor could reach a decision without any knowledge of the family background other than disclosed by a girl who may be undergoing pressure from other persons. Surely, the person who makes the decision whether or not to consult the parents ought to know the parents.

Another aspect of *Gillick* which is less than satisfactory is the discussion of parental rights. At the heart of the child parent relationship is responsibility for the child rather than right. The real issue, only partially discussed in Gillick, is how can the person who has the care of the child exercise that care in a state of ignorance of a child's sexual behaviour. This argument would not affect girls who had left home. But it is hard to understand how a parent can be responsible when others can assume their responsibilities without their knowledge. Society cannot have the benefits of parental responsibilities and yet deny the very basis of their exercise, namely, the knowledge and consent of parents.

Finally, the case only applies to England. Given, however, that there is one common court of appeal, in civil but not criminal matters for Scotland and England – the House of Lords – we should probably accept that a similar approach would be adopted in Scotland. It must be noted, however, that there are differences of approach. Common to both legal systems is the principle that the welfare of the child is paramount and that might provide a foundation for a similar decision in Scotland although a principle based on parental right may be impossible in Scotland.

Notes

1. Gillick v. West Norfolk Area Health Authority and DHSS. Reported (High Court) [1984] 1 All E.R.365; (Court of Appeal) [1985] 1 All E.R.533: (House of Lords) [1985] 3 All E.R.402.
2. Re Agar-Ellis, Agar-Ellis v. Lascelles (1883) 24 Ch D317.
3. It should be noted that the section does not make the consent of a mentally handicapped child valid in law.
4. Section 6; this Act only applies to England and Wales; there is a similar provision for Scotland – see Sexual Offences (Sc) Act 1976, Sections 3 and 4.
5. [1985] 3 All E.R.428
6. [1985] 1 All E.R.551
7. [1985] 3 All E.R.418
8. [1985] 3 All E.R.436
9. [1985] 3 All E.R.412
10. [1985] 3 All E.R.420
11. [1985] 3 All E.R. 423-424
12. [1985] 3 All E.R.425

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of the moral and ethical issues raised by the Warnock Report. The preparation of study and discussion material for congregational groups and individual study would be of great assistance. As a first step members might be encouraged to obtain copies of their denomination's comments on the Warnock Report and use these as the basis for discussion. Consideration of such issues should form a normal part of Christian education within the life of the congregation. Ideally, young people should be given opportunities to consider moral and ethical questions as they grow up within the Christian faith, for they should not be expected to think about the morality of such emotional and traumatic issues for the first time when they are personally affected by the prospect of a handicapped child, congenital abnormality, or the problems of infertility.

3. In some ways the easier task for the Christian church is to produce reports and comments on specific issues. The more difficult task for Christian people is to live in the world serving their Lord faithfully, bringing his healing touch to those who are in need, even being true in their own lives to what they believe. Hereditary disease, handicap, and infertility are amongst the most perplexing and emotive of human problems, drawing on individuals' and couples' deepest resources either in facing these for themselves or in helping others directly affected. In recognition of this, the Royal College of General Practitioners in its response to the Warnock Report has drawn attention to the need for GPs to be trained to provide the support and counselling which couples require. The way in which these are met by Christian people will speak loudly of their faith and of God. Through their dealings with other people an image can be conveyed of God as either a cruel and capricious God who grants children to some but not others, like favours, and who deals out handicap and illness almost like a punishment – or as a loving God who wants only good for his people.

It is important that Christian people as individuals and as members of congregations should meet together to consider the deeply personal issues covered in reports like this and talk about how they would face them in their own lives and how they would hope to help others.[3] Opportunities could be provided for childless couples or for parents with handicapped children to meet together to discuss how they face these situations in the light of their Christian faith. Thought should be given within the life of the whole congregation to the particular contribution to the Christian family which is made by handicapped people, by childless couples, the single, etc. – also to their needs. Doctors and other members of the congregation whose work involves such moral questions could be invited to meet together and with the congregation as a whole to talk about questions which affect them all as Christian people.

Notes.

1. Readers are urged to obtain a copy of their own and other denominations' comments on the Warnock Report, for private study.
2. For discussion of this point, see for instance T. F. Torrance, *Test Tube Babies*, Scottish Academic Press, 1984, and also articles in earlier issues of *Ethics and Medicine*.
3. A most helpful resource for congregational discussion or individual study is *Choices In Childlessness*, the report of a Working Party set up in July 1979 under the auspices of the Free Church Federal Council and the British Council of Churches – obtainable from the Free Church Federal Council, 27 Tavistock Square, London WC1H 9HH, for 80p.

* *A version of this paper was read at the* Embryos and Ethics Conference, *Edinburgh, 23 November 1985.*

News

Helsinki Medical Group

The recent formation of this new grouping is to be welcomed. It takes its name from the Declaration of Helsinki of 1964, revised in Tokyo in 1974, which it states that 'in research on man, the interest of science and society should never take precedence over considerations related to the well-being of the subject'. The *Bulletin* of the *Institute of Medical Ethics* reported the establishment of the Group, with the distinguished Cambridge embryologist Dr David Woollam as its Chairman, with characterstic jaundice. The *IME Bulletin* could not see the relevance of the Helsinki Declaration to research on the human embryo. We may be forgiven for seeing in this response a comment on the *IME* rather than the Helsinki Group.

More information is available from the Secretary, Dr H. B. M. Hickey, at 12 Gunnersbury Avenue, London W5 3NG.

The National Council for Christian Values in Society

The Editor of *Ethics & Medicine* was interested to be present at the launch and initial press conference of this new organisation in London. Speakers at the opening included Malcolm Muggeridge and the President, Lord Halsbury. A MORI poll had been commissioned on behalf of the National Council on public attitudes to moral and other questions, and its results were in part surprising. Among other things, many people thought that churches should give more of a moral lead.

Details from the Secretary at Whitehall, London.

CARE

Care Campaigns and Care Trust are the successors to what was once called the Nationwide Festival of Light. Care Campaigns has been holding a series of conferences around the country, stimulating interest on the part of Christians in becoming politically active – with particular interest in the issues of abortion and obscenity. The Editor of *Ethics & Medicine* was among the participants at Care's Glasgow Conference in April. The next ones are planned for Birmingham on July 5th, Southampton on July 12th, Bristol on October 4th, and Cardiff on October 11th.

Details from Ian Prior at CARE, 21a Down Street, London W17 7DN.

LIFE

LIFE, the profile organisation, is planning its 1986 Annual Conference for 12th-14th September. The Conference includes a special look at 'hard case' arguments for abortion. There is also a Conference planned for the LIFE Doctors' and Teachers' group, from 11th-13th July.

Details of both from LIFE, 118/20 Warwick Rd, Leamington Spa, Warwickshire.

Rutherford House Medical Ethics Project

As advertised elsewhere in this issue of *Ethics & Medicine*, the Project's next venture is a series of meetings in different parts of the country at which the guest speaker will be Dr C. Everett Koop, the distinguished paediatric surgeon who was appointed several years ago to be Surgeon-General in the US administration.

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.

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It is neighbour love towards human beings which requires that they are not to be used as means to another end, however good.

And that, so it seems to me, includes the youngest members of the species as well as the rest of us.

Much of the material for this article appeared in the Nov. 85, Dec. 85, and Jan. 86 issues of Third Way.

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Rutherford House
Medical Ethics Project

Visit to Britain of

Dr C. Everett Koop

Surgeon-General of the Public Health Service,
United States of America

October 24th-31st, 1986

Edinburgh: Day Conference, Saturday October 25th
Life, death and the handicapped new born
Dr Koop will be joined by Professor Peter Gray, Professor of Paediatrics at the University of Cardiff, and Dr Richard Higginson, Tutor in Ethics, Cranmer Hall, Durham.
Birmingham: Seminar at 7.30 p.m., Monday 27th
Cardiff: Seminar at 7.30 p.m., Thursday 30th
London: Seminar at 7.30 p.m., Friday 31st

Fees
Edinburgh Conference: £6.50, including coffee (students £4.50). *Buffet lunch £4.50 extra if required.*
Seminars: £5, including coffee (students £3).

Please book early on the form enclosed since accommodation will be limited.