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A Christian Perspective

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Rutherford House Medical Ethics Project

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Some Questions for IVF

Ken Hargreaves, MP delivered this speech to the SPUC Mass Lobby of Parliament on Wednesday, 9th July 1986.

Almost exactly one year ago, on this very same platform, my colleague Enoch Powell stood and spoke to you. Like mine, his Private Member's Bill, the Unborn Children (Protection) Bill, had ground to a halt in the House of Commons. Like mine it had received considerable, indeed overwhelming support from Members of Parliament of all political parties. It had the support of millions of people around the country – yet was thwarted simply due to lack of available time in the legislative timetable.

One year ago we met here to call for action from the Conservative Government - action that would see enshrined in law the protection that we demand for the human embryo. We repeat that call to-day. For, although the Government has delayed, we are not deterred. We are here in as great a number as ever to repeat our call to the Government either to introduce its own legislation on this score or to assure us that sufficient time will be given to any Private Member's Bill on this subject to allow the House to reach its conclusion on a matter which is too important to be left on the shelf. Let those who are planning the timetable for legislation which will be announced in the Queen's Speech take note of our message that we will tolerate delay no longer. We must move towards the conclusion that we know to be right.

And speaking on this platform last July, Enoch Powell laid down another challenge to the Government, a gauntlet which they have so far refrained from picking up. The most glaring omission from the Warnock Report, the Pandoras Box which released page after page of inconsistencies, horrifying practices and of unjustified conclusions, the most glaring omission was evidence. Where was the evidence to justify sentencing one human embryo to the role of laboratory rat? Where was the evidence to justify many of the claims made in the report, or any evidence to show what is going in Britain's laboratories right now?

If we look at the Warnock Report we find that there are large gaps where evidence should be, where questions are ignored and stark figures left unanalysed.

Twelve months have passed. The Government have not introduced a Bill and neither have they had the courage to publish the evidence to justify the conclusions of the Warnock Report which they were so quick to embrace. Could it be that the evidence does not exist? Could it be true - as Enoch Powell said last year - that the evidence was deliberately suppressed? As time passes and the material is not published, then our opinion of the Government is forced to sink.

If we look at the Warnock Report we find that there are large gaps where evidence should be, where questions are ignored and stark figures left unanalysed. I will give you just one example.

Section 5.12 of the Warnock Report looks at the performance of the Bourn Hall Clinic, that 'pioneering' establishment where IVF was first developed. The Report looked at the performance of the Clinic in terms of its success rate in achieving pregnancies.

This secion reveals the fact that of the 215 babies born as a result of IVF, not one suffered from major congenital handicap. That is, by any standards, an excellent record. But if we look again at the figures, an interesting and, indeed, crucial question is raised - a question which is obvious to me and which must have been obvious to at least some members of the Warnock Committee but which seems never to have been asked.

It is these inconsistencies which so discredit the Warnock Report in the eyes of even some of those who otherwise oppose us

The 215 births referred to by Warnock were from a total of 439 pregnancies, of which an additional 131 were ongoing. The balance of the pregnancies (allowing for the fact that the births included 18 sets of twins and one set of triplets) amounted to about 110 or so cases which were either 'clinically recognisable miscarriages' or which may have been induced abortions. Now what I want to know is, quite simply, in how many of these 'clinically recognisable miscarriages' were the babies developing abnormally? Indeed, now many abortions were performed to dispose of handicapped IVF children, abortions which would indicate the possible effect of the technique upon the developing child? It may be that there were no handicapped babies among those spontaneously miscarried and it may be that there were no abortions for handicap - all of which would be quite astonishing. But, either way, the question should have been asked, and more importantly answered.

It is these inconsistencies which so discredit the Warnock Report in the eyes of even some of those who otherwise oppose us. We must use all our power and influence to get the message across. The Warnock Report was a sham. We remain fundamentally opposed to many of its recommendations and the Government ignores the strength of our opposition at its peril. It is twelve months since we first met here to demand action - but that does not mean we have achieved nothing since then. Our support in the House remains strong - and do not believe anyone who tells you otherwise. The level of debate around the country on the subject has never been more active and the feeling of outrage at the Government's inaction has never been stronger.

Defending Abortion

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In April of this year IVP of Leicester, England, published Abortion:the Crisis in Morals & Medicine *by Nigel M. de S. Cameron and Pamela F. Sims, both of whom are associated with* Ethics & Medicine. *We are pleased to have permission from the publisher to reproduce one chapter below. The book is available form bookshops in paperback at £2.25.*

There is a way that seems right to a man
but in the end it leads to death
Proverbs 16:2

There are, of course, Christians who disagree with the case which we have been making. They would generally share a profound unease at the widespread availability of abortion in Britain. They would agree that most, at least, of the 'social' abortions ought not to be done; the 1967 Act has made possible something which is not far short of 'abortion on demand'. On the other hand, they would not accept that every abortion, unless done to save the mother's life, is wrong. Sometimes, out of compassion for the mother or for the future of the child, abortion may be right. How is this view, held in good conscience by some Christians, defended? How is it, that is to say, that in the face of the kind of evidence which we have discussed in the preceding chapters, such a conclusion may be reached?

Brave New People

The fullest recent defence of this position is found in the latest book by Professor D. Gareth Jones, *Brave New People.*[1] This book, which addresses many of the major ethical dilemmas confronting Christians today in the field of medical science, has itself caused considerable controversy. Because of its defence of abortion in some circumstances the first American edition was withdrawn by its US publisher, in the face of a major public outcry. In fact it presents a considered and reasoned defence of abortion under very limited conditions. We shall devote the first part of this chapter to an examination of Professor Jones's position, as outlined in his chapter 'The ethics of therapeutic abortion'. It should be noted that Professor Jones's own conclusions are apparently more conservative than those of some other Christians.

'Fetuses are human beings', Professor Jones writes, and such, as we have pointed out, may scarcely be denied; 'they are genetically part of the species, *Homo sapiens* '. But, he goes on, 'is a fetus at a particular stage of development a *person*, in the sense that it has as strong a claim to life as a normal adult human being?' He sees this as the crucial question, since 'if it is a person in this sense, it also has the claim not to be killed'.[2]

Professor Jones begins by rejecting the notion that there is a particular point in fetal development at which a line may be drawn, before which it is a 'non-person' and after which it is 'fully personal'. A variety of possible stages has been canvassed, all the way from conception to birth and, indeed, a year or so later. This suggestion is passed over in favour of the notion of 'potentiality' as governing our ethical response to the fetus. The 'potentiality principle' takes seriously the 'developmental continuum of which the fetus is a part'. We may remark in passing that the fundamental *dis*continuity is at the point of conception (fertilization), where the biological continuum begins. This marks out conception from all the other possible 'critical stages' listed in *Brave New People,* and is plainly accepted by its author as the point of departure for the process of growing potential which he takes as his ethical guide-line.

The 'potentiality principle', as Professor Jones defines it, has certain distinct implications. It does not *deny* the 'personhood' of the fetus, although 'it is prepared to assess fetal capabilities in terms of the extent of its biological development'. So, 'while fetal material is always genetically human, the very rudimentary stages of its development manifest few qualities of established personhood'. The discussion which follows is hampered by the failure to provide a working definition of either 'potentiality' (which is illustrated rather than defined) or 'personhood' (which is, of course, a term with a long history in philosophy and theology). Professor Jones is at pains to point out that such an emphasis on fetal *potential* does not imply anything other than the deepest respect for fetal life at every stage, and that the possibility of the deliberate destruction of that life can only be exceptional: 'the fetus will be protected under all normal circumstances'.

The real problem with this argument is that its terms are so loose that they can be given almost any meaning. We have already hinted at this in saying that many of those who would accept the ethical analysis set out in *Brave New People* would wish to draw wider, perhaps much wider, conclusions as to the acceptability of abortion. This is not a mere quibble about the terminology or the way in which Professor Jones sets out his case; it is rather a deep-seated difficulty with every attempt to argue for a middle position, in which the life of the fetus is given respect and yet in certain circumstances can be forfeited. In the terms of Professor Jones's own statement which is quoted at the end of our last paragraph, what is it that defines where 'normal circumstances' end and 'abnormal circumstances' begin? The fact that the author of *Brave New People* would seem to limit the 'abnormal circumstances' to certain cases of genetic disorder, while other Christian writers (such as R.F.R. Gardner, to whom we shall turn below) allow of the 'abnormality' of many other

circumstances, demonstrates the essentially arbitrary nature of this kind of argumentation.

That is to say, the notion of the fetus as *potentially* a person is of little ethical help to us in weighing the claims of fetal life against other claims. We are not here arguing that the fetus *is* a person, since an answer to that question depends to such an extent on what 'person' is understood to mean.[3] The question is, what is it that the fetus is not already which it will (at birth, or viability, or whenever) later become? And what significance does this have for our attitude towards the life of the fetus and its claims upon us? *Brave New People* gives evidence of the kind of thinking behind its author's position when it says, after speaking of the degree of protection which should be accorded the fetus, that the idea of 'potentiality' is 'prepared to assess fetal capabilities in terms of the extent of its biological development'. In plain terms, what the fetus is capable of *doing* determines the extent to which its life shall be protected.

It is human beings who are made in the image of God, and anything which is a human being is one of us, and nothing less.

The fundamental difficulty with every criterion which depends upon *capabilities* as defining the extent of personhood (or 'potential' personhood) is that it must face the fact that the capacities which the fetus acquires (for movement, for reasoning, for relationships, and so on) are things which it can lose in later life. We do not as a rule deny that children or adults are 'persons' because they are unable to move, or think reasonably, or to relate to others. The biblical attitude towards handicap (mental as well as physical) is one of compassion and care which implicitly recognizes the full personhood of those who suffer disability. Rather than viewing physical and mental ability as the criteria for the degree of protection which a life deserves, the dice are loaded the other way: the degree of *dis*ability, the weakness, unattractiveness and lack of the general attributes of human persons are what call for the special protection and concern of the people of God. The degree of fetal 'capability' is a hazardous criterion of the degree of protection which fetal life deserves.

This raises the question of the nature of human 'personhood', on which a brief comment may be made. It is very difficult to find any general definition of what a 'person' is, since we acknowledge and accept as persons human beings with a very wide range of characteristics, from babes in arms (whose abilities in any formal sense are strictly limited) to reasoning adult men and women who live in a web of sophisticated relationships, all the way to the severely subnormal and physically handicapped - and demented old people who make up a growing portion of our population. Any attempted definition of what it means to be a human person will fall down by failing to take account of people whose humanity and whose personhood we would not wish to deny. In so far as it adds anything to the fact that someone is a human being (a member of the species *Homo sapiens)* is not merely one species among many, but is that one brought into being by God to bear his image (see chapter 1).

So *Brave New People*, in admitting that from the moment of conception the fetus is a human being, answers its own question. The suggestion that being a 'person' is something extra to being a 'human being' (and this extra thing is needed if the human being is to have 'as strong a claim to life as a normal adult human being') is unnecessary. We can leave aside the idea of 'personhood' and what it means. It is human beings who are made in the image of God, and anything which is a human being is one of us, and nothing less. The idea that something extra is required, on top of being human, to justify 'as strong a claim on life as a normal adult human being' is fraught with danger, for it rests upon the acceptance of the principle that *merely* being human does not in itself guarantee the normal regard which we have for our fellow-humans. The prospect that human beings might be designated 'non-persons' and granted less than human rights is a fearful one. Yet it is implicit even in the very limited defence of abortion which we find in *Brave New People* , and it is the same principle upon which many of the world's most barbarous regimes have operated.

We can add a comment on the idea of 'potentiality' of which this book makes so much. It is a word which covers two quite different ideas, and its usefulness in defence of abortion largely depends upon their remaining confused. In one sense something can be spoken of as 'potentially' *something else.* So a piece of waste-ground is 'potentially' a developed site, with gardens and buildings; a separate sperm and ovum are 'potentially' an embryo. But with such an idea of 'potential' there remains a fundamental distinction between what we now have (the waste ground; the sperm and the ovum) and what we may later have (the landscaped buildings; the embryo). If we do not interfere, if we leave things as they are, nothing is going to change, and what is 'potential' will never be 'realized', but remain one of many possibilities. In another sense, however, potential can be, as we say, *built-in.* Nothing needs to be altered. What is 'potentially' present is also *already* present. And it is plainly in this sense that we can speak of the embryo and the fetus as 'potentially' human persons. So Professor T.F. Torrance writes: 'If then we want to think of the human embryo as 'potentially person', that must be taken to mean, not that the embryo is in the process of becoming something else, but rather that the embryo continues to become what he or she already is.'[4] If – as is plainly the case - the fetus already is a human being, the process of becoming what we more readily recognize as a human being (and feel happier about calling a human 'person') is one of the unfolding and development of what is already present, in the first stages of the biological continuum which stretches all the way from conception to full adult maturity. Nothing is or requires to be added to the genetically complete human embryo. Like every other biological organism, including the mature human adult, the embryo's life and growth depend upon a supply of nutrients and a favourable environment. The process of realizing what is potential in the embryo, in biological and personal terms alike, does not carry any implications for the nature of the unborn human life

itself. It is already what it shall be.[5]

Abortion: the Personal Dilemma

The publication in 1972 of R.F.R. Gardner's lengthy volume with this title was of importance in helping develop a Christian mind on the question of abortion in the United Kingdom. The scope of the volume, encompassing 'medical, social and spiritual issues', in the words of the sub-title, has made it a major resource for Christians seeking their own understanding of the question. Its 31 chapters are documented in detail, and it is no surprise that it remains in print today. Its author, who is an ordained minister as well as a Consultant Gynaecologist, is well known for his Christian commitment. Since his defence of abortion as a Christian option under certain circumstances has proved so influential, we turn to examine the way in which that defence is developed.

The essence of Mr Gardner's theological and ethical argument is spread over a series of chapters in the second part of his book under the heading, 'The Ethical Question: is abortion ever justified?' Essentially he argues for three positions. First, the fetus does not posses a soul, and therefore in this debate we are not considering the destruction of a human life destined for eternity. He suggests that it is when the child takes his or her first breath that the soul enters the body.[6] It may be objected that to speak in these terms is to employ the categories of an unbiblical anthropology, since the idea of a living human body that is soulless is unknown to Scripture. Indeed, as a writer whom Mr Gardner cites says, the soul is 'not an entity with a separate nature from the flesh .... Rather it is the life animating the flesh .... Man does not have a soul, he is a soul'.[7]

This is certainly the testimony of Genesis, where we read that man '*became* a living being (soul)' (Genesis 2:7), not that he was entered by one. Much of the discussion of abortion among Christians takes the form of the question 'When does the soul enter the body?', but this is founded upon an unbiblical notion of the nature of man.

Three 'scientific pointers' are offered, bearing on the question of the 'spiritual status' of the fetus. First, the question of identical twins. At some point after conception, and sometimes even after implantation, the embryo divides into two. 'Unless', writes Mr Gardner, 'we are to agree with the suggestion that the soul splits likewise we are driven to conclude that in some cases at least its infusion is not before the fourth week of intrauterine life.'[8] This conclusion of course depends heavily upon the soul theory lying behind it, with the soul perceived to be a quasi-physical entity which is added to the physical human being to make him a spiritual being. In any event, part of the difficulty is removed when it is remembered that there is a hereditary element in identical twinning, which suggests that it may be genetically programmed and therefore that both twins are present in the genetic material from its first organization at fertilization onwards. If there are other cases, where by reason of external accident or other circumstance the embryo splits into two, there is still no fundamental difficulty. Plainly, where there was once one human being there are now two. Why need this imply anything about the spiritual standing of the two or of the one?

Secondly, Mr Gardner, in common with others, draws attention to the phenomenon of fetal 'wastage' whereby 'anything up to half of all conceptions end in spontaneous miscarriage, usually very early on'.[9] He considers it inconceivable that God should fill his heaven with these young lives, and concludes that it is evidence for the absence of 'spiritual status' on the part of the fetus. It is, of course, nothing of the sort, any more than the fact of very high infant mortality rates in some parts of the world is evidence for the lack of 'spiritual status' of small children. We may find it hard to understand the purposes of God in this as in other matters, but fetal wastage is not an evidence for the sub-spiritual nature of the unborn child. We discuss this further in chapter 8.

We can add here that fetal wastage had been widely used by those who favour abortion for another purpose: to suggest that abortion is permissible because it is a human imitation of nature. In particular, the fact that many spontaneous abortions are the result of fetal abnormality leads some to argue that fetal abnormality is a proper ground for therapeutic abortion. This is a dangerous argument, since it is logically identical to an argument from the fact of high infant mortality in the Third World to the propriety of infanticide. The fact that something occurs in nature by no means implies its ethical acceptability. In fact, the practice of medicine is largely concerned with an uphill struggle *against* the suffering and death which occur 'naturally', since they are considered to be destructive and evil. In more general terms, it is of course the case that human 'wastage' is as high as 100 per cent, since man is mortal. The particular point at which mortality takes its toll - whether before implantation, *in utero*, in infancy or after three score years and ten - is but a secondary feature of the common destiny of man. The fact that every man and every woman who is conceived will at some stage die is of no special ethical relevance, any more than it is relevant to our perception of the 'spiritual status' (Gardner's phrase) of man at any other point in his brief life. Man is spiritual, but man is also mortal.

Thirdly, Mr Gardner writes of *in vitro* fertilization, referring to one of the early experiments in an area which has advanced rapidly since his volume was published in 1972. The fact that an embryo can now be cultured in a glass dish in itself tells against the 'possession of a soul' by the fetus. He asks, rhetorically, 'When the experiment is over and the material is tipped down the sluice, is a soul being destroyed?'[10] The suggestion that a 'soul' *is* present would, we read, trivialize 'the meaning of the soul'.

Having advanced these arguments and, to his satisfaction, disposed of the equation of human life with 'spiritual status', Mr Gardner turns to his own ground for abortion. His starting-point is Christian compassion, and it is plain that it is his anxiety to be compassionate towards his patients which determines his acceptance of the practice of abortion. The Christian physician confronts the suffering of the patient and, in some cases, will feel obliged to agree to terminate the patient's pregnancy as the only adequate compassionate

response. 'Real compassion', we read, 'involves taking into account the factors to be discussed in part three of this book' medical and social questions), 'in order that one's decision will help not only the woman's short term problems, but her future life.'[11] In other words, having concluded that *prima facie* we do not need to regard the fetus as possessing the 'spiritual status' of a human being who has been born, it becomes necessary for the compassionate Christian to look at each case as it presents itself and to decide what is best for the woman. Mr Gardner does not leave altogether out of account the other party to the problem: 'We must not forget that there is to be compassion too for the fetus', he writes; but this matter is not pursued.

If abortion is an option, and compassion is the motivation, how is the Christian to decide in individual circumstances? The third part of *Abortion: the Personal Dilemma* addresses medical and social factors which bear on the debate (with chapters, for example, on 'Illegitimate Pregnancy' and 'The Pregnant Student'). But, at the end of the day, the Christian physician's decision will be determined by his perception of the will of God: 'Before he can decide what, in this particular instance, is the compassionate decision, he must weigh up all the factors.' And there is seeming approval of the statement of an American gynaecologist: 'When a pregnancy threatens the well-being of a patient and her family I will explore the threat just as thoroughly as I would a fever, a fibroid uterus, or an ovarian cyst. Then it becomes a matter of seeking the Lord's will in each particular case. I am confident that He can guide me in these decisions as He does in other areas of life.'[12]

The importance of compassion and the perception of the will of God are not, or course, *arguments* in favour of abortion. They are rather indications of how someone who is convinced that abortion is ethically permissible goes about the practice of his principles. That is to say, we do not (at least, we should not!) come to conclusions about what is right on the basis of being compassionate or of our feeling that we ought to do it, *unless it is already clear to us* that this thing is right in itself. It is because Mr Gardner thinks abortion to be sometimes 'right' that his compassion and his sense of the will of God are called into play. By the same token, if we are convinced that abortion is not 'right', it can hardly be said that we are lacking in compassion or in perception of the divine will if we then refuse to agree to it.

What must always be central to the Christian's thinking is the teaching of Scripture and its revelation of the will of God. Our compassion and our sense of what God wants us to do have to be informed by Scripture. The alternative is some kind of 'situation ethics', in which even the ethical guide-lines in the Bible (like 'Thou shalt not commit adultery') can be set aside out of compassion or because someone thinks that this is what the Lord wants them to do. Every attempt to make ethical decisions that does not base itself squarely on Scripture is destined to lead us astray.

Other Recent Discussion

Brief reference may be made to a number of recent contributions. Professor Gordon Stirrat, in *Legalised Abortion - the Continuing Dilemma,*[13] offers a distinctive understanding of the problem with which abortion confronts the Christian. For him, abortion is always wrong, and two logical and consistent alternatives present themselves - one permitting abortion only where the death of the fetus is in any case inevitable, and the other openly utilitarian, where 'the mother does have a say as to whether or not her pregnancy shall continue'.[14] The difficulty for him as for others is that, if patients and society at large do not share such a conviction, the physician is in no position to impose it. He has to live with patients who wish to avail themselves of the opportunity to have their pregnancies terminated, and he must be seen to care for them and to support them.

The problem with this kind of approach to abortion is that it fails to grasp the nature of the ethical issue that is at stake. It is plainly true as a general rule that the Christian has no right, and indeed little opportunity, to insist that those with whom he disagrees nevertheless live their lives according to his code of conduct. He would also be wrong to make their misconduct a reason for his failing to help and support them when things go wrong. But this is not the same as aiding and abetting them in doing what he knows to be wrong *where there is a third party involved.* This is the fundamental reason why those who accept that abortion involves the taking of a human life can never assent to participate in the abortion procedure (and, by statute, their participation cannot be required). For if a woman has her heart set on an abortion she is contemplating something which is not just wrong for her, but which commits the ultimate crime against her innocent child. No Christian needs to be reminded of his responsibilities towards the weak and defenceless, responsibilities which always override the freedom of others to act as they choose.

So, for example, a physician or a social worker may have laboured long to gain the confidence of a woman in distressing and difficult circumstances. But, if it emerges that she is abusing her child, the counsellor's duty to the child will always be paramount, if necessary to the extent of undermining the relationship which has been built up with the mother. He can never, in Professor Stirrat's phrase, say to her *'whatever* your decision I will support you in it and carry you through with it', because higher obligations arise from his duty to the child.

In this connection we should note an analogy drawn by Professor Oliver O'Donovan in his booklet *The Christian and the Unborn Child*[15] The test, he writes, of an abortion policy is 'whether we are prepared to apply it in other cases' where conflicts of interest arise.

> Let us imagine a daughter caring for a difficult, but not senile, mother, in an area where neither Social Services nor neighbours were available to help her bear the load. The doctor judges that the daughter is heading for a major and permanent breakdown, and sees no way of avoiding it short of killing the mother. If we valued mental health equivalently to human life we might feel able to advise him to take that drastic step (provided he could get away with it). This is a conclusion from which most of us would shrink. In the last resort it is hard to accept that mental health or physical health or any *social* good is a

value quite equivalent to human life .....[16]

R.F. Gardner has himself written as follows:

> Here is a woman, we will suppose, who has a house full of children. One of them, imbecile or paralysed, exhausts her strength and monopolises her affection. In addition, she has the care of an aged and cantankerous father-in-law. And now she is pregnant yet again. So the argument is advanced: how can she be expected to cope; the burden must be reduced. I have terminated such prenancies, and I shall do so again no doubt. But I ask myself, and I ask you, would not the same argument be equally valid to support infanticide of the imbecile child? Would it not be even more cogent to support the euthanasia of the over-demanding father-in-law?[17]

Conclusion

We see then that Christian defences of abortion generally operate on the principle of denying to the fetus, at some stage or at all stages, the respect due to full human life outside the womb. Sometimes this takes the form of speculation about the moment of ensoulment; sometimes it is more concerned with the development of 'personality' defined in a way that will accord with the biological development of the fetus; sometimes agin it refuses to pin down any particular moment and suggest a gradual growth into that which finally (after viability, or perhaps at birth) makes full demands upon us as 'one of us'. These various proposals all fail to do justice to the biblical testimony which so plainly convinced the first Christians to take their stand against the practice of abortion in the Graeco-Roman world.

The modern developments in genetics and embryology which have emphasised the completeness of the original constitution of the conceptus, and stressed the gradual continuity of its development *in utero,* have made it increasingly difficult for any clear line to be drawn during pregnancy before and after which different moral assessments of abortion could be made. 'Viability' has become obsolete, with 'animation' and 'quickening', as the prospect of ectogenesis, the fertilization of an ovum *in vitro* and the bringing of the resulting embryo to term in an artificial womb, has disposed of the artificial principle which suggested that the coming of the fetus to a capacity for 'independent existence' was of any significance other than merely in relation to current levels of medical technology.

It is evident that serious Christian arguments for abortion have to depend on the notion that there is such a thing as 'human life' which is not invested with the qualities we normally associate with all human life - not made in the image of God, not of infinite value to him, nor destined to a future of glory or shame, not *known* by him, irrespective of its capacity for response. Only thus is it possible to claim that this thing which we know to be, like us, *Homo sapiens,* does not demand of us the reverence and the protection due to a fellow-man because of what he or she means to God. The reader must come to his own conclusion, but ours we find to be unavoidable. The notion of something that is man and yet not man, one of us and yet not one of us, a small 'somebody' and yet 'nobody' at all, is as repugnant to the teaching of Scripture as it is to human reason. It is *man,* male and female, black and white, born and unborn, whom God has made in his own image; and this truth is sealed to us and established without challenge in the coming of Jesus Christ, conceived *in utero* by the Holy Ghost.

Notes

1. Leicester, 1984. Now republished in a second edition in the USA by William B. Eerdmans (1958).
2. *Brave New People,* pp 162ff.
3. For an argument that does use this category, see Oliver O'Donovan, *Begotten or Made?* (Oxford, 1984), Chapter 4. This book, though not easy reading, is a most important contribution to discussion. Professor O'Donovan holds the Regius Chair of Moral and Pastoral Theology at Oxford.
4. T.F. Torrance, *Test-tube Babies* (Edinburgh, 1984). This short booklet represents a major statement by one of the world's leading thinkers about the relations of science and religion.
5. Professor Jones' ready acceptance, clearer in the US second edition of his book, of much of the theological and biblical analysis which we have presented above, makes his conclusions the more difficult to accept. The prominence of this book in recent controversy in the USA, where he has been labelled 'pro-abortion', has not taken account of his deep and plain unhappiness with every abortion. His arguments and his instincts seem, alike, to be against it. But the door is left ajar for the exceptional case of serious genetic disorder, where the logic is that of the termination of the life of the severely disabled. This is, from a Hippocratic and a Christian perspective, compassion that has gone seriously astray. The door remains open also for abortion after rape, and Jones suggests (somewhat prejudicially) that the issue is 'whether a woman should be allowed to be treated as anything other than as a fully human person', whether she 'should be forced to be a mother against her will'. But if she has become pregnant through rape she has *already* been 'forced to be a mother against her will'. Professor Jones' question-begging terminology is less than helpful here, and his compassion leads him to imply that those who respect the fetus as well as the mother are lacking in compassion. Their compassion is informed by another, and a more rigorous, ethical analysis. Professor Jones' 'compassion' denies the biblical ontology of the fetus which he has earlier accepted.
6. *Abortion: the Personal Dilemma* (Exeter, 1972), p 126.
7. *Ibid.,* p 124; citing James Barr.
8. *Ibid.,* p 123.
9. *Ibid.,* p 123.
10. *Ibid.,* p 124.
11. *Ibid.,* p 131.
12. *Ibid.,* p 140.
13. London, 1979.
14. *Legalising Abortion,* p 29.
15. Nottingham, 1973.
16. *The Christian and the Unborn Child,* p 19.
17. *By What Standard?* (London, 1977).

The Pro-Lifer and the Aborted Woman

For reasons which will be obvious it has been decided that the writer of this article should remain anonymous.

It is an idea common to both sides of the abortion lobby, that the abortion debate is based upon a conflict of rights and interests. The rights and interests of the pre-born child are weighed against the rights and interests of the woman who is seeking an abortion. This picture, this shape of conflict, is a natural interpretation for those who accept abortion. It is most unnatural and, sadly, far too common among those who call themselves, 'Pro-Lifers'.

Pro-Lifers often plead, (though indirectly, for very few of us ever approach the woman entering an abortuary), for women to make the "unselfish decision and let their babies live". It is a heartfelt and wholly well-intentioned plea. It is also wholly misplaced. It falls into the anti-life trap of regarding abortion as something which may serve the woman, even while destroying her child. It is true that warnings about possible physical and emotional damage to the woman from her abortion, do regularly form part of that pro-life plea for the unborn. But without exception these are presented like medical case notes, missing the heart and the truth of the matter.

To the pro-abortionist the child is merely a passenger, the pregnant woman either a willing or unwilling host. In a sense, it is true that the child can be likened to a passenger and the woman to a temporary host. But while this is an accurate description of their roles throughout the pregnancy, it is not a true description of the relationship between them. And this is, in fact, the heart of the matter here. For it is*not* the relationship of passenger and host which is at stake, but that of mother and child, from the moment that conception takes place and for the rest of both their lives.

Against the background of this simple truth, can we re-evaluate the crime that is abortion and our own response to it? This response begins properly, of course, with the way that we approach the distressed and pregnant mother.

A pregnant woman very often feels ambivalent about her pregnancy, even when it has been planned and is 'wanted'. The hormonal changes accompanying early pregnancy are such that this ambivalence has been described as being almost a symptom of pregnancy itself! Added to this, in an unplanned pregnancy there may be feelings of doubt and anxiety, while in a definitely unwanted pregnancy there is often terrible panic and something very close to despair. (Although, interestingly, pregnant women are, of all social groups, the least likely to commit suicide). The attitude of the distressed mother to her unborn child might be, understandably, anything but loving. Strong fear distorts and twists. It produces feelings of hostility or hatred for whoever or whatever seems to be threatening your life, including your own unborn child.

The nearest clinical analogy to this would seem to be that of the post-natally depressed mother. Once again there is that mixture of hormonal upset and external pressure, occasionally producing in a mother a similar hostility towards her newborn child. The sane and natural response of the medical profession, is to try to restore her to normal health. Her hostility is not seen as being normal, her depression is not treated as a rational state. Rather, good medicine will try to alleviate the external pressures, explain some of the possible reasons for her state of mind, in fact will do all that is possible to restore this mother to a normal relationship with her child. But for the woman who is pregnant and desperate, the prescribed 'medical' treatment is very different. The fact that she has a child with whom she cannot cope, is denied or ignored. Thus her needs cannot and will not be diagnosed properly or, therefore, met. What she needs is to be enabled to come to terms with her frightening, new identity as a mother. Good medicine would seek to restore her, like the post-natally depressed woman, to a normal relationship with her child.

Instead, her hostility towards her 'pregnancy' is treated as a choice, her panic as a reasoned response to a 'dilemma'. Her desire to end the pregnancy, which is in fact only a desire to end her fear and unhappiness, is considered as a sane and natural request. The child itself is seen as the cause of her derangement and the solution to her distressing pregnancy is the extinction, not of the distress, but of the child. It is about as reasonable and as helpful as offering to smother the child of a post-natally depressed mother.

To the pro-abortionist the child is merely a passenger, the pregnant woman either a willing or unwilling host.

It is equally bad medicine. Having destroyed a child and, therefore, the problem pregnancy, abortion replaces these with the emotional, spiritual and psychological damage done to a woman by becoming the assenting, if frightened and uninformed, party to the death of her own child. Once the discomfort, panic and hormonal disorder of the pregnancy have subsided and she has recovered from the abortion (assuming it has not left her with a ruptured uterus, pelvic inflammation, retained products or any of the other nasties which are regularly associated with induced abortion and just as regularly played down), she will be left, alone with the fact that she is the mother of a dead child.

To begin with this fact may be simply an emptiness somewhere within her. But given time, the emptiness grows to chasmic proportions. A woman may not openly acknowledge the death of her child as such, even to herself. In fact, in the majority of cases she will not. But the widening chasm of loss, the possibility that she has aquiesced in a killing and the certainty of having conspired against her own child, will become un-named terrors which remain with her for the rest of her life unless she receives the right kind of help.

The pro-abortion lobby may claim that post-abortion trauma is caused by pro-lifers trying to make women feel guilty, but the truth is much more simple. What we deny intellectually, our bodies, if not our souls, know only too well. If a mother whose body has been preparing for a birth is suddenly no longer a mother, her biological system will react to this fact.

Nowadays women, and often their husbands too, are encouraged to give themselves time for mourning after they have had a miscarriage. We mourn people, not things so this is a very eloquent testimony to the relationship between pre-born children and their parents. Following suit, many abortion promoters encourage a similar period of mourning after an abortion - for the 'potential' child, of course. The idea seems to be that one looks at abortion as a sort of desired miscarriage. A concession to the overwhelming evidence of the grief of aborted women, it comes as close as any of the pro-abortion illogic to cracking open the whole deceit. For how does one mourn for someone who never was and why should one want to? One cannot relate to someone who might have existed but didn't. Yet how is it possible to feel grief for someone you did not relate to?

Most aborted women, sensing the direction of logic, do not allow themselves the release of grief. Many bury their wounds and give every outward appearance of being untouched by their ordeal. To the very few who are likely to know about the abortion, it may be a very convincing appearance. My own experience, without exception, has found it to be just that; a performance.

Pro-lifers who have been shocked by the display of indifference given by an aborted friend or relative should consider what the alternative for the woman is. Grief, shock and loss all belong to death. Death occurs only where life has been. If there has been life and death then she has had a living child. *Ipso facto* there can be no real loss, no shock no grief. The performance is for her own sake, more than for the world around her. But I have never met a woman who has not been badly damaged by her abortion. Or, to put it into true perspective, I have never met the mother of a dead child, who had not been deeply affected by its destruction.

The pro-abortion lobby may claim that post-abortion trauma is caused by pro-lifers trying to make women feel guilty but the truth is much more simple.

Let me illustrate with some examples. One girl, a student, was expected to take a first class degree in a very difficult discipline. She was a rising star in the university before her pregnancy. She loved the father, but it was a bad time to have a baby. She had an abortion. Some months she was having treatment for depression, which she did not in any way connect with the abortion. Some months after that she adopted a kitten which she treated like a baby. She was unable to deal with very small children, although she painstakingly hand sewed and knitted garments for a friend's baby - a baby she could not look at or touch. She required two years extra to complete her degree, due to nervous depression, and she took second class honours. Before she did so, however, she had deliberately become pregnant again and had a child in conditions very much worse than they had been the first time.

(Repeat pregnancy is part of a pattern among aborted women. However badly you want to be rid of the pregnancy, the biological and subconscious preparations for birth create a need, especially in the case of a first child.

> .... among 211 women who became pregnant again after legal termination, did so within a year of the termination - a figure in keeping with the results of Clow and Crompton. Either our contraceptive advice is not heeded, or these women subconsciously desire pregnancy. The social grounds on which the request for termination had been mainly based often remained unchanged at the beginning of the subsequent pregnancy.
> [Richard & Dixon, Bristol Maternity Hospital, 1976]).

After the abortion, her feeling for the baby's father, with whom she was living, acquired first a habit of anger, then hostility. Finally the relationship ended - part of a pattern so common it is practically one of the abortion sequelae. The second child was born into a relationship soured by the previous abortion.

I have never met a woman who has not been badly damaged by her abortion.

In the second case, the woman is among the least disturbed of the aborted women I know. She is well, balanced - apart from a pronounced dislike of any fetal imagery in any context – happily married and content. She has successfully put the experience completely behind her. Except that she is voluntarily childless. She decided not to have children after her abortion, on the grounds that she had given up her right to have any more when she had her first aborted. She lives with herself easily because she has a sense of expiation.

The third example is a woman who has a very successful business career, one of the few women in her field, who finds it impossible to make personal relationships work. She had an abortion at fifteen because her mother threatened suicide otherwise. Her first acount of the experience came in the form of an assurance that she must be one of the few exceptions I had allowed for, a woman who had not been marked in any way by her abortion. Adolescents, who are considered the group least able to cope with an unwanted pregnancy and most 'in need' of legal abortion, are actually least equipped to deal with the trauma of abortion. She had been no exception. Some sympathetic questions later, she was crying her heart out over something which had happened more than fifteen years previously, to the utter astonishment of a mutual friend who was present. Her lifelong hatred of her mother was explained to this friend for the first time. Indeed, the woman herself understood it, for the first time, as the direct consequence of her abortion. The long-buried nightmare included a post-abortion 'delivery' of unmistakably

human pieces of 'fetal tissue' into a bedpan. The girl had never asked for, or been offered, help of any kind to deal with this shock. It remained, an emotional trap she had never got through or around. This too, she shared for the first time.

Like so many others, her abortion had left deep wounds which affected all the major relationships of her life thereafter. But she was lucky. Tears are the first step towards recovery, signifying that you have at least faced the fact that you are hurt and do need healing. Many women never get this far. There is an irony in this because the very feelings which she is afraid to face are those which trap the aborted woman in depression and, sometimes, despair.

Those unnamed feelings and fears a woman buries after an abortion, become unexploded bombs which may do terrible damage if they are mishandled.

Reaching out to her is an urgent and long overdue undertaking. It can also be like walking through a minefield. Those unnamed feelings and fears a woman buries after an abortion, become unexploded bombs which may do terrible damage if they are mishandled.

The essence of post-abortion healing is really no different from that of all good medicine. Its purpose is to return the sufferer to a state of true health. I use the word true quite deliberately, for truth plays an enormous part in this process. The re-establishment of the natural status-quo depends principally on re-establishing the truth.

The truth which should have formed the basis of the woman's medical treatment while she was still pregnant, was that she was a mother who had emotional and material problems which prevented her from accepting her child. The first truth to be encompassed then is this, the reality of her child and of her own motherhood. But this realisation leads inexorably to the recognition of the death and loss of her child and the betrayal of her own motherhood. This betrayal is, finally the thing which makes the process of healing from abortion so difficult.

Motherhood is ordained to nurture and to protect. It's instinct is normally self-sacrificial. The hardest thing of all to bear, harder than the loss of the child itself, is the fact of having deliberately surrendered your own child to death. Many women suffer agonies after a miscarriage, feeling that they failed their child and that their bodies betrayed them and their maternity. It is very hard then to imagine what it is like for a woman who has had an abortion to face the fact that there really was a child, she really was a mother.

Face it, however, she must, because until she does, it is at best a time-bomb which could explode at any moment. There are many women receiving psychiatric help and still more on anti-depressants because they cannot face what, to a greater or lesser extent they know and fear to be true. For a very few there is, for a time, no instinctive understanding and no corresponding fear. Realisation does not dawn gradually. When it does, however, it is sudden, brutal and there is no way of dealing with it alone. The pro-abortionists name this state 'a sense of guilt' and blame the anti-abortionists. They are wrong; guilt is bearable. This is remorse, the most relentless and excrutiating of all human emotions.

Mourning has a natural sequence, but it is difficult either to begin, or to complete, because of its logical consequences, for the aborted woman. The difficulty in beginning to mourn, has already been discussed. The difficulty in coming through it successfully, lies in the fact that someone suffering from remorse tends to blame themselves completely and unsparingly for what they have done. It requires very strong and determined love to help a woman face the reality of what has happened to her and to her child and, at the same time, prevent her from succumbing to the lie that she is wholly to blame and wholly guilty of the abortion.

The counsellor, must make the aborted woman understand and believe that she is not solely, nor necessarily culpably responsible. She is no longer the same person she was while pregnant and under pressure. Her reactions are different, her rational capacities changed.

It is important to establish the degree of pressure the woman was under, the role played by those around her. Whoever else was involved, the doctors who referred her for and who performed the abortion are also deeply implicated Abortion is done to her as well as to her child. She too is a victim: there is no greater violation of a woman than that done by abortion. There is no woman who would ask for an abortion if she understood the violation it entails. Anger is a healthy part of her healing, for she only ceases to be a victim when she is about to be angry at what was done to her.

Finally, when grief and anger are passed, remorse is in its proper perspective and acceptance has begun, there will be something still unresolved: the need to say sorry and to be forgiven. This need is so universal that one practising psychiatrist who is especially concerned with helping aborted mothers, includes prayer as an integral part of his therapy. It does not matter the religious background of his patient. Every woman facing the fact of her own abortion believes in some kind of God, to whom she can and does say that she is sorry.

There is no woman who would ask for an abortion if she understood the violation it entails.

Women of all faiths and none, therefore, can be helped to recover from abortion and to be freed from the really crippling effects it can have on their lives. As someone who wants to see the fullest recovery made possible, however, and yet does not want to place barriers in front of those who are not Christian, I have to admit that there is one problem.

In saying that you are sorry to whoever or whatever you conceive the Divinity to be, you are transferring the need to

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Health, Medicine and Magic

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Formerly, when religion was strong and science weak, men mistook magic for medicine; now, when science is strong and religion weak men mistake medicine for magic.

Thomas Szasz, *The Second Sin*, 1974

It has been a characteristic of this post war world that society expected miracles from medicine. Every advance in medical technology led to greater status for the medical scientist and greater expectations by the patient. Another consequence has been that medicine has become institutionalized, demanding a larger beaurocracy, more staff and, of course, huge amounts of money. The benefits have been undeniable, but often for a very small number of patients who have the conditions suitable for treatment. On the other hand some highly experimental techniques such as coronary bypass operations are now routine and thousands of patients with kidney failure benefit from modern renal dialysis equipment.

So the expectation grew that modern medicine would solve every disease and cure all ills, but somehow the realisation of these expectations has been frustrated by two factors.

Firstly, a rigid attitude by the medical profession has arisen from the complex organisation of modern medical care. This is perhaps more marked in Britain with its National Health Service than in North America where a more flexible approach is possible. Associated with this is the conditioning of doctors to accept only treatments proved 'scientifically' with statistical analysis, 'double blind' technique and dependence on technology. Indeed, Professor Sir George Pickering has suggested that medicine may become 'a technical trades union rather than a learned profession'.[1]

Secondly, there is the inability of conventional medicine to deal with what are often called 'functional' disorders; the aches and pains that do not fit any conventional pattern of symptoms – persistent tiredness and malaise – headaches and migraines. One of the general practitioners using an educational approach with emphasis on dietary factors, the use of breathing and meditation said that on entering general practice 'I found myself facing many situations with patients for which my medical education had not prepared me . The skills that I had acquired were of limited use ....'.[2]

The medical profession has found its organisation, training and practice attacked by those who see it as a self serving and self sustaining fraternity with a vested interest in illness. It is also confronted by a welter of types of alternative medicine, whose practicioners may accept conventional medicine as well or have no use for it at all.

The most strongly entrenched anti-medical establishment position is probably that of Ivan Illich, whose book *'Medical Nemesis'*[3] is well known, with the adage that 'medicine may be dangerous for your health'. This attack on the failings of organised medicine has a basis of truth. However he fails to appreciate that such failings are generally unintended and are the incidental result of the way in which modern medicine has evolved. He also ignores the very considerable relief of suffering and prolongation of life from the use of antibiotics and modern surgery.

For those who see the medical establishment as a powerful monopoly, limited to scientific medicine, and feel that a more natural approach is desirable 'alternative medicine' has much to offer. It is interesting that an authoritarian approach is often one of the characteristics of conventional medicine that is most rejected by such people, yet nearly all types of alternative medicine have some degree of entirely empirical treatment that have to be accepted solely on the authority of the practitioner. Paradoxically, conventional medicine is moving towards much greater freedom of information being available to patients about the medical facts behind diagnosis and treatment. Perhaps the most important aspect is that the patient is seeking someone who cares about all aspects of his or her health and circumstances. Of course there are very many caring doctors, but the context of the hospital ward or clinic, or general practice surgery tends to militate against relaxed and open communication. This is often simply due to large numbers of patients that have to be seen in every clinic. The alternative medicine practitioner on the other hand can be more easily perceived in a pastoral role and is usually consulted in a less clinical and more homely setting. Another factor is that the patient has chosen *this* particular person to consult and has a direct contractural relationship with them. There is often a similar motivation in seeking a private medical consultation.

Medicine has become institutionalized, demanding a larger beaurocracy, more staff and, of course, huge amounts of money.

What of alternative medicine itself? There is a perplexing range of techniques to choose from acupuncture to the system based on Bong Han corpuscles and Thymus Thumps, to Reflexology. These are well described in *'The Holistic Healers'*[4] - a short book by Dr. Paul C. Reisser and his wife together with John Weldon a Christian writer from San Diego. At the time of writing the book is only available in the USA so a review and appraisal appears elsewhere in this journal. In essence the authors review the whole field with chapters on 'The Holistic Phenomenon' followed by a review of the various types of healing. There is not much discussion on the way Christians should approach holistic healing and alternative medicine, however.

So what is the Christian view? If we accept that the answer

to a desire for 'wholeness' has a spiritual dimension then there should be a biblical basis for it. There are two main areas to be considered - the Christian perspective on health and the relationship of this to the alternative medicine movement.

The Christian perspective on health

Modern medical practice has its roots in the institution set up for the care of the sick by the church - from which our existing infirmaries and hospitals developed. Of necessity treatment consisted of the relief of pain and suffering, using cleanliness and adequate food to allow natural recovery to occur as it could. Such natural remedies as were available were combined with spiritual comfort which formed a large part of the ministry to the sick.

The endeavours of researchers into anatomy and physiology gradually led to a better understanding of bodily functions. This was based on the Christian view of science as a study of natural phenomena of nature which was created by God. From this developed knowledge of how bodily functions changed in disease, giving rise to the disciplines of pathology and bacteriology. Organic chemistry provided the tools for analysis and synthesis of effective drugs, often based on old herbal remedies. For example quinine was developed from cinchoa bark, which South American natives had long known would relieve the fever of malaria. The foxglove, the source of digitalis was known to relieve 'dropsy' due to heart failure. With the recent explosive increase in scientific techniques methods of diagnosis and treatment have become much more demanding on the medical practitioner. There is clearly an obligation for doctors, nurses and technicians to be able to use all that modern technology offers for the relief of disease, and this may be at the expense of the more human face of medicine.

For the medical scientist who has a mechanistic view of nature, and man in particular, technical aspects tend to become all important. Of course such a person may be compassionate and caring but for him these qualities are regarded as fortuitous aspects of his personality. The Christian view is that such attributes are good, that there are opposing tendencies towards self-centred indifference and that the conflict between them is real and significant. There is a recognition that the spiritual nature of the person is ultimately the most important, so redemption from sin by faith in Jesus Christ has the central place in Christian belief. Far from leading to a diminished concern of the physical and emotional state of those who are ill the believer is enabled to have compassion based on the power of God's love, which is a constant force not subject to the caprice of inherited disposition or circumstances.

The techniques of modern medicine can be seen in their proper place - as a means to achieving physical well-being but this is not the overriding aim. We therefore have a firm basis of faith in God through Christ for meeting the questions posed by those suffering disease and death, that are part of a world in which there is evil as well as good. The question is often asked as to why God allows suffering and illness but not why he allows happiness and good health. The present world is (like each individual) in a state of having both weeds and good corn. We do not know why God has not yet removed the evil weeds but we can be thankful that he has not removed the good corn and left us knowing only the effects of evil. The presence of virtue and goodness is a basis for hope and idealism. This is not just an abstract wish for those who know the power of God through Christ which can be translated into effective action that actually changes the world.

The example of those who have shown the love of God in practical ways shines as a foretaste of the day when all evil will be removed. The basis of our philosophy in confronting the effects of the fall must be not to be overcome by evil but to overcome evil with good, in God's strength not our own.

The Christian view of alternative medicine

The motivating force in the alternative medicine movement is the belief that a person is more than a complex conjunction of chemical reactions and that the spiritual aspect is important. There are healers with extreme views who totally reject all of modern technology but most accept that their theories are a supplement to rather than a replacement for conventional medicine. Interestingly those who do reject modern techniques employ a technology of their own using acupuncture, homeopathy, ying yang, all of which have their own technology.

When two doctors set up a holistic medicine practice near my own practice in Canada I was interested to explore possible areas of mutual interest. Calling on them was an interesting experience. The reception area was informal and the nurse/receptionist friendly. They explained that the first stage of treatment was a full assessment by means of a very detailed questionnaire - it took an average of half an hour to complete. One of the partners was a follower of Chinese medicine and 'auras'. He said that he assessed this by the smell of the patient. I was incredulous about this but more reassured by the fact that he also carried out a full physical examination and laboratory investigations, when indicated. For this he was paid by the provincial health insurance scheme but the extras came from the patient's own pocket. Subsequently the patient was taken through relaxation, gestalt or acupuncture therapy and repeat visits were arranged as often as necessary.

I asked one of the doctors if it worked. Well, he said modestly , that some people seemed more relaxed, better integrated and less troubled by functional disorders such as back pain and headaches that had no physical cause. Knowing of several people who were deeply troubled by emotional disturbances and guilt who had seen him I asked how they had got on. He replied that they had not improved greatly but if they persevered they would learn to release their feelings and find peace. Further discussion showed up the basic differences between us: that acknowledging the spiritual nature of man by no means meant acceptance of good and evil, sin or the need for forgiveness. While much that alternative medicine has to offer is good and accords with Christian belief that each individual needs to be treated as a whole person, with body mind and spirit there is no answer for guilt. All that can be done is to treat it as an undesirable sign of emotional

disturbance. At this point the biblical analysis of the human state as being sinful and in need of redemption is in direct conflict with the philosophy of alternative medicine.

There are two other areas in which we are in conflict with alternative medicine and holistic health. The occult basis of their philosophy and the undermining of genuine science.

Although the biblical view of man is rejected by the practitioners of alternative medicine spiritual experience plays a very large part in all the numerous types of therapy. The holistic' movement is based on the thesis that the whole is greater than the sum total of the part. Applied to man this means that there is more to a person than just the objective functional element. In the United States wholism is a popular idea based on J.C. Smutt's book *Holism and Evolution* published in 1926, and based on a study of Walt Whitman that he had made 30 years earlier as a Rhodes Scholar at Cambridge. It was partly a reaction to the ruthless reduction of human personality to a set of reflexes then being undertaken by psychoanalysts. The 'extra' part is clearly not physical, but there is no definition of *what* it is. This leaves the way open for all manner of belief and occult spiritual forces related to individual 'auras' (which are alleged to be shown up by Kirlian photography), psychic phenomena and energy points in the body. Behind this lies the age old hubris' of mankind - the desire to control the spiritual world and the forces that direct our destiny. The conflict with the obedience to, and faith in, the one living God is very clear.

The second area of conflict is with genuine scientific research. Successful research depends on the integrity of the scientist. There has to be total objectivity in the recording, analysis and publication of results so that the scientific community can assess every publication in the knowledge that the experiments reported have been carried out as described and the result not 'cooked' in any way. Of course the idea behind the experiments has nothing to do with the scientific method -the original inspiration behind all great discoveries has come at times of relaxation or distraction. The working out of the theory however requires a trained mind and considerable personal discipline. Occult philosophy threatens to discount the scientific method on the one hand, on the other to build up occult practice with an emphasis on only the experiential in a kind of detached void.

For the Christian there is no conflict with science as already mentioned above and we can truly treat both society and the individual as a whole.

Notes

1. Nuffield Lecture, 'Medicine at the Crossroads', Professor Sir George Pickering, *Proceedings of the Royal Society of Medicine*, 1977, 70 p16-20.
2. Dr P.C. Pietroni, *The Times*, 8 August 1983, p6.
3. *Medical Nemesis*, Ivan Illich, Published as *Limits to Medicine*, Penguin Books, 1976.
4. *The Holistic Healers - a Christian Perspective on New Age Health Care*, Paul C. Reisser, Teri K. Reisser & John Weldon, Inter-Varsity Press, 1983.

Reviews

Biblical/Medical Ethics: The Christian and the Practice of Medicine
Franklin E Payne, Jr
Mott Media Inc., 1985, 267pp

'At last - what the Christian world has been waiting for!' says the jacket of this book from the pen of an American physician. Dr Payne is Associate Professor of Family Practice at the Medical College of Georgia, and widely experienced in Christian counselling techniques. Another review in this issue of *Ethics & Medicine* will deal specifically with the counselling aspects of the book. It is my task in this review article to cover the general principles of medical ethics as perceived by Dr Payne in his book.

I came to this book with some anticipation in the light of the jacket descriptions of its content, and of the ground which it covers. Indeed its subtitle is perhaps more acurate in its description of the book than the main title. It is a book about the Christian practice of medicine and a challenge to Christian doctors to reassess their clinical practice in the light of Biblical principles.

When I received the book I wondered what the main title *Biblical/Medical Ethics* implies by the use of the slash - is it 'Biblical *or* Medical' ethics or 'Biblical *and* Medical' ethics? This question lingers after a detailed reading of the book, and to a certain extent flavours this review.

A foreword by Dr Harold Brown (co-founder with Dr C. Everett Koop of the Christian Action Council) sets the book in the context of the work of Koop and Schaeffer in *Whatever Happened to the Human Race?* and indeed in the context of the decline in moral standards and ethical standards experienced in the USA in parallel with the situation in the UK.

The purpose of the book is set out in a short Introduction:

> My purpose is to describe the invasion of wordly (even satanic) principles into the practice of medicine, into the believer's life and his church; and to develop values and guidelines for patients and physicians which will enhance patients' health, establish the authority of the family and the church, design a more consistently biblical medical practice, and further God's kingdom on earth.

The author is aware that this is a very broad reaching aim and also that he will appear to be criticising medicine, and fellow practitioners (including Christians) in the book but he believes that biblical principles are at stake and that a true holistic medicine of spiritual dimensions is essential. It is perhaps in his application of biblical principles to the practice of medicine that many Christian doctors will find his thesis difficult to accept in its entirety. Yet, he says much about the application of Scriptures to our daily lives, and it is undoubtedly in the practice of our Christian principles that we, the Church, most catastrophically fail our Lord.

The first 4 chapters present the background to the entire book, dealing with current medical ethics, theism, naturalism, the credibility of science and the uncertainties of modern medicine.

The first chapter on current medical ethics uses abortion for a presentation of the ethical dilemmas facing doctors in the 1980s. It must be emphasised that this book is American and that nearly all the references to statistics, legal matters etc are from the USA. However the principles are universal, as are the issues involved. The development of governmental positions and legal responses, and the historical changes in the attitudes of the American Medical Association are identical to the changes in the UK, both in lay and medical circles.

The contrast is drawn between secular and Christian ethics, and it is clearly shown how little difference there is between the secular and the 'Christian' position. The Christian Medical Society (the equivalent of the Christian Medical Fellowship in this country) is castigated for its less than biblical position on abortion, it being pointed out that the CMS has sought ethical principles with 'universal appeal' rather than starting from Scriptural principles.

Next, the conflict between theism and naturalism is examined. Ethics and morality are defined and a biblical world view is established. This section is well done, and the author's debt to the work of Schaeffer is apparent. There is an interesting Figure which illustrates the division of world views: Christianity is seen to be split into Naturalistic (Bible-one source) and Theistic (Bible-final authority) groups. The conflict between science and Christianity is briefly dealt with, science being seen as basically antithetical to Christian belief. In this context, of course most of modern medicine becomes suspect:

> The practice of medicine is saturated with, and founded upon, principles that are antithetical to the Christian world view.

The fourth chapter deals with 'Empirical uncertainties of modern medicine'. In this chapter 'a systematic analysis of the empirical foundation of modern medical science' is presented. The efficacy of medical care is analysed with a few quotations which do not fairly reflect the advances in preventative medicine and the control of infectious diseases (eg eradication of smallpox) which have occurred as a result of scientific endeavour, much of it performed by Christian men. Medical research is similarly assessed, again with a bias towards the negative. It is however important that the inadequacies of research and its application in clinical medicine be publicised: the attitude that doctors are always right, that science holds all the answers must be challenged, as I'm sure every scientist and doctor would agree. The problem often lies with the media presentation of scientific hypothesis, as fact: how often have we read 'Scientist believe that ....' when in fact some scientists, including those responsible for the research, have only *proposed* tentative hypotheses.

The issue of iatrogenic disease is discussed in similar terms with reference to tonsillectomy and coronary artery bypass graft surgery. Medical practice is different in the US, where private medicine is the rule. The reason tonsillectomy continued there after the evidence of its doubtful value in many cases was that financially it was a very rewarding operation! Coronary artery grafting is dealt with by reference to out of date figures for its value (a paper from 1978 being cited). Again, current practice is different from these early days of the technique.

At this point my 'scientific' medical calm was beginning to be ruffled - I can understand Dr Payne's reasons for this approach, and indeed much of what he says is true, but I feel that he has overstated the evidence he cites and loaded it in such a way as to prove his point. He will find it difficult to convince a medical readership on the evidence he presents, and I am afraid he may antagonise many of the Christian doctors he is attempting to 'convert'.

I have dealt with these first four chapters at some length (they

occupy only 49 pages including references and notes) because I think they illustrate what I believe to be the major weakness of the book. That is, a confusion between what is possible in biological science and medical practice and what is ultimately desirable. Payne rightly points out that medicine is as much an art form as a science in that many hypotheses are unprovable, and that we should not take every aspect of medical science as 'gospel', and then uses some of the areas which are widely agreed as being difficult to prove to substantiate his argument that modern medicine is, at heart, unsound and even 'satanic'. I left this section of the book disheartened.

In the fifth chapter we reach the concept of Biblical/Medical Ethics, which is the 'integration of medical practice with biblical faith'. The ultimate failure of medical care is emphasised (all of us must die), and the priority of evangelism emphasised. The methodology for Biblical (NB not Christian) ethics is seen to be two-fold: regeneration and inerrant, infallible scripture. At this point we return to safer ground. Evangelicals have in the main departed from this starting point . The role of a local church with a teaching ministry is emphasised as important for both the physician and the patient in this context. The discussion is thoroughly biblical:

> .... Christians must develop principles which focus the Scripture upon the concrete situation. Believer's thoughts and actions must continually link biblical principles with daily practice.

The concept of pneumosomatic health is elaborated in the sixth chapter. Pneumosomatic health is equivalent to holistic health and is preferred as a term for the Christian because of the influences of Eastern religions (is Christianity not an Eastern religion?) on many holistic practitioners. The term implies the unity of man's spirit and body, and in Biblical terms is:

> .... the physical state which results from the comprehensive and diligent application of biblical, ie spritual, preventive, and medical wisdom to an individual person.

How do we achieve pneumosomatic health? The application of three principles is encouraged: salvation through Jesus Christ, and obedience to his Word, a lifestyle based on preventive activities established by medical research (diet, exercise, no smoking etc), and medical practice. The order is important - disease is the result of sin, but it is not always the direct result of any one sinful action. We would surely agree that by one man death came into the world, and that illness and decay are the direct result of Adam's actions. The application of this to the individual pathological process is more difficult, and the simplistic application of this principle to the individual patient may have disastrous consequences spiritually and physically. The corollary is however true - Christian peace, and lifestyle, are associated with a decrease in stress related disease (medical science and clinical research provide this evidence). A helpful summary completes this chapter, itemising 15 statements defining biblical pneumosomatic health.

Chapters seven and eight present a theology of medicine and explore the role of the church in health care. The approach is an analysis of the New testament words used to cover 'medical' healing. I found this section helpful.

The conculsions are startling: the non-Christian patient must first be evangelised, since he cannot be expected to apply biblical principles of pneumosomatic health; a patient who is in immorality cannot be helped; the Christian patient must be directed to fulfil his biblical responsibility. In other words, Christian doctors must first fulfil a primary role as evangelists before applying their medical skills. Payne certainly infers that in his practice, and in the experience of others in the US, this is acceptable. Medicine is different in the UK, and the doctor-patient relationship is in many ways a different one, but most Christian physicians would find this a difficult approach in this country. Are we too reserved? Have we been affected by the world, as Payne suggests? Certainly opportunities for witness occur in medical consultations, but these usually arise out of the patient's questions or responses, not as a result of a direct approach by the doctor *ab initio*.

Did Jesus require salvation before physical healing? Did he require the sinner to repent before he healed? He certainly required faith in those to be healed, but that was faith in his power, not a full understanding of salvation. What does Dr. Payne's thesis say to medical missionaries, or relief workers? I feel that his conclusions at this point are simplistic.

The role of the Church in health care is elaborated and the relationship between spiritual healing and physical healing explored. Again this was a stimulating section, illustrated with several clinical and pastoral examples.

A short chapter on abortion is followed by a critique of psychotherapy which follows much the same pattern as the early chapters on science and modern medicine. The Christian Medical Society, Dr James Dobson and others are dealt with and psychiatry and psychotherapy are analysed with reference to their effectiveness. Needless to say they are found wanting - they are based on unbiblical principles and concepts which have no scriptural warrant. But what of the Christian psychiatrist?

> The Christian psychiatrist has a place within certain well-defined guidelines. My only reason for this allowance is for those Christians who are occupied in these professions.

The conclusion of this chapter places psychiatric illness in the realm of spiritual illhealth:

> Who should a Christian with psychological problems seek for help? First he should see his pastor or that person who counsels *under* the authority of his church.

Chapters eleven and twelve deal with dying, death, grief and euthanasia, and are clearly biblical in their approach.

The final chapter 'Where to Now? Practical Considerations' presents the difficulties which applying Payne's Biblical/Medical ethics will produce. Letters to medical journals, pressure on government, involvement in pressure groups are all recommended. But more is required. In order to practice this sort of medicine some in America have opted out of the usual way medicine is practiced. This has meant financial loss and loss of professional prestige.

What is this reviewer's response to the book? I enjoyed reading it; I was stimulated by it; I was challenged by it; I was irritated by it. It is detailed, well presented and clearly written. It is biblically based and well referenced. I still feel that the main title is somewhat misleading - if one saw this book on the shelf, and glanced casually at the jacket to see whether it was a book dealing with the 'usual' issues of medical ethics one would be misled. The issues we are all concerned about are dealt with but are only a minor part of the book which is an attempt to reach a biblically based approach to the practice of medicine. It appears to me, however, that this pneumosomatic approach involves Christians in the health care professions separating from their professional colleagues and launching a 'Christian alternative medicine'. This may be practical in America with its system of health care, but one can hardly see the

National Health Service supporting another splinter group; also most Christian doctors are firm supporters of the ideals behind our system and would be loath to abandon it. Dr Payne's point would be that the Biblical imperative is to serve Christ no matter the personal cost and that biblical principles are paramount in health care as in all other aspects of our lives.

One irritating feature was the introduction of each chapter with a personal anecdote involving the author's successses in pneumosomatic counselling. These were not sufficiently detailed in clinical terms to allow critical assessment of their validity but could be disturbing for the lay reader with medical problems.

This is a challenging book. It is certainly worth reading by anyone interested in the Christian practice of medicine (or the practice of Christian medicine?). It deals with abortion and euthanasia in a rather perfunctory though conservative manner. It presents an interesting view of the practice of medicine which should stimulate debate in medical circles. Read it. Think it through. You won't agree with all that it contains, but you will be stimulated by it.

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Biblical/Medical Ethics
A General Practitioner's Response

The subject of counselling as an integral part of the psychological support which we give to patients has been very topical in recent years, both from Christian and secular view points. Recent trends towards incorporating trained counsellors into general practice in Britain, and articles substantiating the beneficial effect of such skills, have been found in the last year in many of the major medical journals.

In Scotland there are many Christian medical practitioners involved in some form of counselling, either as part of their work, or more often in church/missionary areas. Formal courses are run by a variety of agencies, and many non-medical people have been drawn into counselling roles. Into this rapidly changing scene comes Ed Payne's book, *Biblical Medical Ethics.* In reviewing it with particular regard to its view of Christian counselling, I write as a family doctor, with an interest in how such counselling could be incorporated into our general practitioner services.

Nobody should be under any illusion that this book is ordinary. The author, from an immense amount of reading, and from his own practice of medicine, conveys a most stimulating vision of the impact the Christian should have within his medical work. Those who are more committed to non-directive counselling may find the thrust of this book difficult to accept. However, his ideas, firmly founded in biblical evidence and practical reality, lend weight to the way he believes counselling should develop. Much of the book deals with those difficult problems a medic encounters, which by their nature require a spiritual solution rather than a physical one, The author writes with considerable urgency about the need for Christian people involved in medical matters to seek primarily an evangelical stance. He does not shrink from dealing with the obvious questions which arise from such a view of one's role with patients.

In our dealing with patients we may be tempted to concentrate only on physical or psychological symptoms. Dr. Payne would take exception to this, as an incomplete rationale for treatment, which ignores the patient's spiritual needs, and provides inappropriate therapy. Thus there are frequent consultations where problems such as relationship difficulties, stress induced tension, inadequacy, depression and family chaos, to name but a few, end with a sense of failure. Lack of progress with patients, Dr. Payne suggests, is a sign that fundamental spiritual pathology is not being dealt with. In addition he describes many cases where physical symptoms have responded purely to spiritual measures.

Like many of my Christian medical colleagues, I have been cautious, (or over-cautious?) about bringing such therapy before patients. Evangelism of the patient is a major stumbling-block for most of us, particularly in British medicine. The author deals with this at length. He agrees that 'abuses in evangelism in medical settings can and do occur'. To avoid these, one must 'realise the patient's vulnerability, and develop a gentle, caring approach which respects the patient and considers his comfort. Time and place are important factors, the physician should not persist if the patient, verbally or non-verbally, indicates disinterest or opposition.'

Raising the question of whether patients are willing to hear the Gospel, he comments on his own experience and those of others, and concludes that generally they are more than willing to hear the Gospel. Here I am surprised, for certainly this has not been my experience. One wishes the author could have dealt more with antagonism and difficulties since undoubtedly these arise. Evidence of the patient's openness needs to be presented. Could the average Briton be less willing to discuss such matters or more habitually sceptical than his American counterpart? Despite these qualifications, his views are refreshingly biblical and worth pondering.

Dr. Payne gives many examples of counselling where patients were initially presented to a physician or psychiatrist with a series of symptoms which clearly had a spiritual basis. It is not the author's view that one should merely encourage insight. Instead he takes a very directive view of counselling. It is refreshing to see how biblical solutions are used as therapy, often changing lives radically. Such therapies involve proper daily devotions, which are seen as essential for wholeness, and where there are particular guidances from Scripture, these are made part of such devotions.

Correct priorities with regard to work, leisure, family responsibilities and relationships are all shown to be important. Spiritual discipline and regular church attendance are regarded as further factors in restoring patients to full health. Many helpful examples were given of the types of problems dealt with. Perhaps even further use of these could have been made, and detail on individual patients would have allowed fuller discussion. Regrettably, scant information is given regarding failures and difficulties.

Where patients were seeking a balanced life, I wholeheartedly agree with much of the directive therapy used. The author lists four characteristics and seven activities which promote such a life. Thus we have 'salvation, obedience, a right internal attitude and outward action (which must be directed to God's glory), and perseverance.' The activities of the balanced Christian life involve prayer, bible study, fellowship, physical health, putting off sin, ministry (ie service or love to others) and daily disciplines. Payne holds that 'the balanced Christian life is well defined biblically and is achieved only by disciplined effort.'

The author is often highly critical of fellow Christian doctors for not challenging accepted medical opinion on the nature of man. Medical

education avoids any acknowledgement of the spirit, teaching that the physician deals with body, psychologist/psychiatrist with the mind, and the pastor with the spirit, (if such a thing is to be believed in). Dr. Payne argues for the inter-dependence of body, soul, mind and spirit. Should we Christian doctors ignore the effect of the state of the spiritual life, as part of our assessment of a patient's health, and not deal with it in our treatment? He challenges Christian psychiatrists to produce a critique of their own speciality, and of psychiatry's role in relation to the Christian faith. Neither of these has apparently been done as yet. He writes,

The current general direction of Christian professionals, is not from the position that the biblical principles are practical and foundational to a healthy body.

The best counsellors, he maintains must be mature and biblically knowledgeable. Such a counsellor needs to follow McQuilkins Thesis that to avoid being a 'giant in his empirical research and theorization, and a pygmy in the knowledge of scripture' he should 'teach at least one bible study or course in Christian doctrine each year' to college or seminary level.

This book is well worth reading, but be prepared for its implications for your practice of medicine. One feels this area of work still requires much further development and perhaps in years to come we may see the growth of evangelical Christian counsellors in Scotland. While not agreeing with all that the author claims, on the whole I believe this book to be a notable contribution to our understanding of the role of Christian counselling in medical practice.

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say that you are sorry to your own child; to offer your love, even though too late, to your own child; to know that your own child forgives you. An act of contrition to the Creator can relieve much, if not all of the guilt a woman feels, but it cannot relieve this need which will remain unmet for life, unless she is a Christian.

I had an unusual counseller to help me come to terms with my abortion. A religious experience is difficult to share and to many people, even more difficult to believe in. All I can say is that I know that it was Jesus Christ who wept with me through an entire night until I came to the place of acceptance and faced this final need, with him . I wanted desperately to offer my love to the child I had rejected, to be forgiven by the one to whom I had been the whole world and the only love there was and whom I had betrayed. I did not know if or how this need could be met until my 'counsellor' spoke.

He asked if I had not understood that what I had done, I had done to him - and had been forgiven for long ago on Calvary. From the 'symbolic', (where I had classified them), the words of Matthew's Gospel, 'whatever you do to the least of these my brethren you do it also to me' leapt suddenly into immediate, tangible reality and Calvary ceased to be only 'the place where Jesus Christ died'. My baby died there too when he died - and rose with him later. Every word of sorrow and love I had poured out had been heard by my child, because he had heard it. All that remained was love and forgiveness, given, mysteriously, by my child because given by Jesus Christ and waiting until this moment to be claimed.

This is complete healing. While it is possible to help a woman to return to a normal life without it, there is no way, without Christ, to restore her relationship with the child she has lost. This restoration alone relegates abortion to the past and makes its pain a thing remembered rather than something still present, if now manageable. The problem in today's humanist society is that we will have to accept that in very many cases complete healing will simply not be possible, at least within the period of 'post-abortion counselling.'

What we can do after the event may be limited, but let us make absolutely sure in future that we really have done everything in our power to prevent this apalling tragedy in the first place. Short of violence, every one of us has a responsibility to do whatever lies in our power to prevent a woman from going through an abortion. It is not a matter of saving her child only. It is also a matter of saving the mother and her motherhood from destruction by the grossest abuse of medicine which has ever taken place.

(Anyone who has suffered directly or indirectly from abortion and wants to get in touch with the author of this article may feel free to do so c/o *Ethics & Medicine*. It is hoped that a Society of Abortion Survivors will be launched shortly.)
