Ethics & Medicine

A Christian Perspective

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Rutherford House Medical Ethics Project

Aims: The aim of the Project is to develop a Christian mind on the complex and fundamental challenges posed to society by technological advance in medical science. Rutherford House is a research centre whose theological position is Protestant and conservative, but the Project is intended to draw together those with a common concern for a distinctively Christian approach to medical ethics.
The Project is currently engaged in publishing and in organising conferences, and hopes to be able to expand these and other areas as support allows.

Associates of the Project: Those who support the Rutherford House Medical Ethics Project financially become Associates of the Project and receive news of the Project together with a complimentary subscription to *Ethics and Medicine*. Publishing and administrative costs are high, and those who share our concerns are encouraged to become Associates. Please write for details.

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COMMENT

From the Editor
Costs and Benefits

Elsewhere in this issue of *Ethics and Medicine* announcement is made of a symposium on the ethics of resource allocation in medicine, sponsored by the Rutherford House Medical Ethics Project. As resources in medicine are squeezed – while the nation's overall resources, as indicated by the GDP, continue to rise – the argument over priorities is going to get louder. The problem is that it is increasingly spilling over into a very different argument, which centres not in the discussion of priorities in medicine but rather in the cost of caring to society. The proper (indeed, inevitable) argument about how best to use scarce (because finite) resources is starting to be an argument about which patients we can afford to have.

This is illustrated with ghoulish candour in discussion of the economics of abortion. The proponents of liberal abortion have long been accused of resort to a cost-benefit approach to human life, and they have long denied it. But there are cases in which candour has prevailed, and one is to be found in discussion of 'eugenic' abortion.

In March 1986 the Scottish Home and Health Department published a report on *Clinical Genetic Services in Scotland* by a Working Group of the National Medical Consultative Committee. The Working Group had been established in October of 1984, and its brief was 'to consider the provision of clinical genetic services in Scotland' and make recommendations 'in the light of current opportunities for the prevention (*sic*) of genetic disease'. So far so good. At least, so far so good if the 'prevention of genetic disease' is just that. But, of course, it is not; it is sometimes of the destruction *in utero* of those already its victims that we speak. The 'prevention' is of the live birth of these children. Genetic counselling itself can perform a most valuable service, but this is not it.

Paragraphs 89 to 97 of the report are headed *Cost-Benefit Analysis of Prenatal Diagnosis*. They summarise detailed tables produced in an appendix. We quote:

> *Duchenne Muscular Dystrophy*
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> 91. The lifetime resource use by a child with Duchenne muscular dystrophy (DMD) is estimated to cost over £80,000. This comprises costs to the family, to society through the loss of the mother's output at work, to the health service and to the education service. Assuming that the parents would try to conceive again following selective termination of an affected pregnancy, some of these costs would not be saved entirely, but rather would be simply deferred or reduced. The net saving is estimated to be about £52,000. False negative and false positive diagnoses would further reduce this to about £49,000.
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> 92. Detecting and terminating an affected pregnancy are estimated to cost about £10,500. Thus these calculations indicate that prenatal diagnosis of DMD would probably produce an overall saving of about £38,000 per birth averted.

The Report goes on to discuss two other common grounds for 'averting births' on genetic grounds: Huntington's Chorea (net saving: £8,500) and Down's Syndrome (£24,500) – all at 1983-84 prices. It concludes its discussion of the cost-benefit analysis in these terms: 'The Working Group consider that the use of screening procedures has the direct result of useful net savings to be achieved in society.'

Why is it that we – many of us – find this cold cost-benefit prose so very disturbing? It is not, and this should be underlined, because we have any wish to be inefficient in our use of what limited resources we have. There are many medical services in which such an approach is useful, while it must be qualified and set in a context of elements that are not so readily quantifiable. In general terms it is most often an asset in strengthening arguments for preventative approaches to medicine. And, *prima facie*, it is in such a context that we find it here. It is offered as a supporting argument for the funding of more adequate clinical genetic services: 'prenatal diagnosis' produces savings of £X,000 for each 'birth averted'.

The real difficulty lies in the ambiguous notion of human life that lies behind any discussion of diagnosis before birth. Despite the fact that it *is* 'diagnosis', there is no patient. The possibility that there is a patient is held, as it were, in limbo, while diagnosis with a view to 'averting' birth proceeds. It is as if – and here we grasp the imaginative fallacy on which every abuse of abortion must depend – as if in 'averting birth' we could actually avert the patient; as if the fetus were a human proposal which we could accept or, if we chose, politely decline. And, of course, there are just such human possibilities thrown up in the statistical assessments by which medical geneticists advise those who are likely to conceive affected children. But there is all the difference in the world between the possible child whom the parents would be wise not to conceive, and the actual product of conception whose tissue can be sampled and diagnosed.

It is not hard to visualise the way in which a similar case could be made for 'averting' continued human life at other stages, and perhaps it is our subconscious awareness of the ease with which the paragraphs to which we have referred, and the lengthy Appendix V by which they are justified, could be thus adjusted, which we find so shocking. The tables in the Appendix lay out such mundane costs as the annual expenditure necessary on education (both ordinary and special) and health care, the mother's loss of earnings, and a column headed 'own consumption'. It is hard to conceive of a more numbing exercise in the reduction of human dignity. But it is not hard at all to see how these same columns could be completed to account for the economic pluses and minuses of us all; and to show the 'useful net savings to be achieved in society' by 'averting' the future life of those who are in deficit.

There can be no better index of a society's compassion and its respect for human dignity than its refusal to be cowed by such an exercise in costing. It is the arithmetic of those who know – in Oscar Wilde's phrase – the price of everything and the value of nothing. The supreme dignity of human existence, on the assumption of which alone can any free society hope to survive, may not thus be quantified. Yet there can be no more sinister warning to us all of the insidious mind-set which eugenic abortion has brought in its wake, and of the kind of arguments which we shall soon face as we seek to defend the dignity of those most frail and dependent members of society, whose care needs must run up large deficits in the accounting sheets. We have begun by weighing the benefits of averting the births of those of us conceived with an abnormality. We must weigh also the costs on the balance sheet of human dignity.

COMMENT

From Michael N. M. Bell, Solicitor

Human Dignity?

History teaches us that although numbers and wealth are important in a war they are not as important as tactics. Time and again the army with the better tactics has defeated the army with more numbers and wealth. We are today seeing a war of ideas in the world. It is between those who believe in the sanctity of human life, and those who do not. Those who do not are far superior in numbers and wealth. Nevertheless, this is not the reason why the pro-life movement is not making the progress which one would expect. The real reason is that the movement has not yet adopted the right tactics, at least most of the time.

The usual approach of the pro-life movement is as follows. It recognises that we live in a world where people are less and less inclined to base their conduct on religious dogma. It therefore avoids religious dogma in its ideology, and relies on reason. It appeals to people to recognise the dignity of man, and accordingly to respect life. It argues that human dignity demands justice for the unborn child from conception onwards.

The time has come to recognise that this approach is not working. We need to understand why it is not working, and to adjust our tactics accordingly.

The rejection of religious dogma as the guiding principle in life arose as a result of the secular philosophies which launched the age of reason. They were based on the assertion that man was not a creature of another's making, but the ultimate and highest product of an evolution which worked by the survival of the fittest. This theory offered mankind a new criterion with which to evaluate our dignity.

This theory of the secular philosophers contained a fundamental fallacy. It alleged that belief in God was not only unprovable, but unnecessary in order to explain the world, and indeed inconsistent with the true dignity of man. Man, it was argued, would only find his true dignity when he recognised himself as a being who had no creator; who was independent of any Lord and Master; who was equal to any god in his ability to distinguish good from evil; who was the arbiter of his own fate; who could make his own morality as he chose, to suit his own interests.

"The truth is that you cannot argue convincingly for the sanctity of life without a specific rejection of the secular philosophy .... it is the devaluation of man inherent in the secular view which has made possible the anti-life movement."

This evaluation of man is the basic philosophy of the anti-life movement, which reached its peak in the legalisation of abortion. The error of the pro-life movement was to believe that they need not reject this philosophy in order to succeed in convincing the ordinary man of the sanctity of life. On the contrary they seem to have tacitly accepted the secular philosophy of man's dignity, and tried to base the pro-life argument on this. This is why they have had so little success in persuading the community to enact legislation which would protect life.

The truth is that you cannot argue convincingly for the sanctity of life without a specific rejection of the secular philosophy. The reason is as follows. All pro-life argument rests on the premise of the dignity of man. It is therefore necessary to base such argument on a philosophy which respects man's dignity. Although secular philosophy purports to enhance the dignity of man by denying that he is a creature of another's making, in fact it does not do so. On the contrary it is the devaluation of man which is inherent in the secular view, which has made possible the anti-life movement. For this reason not only can the pro-life movement not make a convincing case on the basis of acceptance of this philosophy, it cannot make a convincing case without an express rejection of it.

The reason why secular philosophy robs man of his dignity is because man understood as being merely the highest point of

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evolution remains an animal. An animal can never of its own accord evolve into a person. We treat animals in a quite different way from how we treat persons. We consider it to be perfectly proper for an animal to be the subject of property, that is to be owned by a person. We consider it to be perfectly proper to eat animals, or to use them for experiments as long as needless pain is avoided. We consider it acceptable to hunt animals for pleasure, or to put them to sleep if they become unwanted. We would not consider it appropriate to treat a person in any of these ways. The reason is that an animal is a thing, and things and persons have always been treated as separate and distinct. The distinction is as fundamental as the distinction between a stone and a fungus. They may look very similar, but one is alive and the other is not. The stone can never grow into a fungus because it is a different order of being. If a man evolved, without any divine intervention, from an animal, then he remains no more than an animal. A man who regards himself merely as the ultimate evolved animal will always tend to regard other human beings in the way in which he regards animals. For example, he will look on his offspring as property, that is as objects created by himself for his own benefit. Thus in the secular scheme of things man has no ultimate value. His value is contingent on what he is capable of producing, like the value of a machine or a hen.

Handicapped people are non-producers, and therefore are seen as having little or no value. If you have three embryos in a test tube and you require two then it is illogical not to destroy the third. This value theory of man is the essence of Marxism as an economic philosophy, and the essence of anti-life as a social philosophy. The logic of the argument means that man the thing is always disposable, and the only danger we must watch out for

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is that if we make beings disposable who are too like ourselves then we may be putting ourselves at risk. It is only safe to legislate to dispose of beings who are in a category into which we cannot ourselves come.

The pro-life movement must reject the basic thesis of this philosophy if it is to progress. What then must be the basis of the pro-life argument? In the story of Adam and Eve, the devil told Eve that if she became her own judge of good and evil she would be like God, and she would therefore have no more need of him. But as those who read the story from the beginning know he was telling her a lie. In fact she was already like God, because she was made in his likeness. To suggest that her ability to choose, which was one of the ways in which she was like God, should be used to reject him, was simply a clever trick. Once you turn your back on God, and refuse to recognise him, the only basis of your dignity is that you are an evolved thing, of no intrinsic value.

When Adam and Eve passed on to their son Cain their philosophy that man is his own judge of good and evil they indirectly caused the death of their son Abel. Thus the concept of the right to choose, to form my own standards of right and wrong, brought murder into the world, and in due course abortion. Before the triumph of the Age of Reason people believed that God made them, and that every human being had an intrinsic value, regardless of what that human being could do. They had no need to make a distinction between the laws of their being and the laws made by God, because they naturally assumed that what God wanted was what was good for them. This gave them an objective criterion of what was good, which did not depend simply on what they happened to want at the time. They often chose to disobey what they believed were God's laws, but they did not say as people say today: 'I recognise no law higher than my own will, my own choice.'

When we recognise that our dignity derives from our likeness to God we can see that there are objective laws of what is right and good and true. These are the laws of God's nature, which he has written in ours in making us in his likeness. In addition he has given us the gift of reason which makes us capable of choosing what is good and true in preference to self-interest.

The man who has no criterion of what is right apart from self-interest loses his self-respect. He does not become the master of his appetites, but the slave of them.

Where reason is used to orient our lives in accordance with the laws of our nature it makes us superior to the animals. But where reason is subordinated completely to self-interest it makes us lower than the animals because they are endowed with an instinct to protect their young, even at the risk of their own lives. When reason without God replaces instinct it tells man that his own convenience is more important to him than the life of his young. The end result can only be the extinction of the species.

The pro-life movement depends on the concept of the dignity of man. It cannot hold together on the basis of the oldest lie of all, the lie of Eden, which denies the foundation on which that dignity rests. For the child of God the highest law is the will of his Father. But for the reasoning thing the highest law is self-interest. The pro-life movement can only succeed when it recognises that we are children of God, and that therefore every human being is endowed with a unique dignity by virtue of that fact.

Mr Bell is Honorary Secretary of the Association of Lawyers for the Defence of the Unborn.

From the Editor

First-fruits of an Awesome Harvest

The news of a treatment for Parkinson's disease has evoked a predictably mixed response. Press and public reaction – and, of course, medical reaction too – has been alternately ebullient and sombre. The idea of a new cure for Parkinsonism (and maybe Alzheimer's too, and who knows what else) is an apparent cause for rejoicing, of that there can be no doubt. The problem, as so often, is that appearances are not everything. In the United States, it has been temporarily banned. Yet, as we go to press, the British Medical Association is reported as having given its august sanction to the procedure.

The problem is, of course, that this treatment (which may or may not finally prove successful: that is another matter) – this treatment has also a cost. It consists of a new application of the transplant principle. But in this case the donor gives no consent. And his or her death is no accident, but the deliberate consequence of a decision to end a young life. The technique is, as it were, a spin-off benefit of liberal abortion.

The case in favour goes something like this. There is widespread agreement on the principle of transplant surgery. Society has long since accepted the idea that it is fitting for the organs of the dead to be used to save lives of those who aren't. The fetus whose life is lost because of an induced abortion is uniquely able to provide the growing brain tissue which we believe may help those who are otherwise incurably ill. Indeed, as one letter put it in *The Times*, there are advantages in being able to get something positive out of an experience otherwise so negative as an abortion. Shortly after the initial operations were carried out, there were ecstatic press and television reports of rapid improvements in the patients' condition. Another triumph for medical science.

But it is really not so simple. For one thing, the analogy drawn with, say, heart transplants is misleading. In the one case death is accidental, in the other it is deliberately induced. This means that it is hard to see how *anyone* can actually be in a position to give consent for the tissue to be used. The donor, of course, cannot; but, surely, neither can the mother. In the case of donors who die of natural causes we have no objection to allowing close relatives to give their permission on behalf of the deceased. But in this case there are no natural causes, and the closest relative has herself chiefly instigated the death. It marks a distinct advance on her already overweening rights over the fetus, for since her interests have been advanced by his death she can hardly claim to represent him and *his* interests in this decision That is to say, it makes sense to speak of the mother's consenting to the procedure only as giving consent to the use of tissue of her own; as if the tissue to be used were one of her own organs, and not from the brain of another. The ethics committee at the

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hospital in Birmingham decided that it was unnecessary for maternal consent to be given, on the ground that 'women going through an abortion are denying the humanity of the fetus' (*IME Bulletin, April 1988*). Yet the Peel Committee insisted that the mother must give consent to any such use. The question of consent takes us inexorably up a blind alley.

To say this is of course to draw attention once again to the fundamental ambiguity of fetal life in our society. We have liberal abortion, yet there is a general refusal to grant that the fetus is *simply* part of the mother's body; such that, in law, abortion remains a criminal act except under prescribed circumstances. The questions which are raised by this equivocal approach to ante-natal human life will undoubtedly become increasingly sharp as developments in this area multiply.

"The prospect of culling all manner of human tissue for transplant is now very real. The pressure for women to abort in order to provide particular organs for family use will no doubt . . . prove irresistible. The science-fiction fantasy of banks of fetuses maturing in laboratories, whether the fruit of abortion or of ectogenesis, need not be fantasy for long."

The question of consent may seem to pose a merely theoretical difficulty. It arises in another, and more practical, form if it is necessary for there to be something other than a standard abortion operation in order to harvest the tissue. If it is necessary for the more complex and risky surgical procedures to be adopted, then plainly the mother herself must give informed consent on her own account. The sense in which 'informed consent' is to be construed in such circumstances is uncertain. Arguably, in order for the aborting mother to be actually 'informed' she will need to be told things she does not know and has no wish to know (such as – if we may risk being facetious – that her soon-to-be-discarded fetus actually has a brain from which cells may be removed). This presents only a limited problem now, but if such applications of fetal tissue become routine, and tens of thousands of donors are required, its importance will soar. And the pressure will then be on to make the most efficient use of the fetal tissue that is available – involving more efficient collecting techniques than, for example, vacuum aspiration (apparently used in cases in Birmingham). Liberal abortion is possible only in a society which suppresses its knowledge of fetology.

There is also a practical question, to which our attention is drawn in the latest *Bulletin* of the Institute of Medical Ethics, which we have already cited above. Part of the value of obtaining consent lies in the information that can be elicited about the donor/donor's mother, to help ensure (for example) that the tissue will be clear of any infection. What about the need for HIV testing? The *IME Bulletin* points out that 'counselling, as well as consent, would then be required', but even to put this into words indicates the impossibility of carrying it through. One wonders whether those who have initiated the project have really considered these wider ethical issues and their practical implications.

A related question is one which we have conventionally avoided, and indeed upon the avoidance of which is premised the entire policy of liberal abortion: fetal sentience. Elsewhere in this issue of *Ethics and Medicine* we review one of the most important books ever written on fetology. Its subject is the *Foetus as Transplant Donor*, and its most disturbing chapter addresses this very question. What of the experience of the donor him or her self? We are rightly concerned about the experience of other sentient beings, and only under strict legal safeguards are vivisection and factory farming methods allowed. Many consider these not to be strict enough. Yet it is simply appalling that so little concern is shown for the sentient experience of fetal members of our own species. If, as we believe, these first British transplants have used material from already-dismembered fetuses, there is plainly no special problem raised; though our attention is drawn in passing to dismemberment as an abortion method. If other methods come to be used, such as hysterotomy, in which the fetus is delivered alive, when is the transplant team to be allowed access? Who will speak for the donor, and ensure that death has supervened before harvesting begins? There is need here for fresh ethical and clinical work, since the generally accepted criteria of human death do not readily apply to previable but living fetuses ex *utero*. A nation whose concerns for animal welfare and child abuse are legendary must not be allowed to extend its abuse of its smallest children unawares into this sorry territory.

For the real significance of this attempted treatment of Parkinsonism lies in the opening up of a potentially unlimited area of fetal exploitation. For some years now the medical ethics world has grown accustomed to the awesome concept of 'harvesting' the fetus. Professor Hitchcock's team have brought in the first-fruits. And they have brought us face to face with the unnervingly ambiguous status of the fetus, since it is both a human being and it is not. It has a growing set of human organs and tissue of every kind, yet it is available by the tens of thousands. The prospect of culling all manner of human tissue for transplant is now very real. The pressure for women to abort in order to provide particular organs for family use will no doubt (and whatever rules are laid down) prove irresistible. The science-fiction fantasy of banks of fetuses maturing in laboratories, whether the fruit of abortion or of ectogenesis, need not be fantasy for long. The technical objections to this kind of 'harvesting' are falling away, one by one. The BMA has thought it necessary, as its blessing is given to this new technique, to declare its opposition to the (hypothetical) transplanting of the whole fetal brain (though how long that opposition would last were this operation possible and advantageous we may reasonably question: it is easy to seek the banning of things that are impossible, and desperately difficult to stand against those which can be done and are of benefit). We shall soon be faced by the very toughest ethical questions, as our last line of defence against the total de-humanising of the human fetus (and with it, we may expect, the conditional humanity of the young human child).

Experiments on live, aborted fetuses and on *in vitro* embryos are now a matter of history. 1988 is the year in which a use has been found for the brain tissue of the *abortus*. While others rejoice at the prospect of a cure for a dreadful disease, we must keep our heads. It is achieved only at great cost. The brain cells of the fetus are the first-fruits of an awesome harvest, and as the reapers labour we must not lose sight of the fact that this is the harvest of our selves.

Confidentiality and Young People

MRS VICTORIA GILLICK, *Wisbech, Cambridgeshire.*

It is sometimes said that there is no activity quite so tedious as reading last week's news! Coming across a newspaper several years old, however, can be most entertaining, and with the benefit of hindsight may even be a real eye opener. More interesting still are tape recordings of old broadcasts, made at the time of hotly debated social issues. Listening to them once again, one can catch a flavour of the age and compare the arguments of the time with what has since become the current wisdom.

Thus it was that a few weeks ago I was huddled over my tape recorder listening for the first time to a recorded BBC Radio broadcast in which I myself had taken part, way back in April 1984. The programme was called 'In the Lions' Den' and I (as the Daniel) was up against five Lions in the shape of Dr. John Havard (B.M.A.), Dr Angela Mills (F.P.A.), Fay Hutchinson (Brooks Clinic), Dr Lotte Newman (G.P.) and Marjorie Proops (Agony Aunt) plus the presenter Patsy Caldwell, herself overtly hostile to the poor, benighted Daniel.

It was a tough line-up all right, but together this grouping presented an extremely accurate picture of those most actively engaged in opposing my case against secret schoolgirl contraception, which at that time was waiting to be heard in the Court of Appeal. Indeed I even made so bold as to open that broadcast debate by suggesting that it was more of a Hydra's Den than a Lions'!

As I sat listening to the old tape recording, and the high emotion it engendered among the angry participants, I couldn't help grinding my teeth in sheer frustration. 'If only I knew *then* what I know now', I kept thinking, 'those Lions wouldn't have had a leg to stand on!' There was Dr Newman insisting that secrecy was necessary for girls with poor family relationships, while the Brooks chairman and the ageing Agony Aunt trundled out the timeless 'hard case' of the schoolgirl with an undiagnosed pregnancy, leaving her newborn baby in a dustbin.... The F. P. A. doctor took a different line and spoke of 13-15 year old girls as 'young women', whose mature and responsible attitudes towards sex and contraception and request for secrecy, should always be respected. Dr Havard, on the other hand, referred to the need to reduce under-age pregnancies, calling it a 'public health matter', and having been given the last word by the presenter, predicted confidently that if the Courts should insist on parental consent to contraception, there would be rocketing pregnancies, with girls resorting to back-street abortionists and the escalation in the cases of untreated V.D. among schoolgirls.

These then, were the chief arguments most popular at that time. Eight months later the Court of Appeal found in my favour and outlawed all secret contraceptive and abortion treatment to girls under 16 (except in cases of emergency) and in doing so brought the wrath of all hell down upon my head from these same vociferous groups. For a full ten months they continued to bombard the media with their direful prediction until mid-October in 1985, when the House of Lords appeal substantially overturned the ruling. But it was not until two years later that government statisticians were able to reveal the actual consequences of the Appeal Court Ruling and set them in the context of the preceding years' teenage conception and contraception figures.

Yet the information, when published a few months ago, was not greeted by the media with the demands for a public enquiry. There were no controversial T.V. documentaries about these highly revealing figures and most newspapers didn't even bother to report the damning new evidence, despite my lively 'I told you so!' press releases at the time. As far as news-hungry journalists were concerned, Schoolgirls-on-the-Pill was a dead subject, and nowadays they were far more interested in AIDS, the sexy 'wild child' cult, and how to get young men to wear cheap condoms, all the time. Am I being unduly cynical or are *they*?

So what did those statistics reveal in the end? The ungarnished and unpalatable Truth, of course; which was why they were so carefully ignored by Government officials and the media alike.

"As far as oral contraception for schoolgirls is concerned, I can see no valid reason why, at some future date, Parliament should not take a leaf out of the Appeal Court's book, and unambiguously fix the medical age of consent at sixteen."

But to understand what had happened we need to take a brief look back to the early 1970's and the original – if conflicting – arguments in favour of a DHSS policy of free birth control for all.

The Government had made it clear in those days that, in order to reduce the ever increasing number of schoolgirl pregnancies and abortions, it was necessary for schools to give more explicit sex/contraceptive instruction to adolescent pupils, and for doctors to be free to give them the goods, in secrecy if need be. The birth control experts, on the other hand, were making little or no mention of the rising pregnancy problem, but were concentrating on the 'sexual rights' angle among the young. We therefore read in 1974 of Lady Helen Brooks (the founder of the clinics) being quoted in *F. P. News* as saying that her own clinics had already been giving secret contraception to girls under 16, 'long before the decision was taken nationally'. She carried on to say that she considered that she and her colleagues were right to do this because: 'All major social changes bring new problems; and contraception is only one little bit of women's fight for freedom, but it may take until the end of the century before women have the same opportunity to enjoy sexual experience as men'.

In the light of the present AIDS epidemic her words now have an unexpectedly gruesome significance to them, don't they ?

The central question we must therefore ask, is whether the Government's birth control policy has succeeded in its primary aim of curtailing adolescent pregnancies and abortion, or if it has merely encouraged greater promiscuity and created a commercial market for teenage sex ?

If we look at the year 1969 we find that schoolgirl pregnancies numbered 6,500 (a rate of 6.8 girls per 1000) with 1,700 of the babies being aborted (rate:1.7).

By 1973 the pressure on the young to fall in line with the fashions of their sexually emancipated older sisters resulted in the annual schoolgirl pregnancy figures rising to 9,700 (rate 9.1) with 4,400 (rate 4.1) being aborted.

"During the ten months of the Appeal Court ruling the attendance by schoolgirls at their clinics and G.P.s' surgeries had fallen by a dramatic one third (so much for the 'exceptional case'!), yet there had been *no* subsequent rise in the number of births or abortions during that time."

Then the Government stepped in, and in 1975 clinics and G.P.'s were given the go-ahead to prescribe oral contraceptives to one and all, irrespective of age or parental consent. Within a year, 8,000 schoolgirls received the Pill from N.H.S. and agency clinics (rate 2.3), while an estimated 30,000 received their supplies from the hands of G.P.'s (one girl per doctor, per year). In other words around one girl in 15, in every fourth and fifth form in the country, was now taking a daily dose of hormone contraception, and starting out on her promiscuous future.

Three years later the DHSS stepped in once more and quietly distributed a secondary memorandum to doctors and health authorities, this time giving the green light to secret *abortions* on schoolgirls as well. Presumably this was in response to the increasing number of requests for 'quickie' lunch time operations, and the fact that 50% of pregnant schoolgirls were turning to the private sector clinics for abortions. It may also be fair to conjecture that the primary aim of the Government was the reduction of births, rather than merely pregnancies, to the young, since despite the increasing contraceptive uptake by the under- sixteens this had not succeeded in reducing the annual number of conceptions to the level of the 1960s.

The reduction had in fact been minimal and had never managed to fall below eight and a half thousand a year (rate 7.2) which was achieved in 1980. From then on it began to rise steadily each successive year, and every year the proportion of pregnancies ending in abortion grew greater. 1980 however was paradoxically the year in which the DHSS chose to re-word its guidance to doctors, giving greater emphasis to parental involvement and urging the medical profession not to undermine parental authority or family stability. Secret prescribing, said the DHSS, was only for the most 'exceptional cases' of parental neglect. To most people that would suggest no more than five or ten per cent of the total, but to the birth control zealots, as we now know, it meant a far, far greater proportion.

Fearing the catch-all nature of this policy, I challenged the legality of those 'exceptional cases', but in 1983 the High Court rejected my case, with the presiding judge stressing the need to maintain the liberal DHSS approach, in order to reduce pregnancies among the young. In the wake of that ruling, the following year of 1984 saw the highest ever contraceptive uptake by schoolgirls with 18,000 (rate 4.9) now attending the clinics and private agencies, and an estimated 60,000 seeing their G.P.s.

In graphic terms once again, that meant that one in seven older schoolgirls were on the Pill and sleeping around, and several thousand more were having unprotected sex and getting pregnant. Unbelievable as it may seem, Government logic was still insisting that more sex/contraceptive instruction and uninhibited supplies were the only answer to the problem. The blinkers were firmly in place.

Young girls, however, are not logical, and it therefore came as no surprise to learn that 1984 also saw the highest number of under-age pregnancies and abortions since the DHSS policy was launched, with 9,600 conceptions (rate 8.6) and 5,300 abortions. Two other important factors had come into play around this time. One was the emergence of a new kind of glossy, hard-sell teenage magazine for girls aged 12-15 years, whose undisguised aims were to hype-up the glamour of teenage sex, while giving regular information on contraceptive 'rights' and where and how to get confidential supplies.

The second pressure came from the adult media itself, whose interest in my case – and deep antipathy towards it – had caused a continuing barrage of propaganda to centre around it for a full two years. It reached its peak of ferocity during 1985 while the Appeal Court ruling against secrecy stood as the law of the land.

Girls would not stop having sex just because they could no longer get the Pill, said the angry commentators up and down the country; they would simply carry on regardless and get pregnant. I read and listened to these diatribes in mystification. Suddenly so it seemed, these 'mature and responsible' girls, whose former cunning had enabled them to get their Pill supplies without anyone at home knowing of it, had overnight turned into stupid and feckless children who couldn't possibly be expected to curb their newly awakened sexual appetites. Such was the cynicism and dishonesty of those perverse adults who had been cheering them on during all those previous years.

"Six thousand girls had come off their clinic-supplied Pills when they could no longer get them in secret, and G.P.s had experienced the same one third drop in contraceptive requests."

For two whole years we have had to wait to see if their direful predictions about that fateful year were true or false. Sheffield Health Authority couldn't wait that long, and in January of 1987 their family planning department published the findings of their own district survey for 1985. It turned up in the magazine of the National Association of Family Planning Doctors under the heading 'Was Mrs Gillick Right?' During the ten months of the Appeal Court ruling, said the authors, the attendance by schoolgirls at their clinics and G.P.s' surgeries had fallen by a dramatic one third (so much for the 'exceptional case'!), yet there had been *no* subsequent rise in the number of births or abortions during that time. The authors therefore concluded that this result was 'presumably because those girls (formerly on the the Pill)

either used some non-prescriptive method of contraception or abstained'.

It was not until September 1987 that the full, national figures were published and we were able to see that the same phenomenon had occurred all over the country. Six thousand girls had come off their clinic-supplied Pills when they could no longer get them in secret, and G.P.s had experienced the same one third drop in contraceptive requests. The total number of girls who were therefore supposed to carry on regardless and become pregnant, was around 25,000! But they didn't, did they? The annual pregnancy rate for that year was exactly the same as for 1984; and because of the falling population among teenagers generally the numbers even showed that for the first time in five years there were *fewer* schoolgirl births and *fewer* abortions (100 and 200 respectively) during that period.

"If the Government and the medical and teaching professions honestly want to prevent the further spread of AIDS and all the other multiplicity of disastrous and costly sexual diseases, then they must do something more than just talk about it. Parliament has the power to act."

Even more revealing was the fact that among girls over sixteen and in every other age group under 35, the illegitimate conception and abortion rate continued its upward trend. Only among the under sixteens was promiscuity and pregnancy halted and put on a downward course.

Unfortunately, the ten year old DHSS policy combined with the media 'sexual revolution' during the sixties and seventies had already done its damage and taken its toll among countless thousands of teenage girls. Only now do we read of the epidemic of malignant cervical cancer and pre-cancer among the under 25s. Only now do we learn of American surveys that show that one in five promiscuous teenager girls have caught that secret and permanent sterilizer – chlamydia. Only now do we hear of the heartache of depressive post-abortion women. Only now, after ten years of unchallengable medical practice, do we hear doctors bleating about the 'bleak future' that awaits the young men and women who have become the victims of that viral revolution, boiling away beneath the surface, and which the same profession and the commercial cheer leaders once hailed as a 'woman's right to choose'.

Mercifully, despite the Law Lords irrelevant ruling in October 1985, the young at least, do seem to be hearkening to the current warning against promiscuity. They have seen the mess and misery that an older generation has made of their lives, and the signs are that an increasing number of youngsters are determined not to go up that same blind alley.

There will still be victims a-plenty, sad to say; especially if the Government insists on allowing condom manufacturers and their middle-aged pop promoters to carve another graveyard for the young and the unborn by pretending that a flimsy bit of porous rubber is all that is required to save them from disease or certain death.

But as far as oral contraception for schoolgirls is concerned, I can see no valid reason why, at some future date, Parliament should not take a leaf out of the Appeal Court's book, and unambiguously fix the medical age of consent at sixteen.

After all, that unique ruling did actually manage to cause a remarkable one third drop in the level of promiscuity amongst the most vulnerable age group, in less than a year and even in the teeth of a hostile and unhelpful media machine. Equally it dispelled the myth – the 'sacred cow' of a generation of theorists – that more birth control means fewer pregnancies; and revealed the reality: that among the young and unmarried more contraception means simply more promiscuity and an increase in illegitimacy and abortion.

If the Government and the medical and teaching professions honestly want to prevent the further spread of AIDS and all the other multiplicity of disastrous and costly sexual diseases, then they must do something more than just talk about it. Parliament has the power to act, and it now has all the evidence it needs to realise that law can – and does – affect the way young people behave, and can be the way to give them maximum protection.

While this adult generation has the responsibilities and duties of parenthood still in its hands, there will be those who will act wisely and those who will not. But the times are now far too dangerous for our Government to take guidance from those who promote 'children's rights' or those who once claimed that pregnancy was the worst possible outcome of promiscuous sex. Such thinking is just so much discredited old hat; for we are living in the age of the New Enlightenment now, and we must respond to it accordingly, with courage and real, forward-thinking intelligence.

Medical Notification Form

Mrs Gillick has devised a 'Medical Notification Form' designed for parents to send to their G.P., Health Authority and local private clinics, worded as follows:

CONCERNING THE PROVISION OF CONTRACEPTIVES TO GIRLS UNDER THE AGE OF SIXTEEN.

In allowing contraceptives to be given to girls below the age of consent (16 years), without parental knowledge and consent, in exceptional circumstances, the Law Lords gave a specific warning to doctors –

'That result ought not to be regarded as a licence for doctors to disregard the wishes of parents on this matter whenever they find it convenient to do so. Any doctor who behaves in such a way would, in my opinion, be failing to discharge his professional responsibilities, and I would expect him to be disciplined by his own professional body accordingly.'

– Lord Fraser, House of Lords. (Gillick v. D.H.S.S.) 17.10.85.

I, [Name] therefore give formal notice that, as the parent responsible for the moral and physical welfare of my daughter/s [Names], I do not wish her/them to be given any contraceptive advice or treatment, while they are under 16, without my prior knowledge and evidence of my consent. Should such advice or treatment ever be given in secret to my under-age daughter/s, I shall consider taking immediate steps to report the doctor concerned to the General Medical Council, as advised by Lord Fraser.

Copies of this form may be obtained from Mrs Gillick, 2 Old Market, Wisbech, Cambs., PE13 1NJ.

Confidentiality and Young People:
A General Practitioner's Response

DR HUW MORGAN, *Caerwent, Gwent.*

As a Christian GP it seems clear to me that what is threatened by any ruling that doctors have a duty of confidentiality towards minors is no less than the integrity of the family, and particularly the duty, responsibility and right of parents to care for and guide their children.

In this paper I propose to do four things. Firstly (and briefly), to consider the purpose of confidentiality from a medical viewpoint; secondly, to outline the particular problems that confidentiality towards young people poses; thirdly to illustrate these problems with two case histories, and finally to consider the lessons we must learn from these.

The Purpose of Confidentiality

The convention of confidentiality exists essentially for the benefit of the patient. It protects his interests from a third party (such as his employer or neighbours) who may have their own interests served by knowing his medical details, but probably to the detriment of his own. It also assists the truthful sharing of information – perhaps of embarrassing personal detail. This may be necessary for an accurate diagnosis, and therefore appropriate treatment, to be given.

Generally speaking, a Christian doctor has no problem with confidentiality towards mature individuals, since such a principle respects the importance of each person – something Christians should be committed to doing.

Problems Posed by Maintaining Confidentiality Towards Young People

Firstly, it is necessary to define what is meant by a 'young person' in this context. Individuals of 14, 15 and 16 are included, and perhaps some 13 year olds. Generally in my experience 13's and under are still 'children' within the parental nest, and 17 year olds and older have achieved a measure of maturity and independence. 16 is of course the age of consent, but the fact that the law regards 16 year olds as capable of making informed decisions about themselves and their welfare does not mean that they are necessarily able to do so.

The present General Medical Council and DHSS guidelines for doctors regarding confidentiality and under 16's leaves it to the doctor to decide whether the particular individual is mature enough to be responsible for the medical help they are requesting, and to understand the potential consequences of their actions.[1,2] These guidelines are not ultimately satisfactory for concerned parents, for reasons outlined below.

Immaturity

There can be no real doubt that the vast majority of 14, 15 and 16 year olds' lack the emotional stability and intellectual maturity to make decisions for themselves about important medical issues such as contraception and abortion. They usually have little capacity for appreciating the possible consequences of such decisions as they may make. Coupled to this are the considerable physical risks of sexual activity involving young people. Under 17 year olds who have sexual intercourse have twice the normal risk of developing cervical cancer (20% of sexually active teenagers have an abnormal cervical smear). 1 in 50 15 year olds conceives, and many more contract sexually transmitted diseases with potentially serious and irreversible consequences in later life. Most young teenagers simply cannot adequately assess these risks and problems as they relate to themselves personally.

The Deliberate Deceiving of Parents

A doctor who agrees to provide contraceptive advice or advice and help concerning abortion to a girl under 16 without the knowledge and consent of her parents or guardians is involved in the girl's deliberate deceit of her parents. To collude with deceit in this way is unacceptable for the Christian doctor, particularly as this involves professional interference in family life in a way which threatens to undermine the stability of the family unit. Of course not all girls seeking help with these matters have concerned parents, although it is likely that most will have at least one relative who is concerned and responsible for the girl's welfare. (In my own inner-city practice with many families in social classes III, IV and V, I have yet to meet an under 16 year old girl who lacks at least one caring relative, even if parents are absent or unconcerned). The lack of such a parent does not however mean the doctor should go ahead and treat the girl as though she were a mature adult. Rather, it means that steps must be initiated to provide a responsible and caring guardian for her who will act *in loco parentis* for such decisions as need to be taken for her future welfare.

"I have yet to meet an under 16 year old girl who lacks at least one caring relative, even if parents are absent or unconcerned."

There are occasions when withholding information from one family member about another may be appropriate, when dealing with mature adult individuals, but I would submit that it is never appropriate for those who are below the legal age of consent and who are insufficiently mature to appreciate what the consequences of their actions may be. To do this is simply to potentially hasten the emotional and physical trauma that such young people will encounter, and may undermine the stability of the family and therefore untimately of society itself. Pretending that immature young people are capable of functioning and behaving like responsible adults is simply unrealistic and could amount to a failure of the doctor's duty to care. I will attempt to illustrate these problems with two case histories.

Two Case Histories that Illustrate these Problems

Miss A, aged fifteen and a half years, attended with a friend, complaining that her period was a week late. She denied having sexual intercourse, although it was obvious that she wasn't

telling the whole story. I urged her to return with her grandmother with whom she lived, and to confide in her. A week later she attended again, alone, saying that her period had now come, but this time admitting that she had given in to the advances of a 17 year old boy at a party. Her grandmother didn't know about it. There were now three issues to face.

1. The youth who has had sex with Miss A has broken the law.

2. She was at risk from pregnancy, sexually transmitted disease, cervical cancer and psychological disorder if she continued to have relationships of this kind.

3. She was below the age of consent for contraceptive use, which would have been necessary if she was to continue sexual activity.

I pointed out all these things to Miss A and urged her to return with her grandmother if she required further help. She said she intended to avoid such behaviour in future.

A year later Miss A attended again, this time with grandmother. Her period was two weeks late this time, and a urine test had confirmed that she was pregnant. Her record showed that she had obtained supplies of the contraceptive pill from another doctor when she was aged 16 years and 2 months. It was clear that grandmother didn't know about this. Miss A was pregnant because she had failed to carry out clear instructions about renewing the pill prescription.

Fortunately this story has a happy ending. Miss A married the father of her child, grandmother helped look after it initially, and later she went on to have another (planned) baby. Now in her twenties, she is able to manage contraception in a way that was beyond her at 16.

Miss B was aged 16. Her father had died several years previously, and her mother had subsequently developed cancer, which for 4 years she had successfully fought with the aid of surgery and radiotherapy. She attended the hospital for annual check-ups, after which she always came to see me for my explanation of the test results and reassurance that all remained well. It was thus vital to her to be able to trust me completely and rely on my honesty.

Miss B attended with her aunt (mother's sister). She was 9 weeks pregnant and hadn't told her mother for fear of upsetting her. The plan she and the aunt had devised was to get an abortion quickly, without mother's knowledge, for fear that if mother found out the whole thing might precipitate a relapse in her condition. The pregnancy resulted from a casual relationship which Miss B had no intention of continuing.

Leaving aside altogether the fact that I as a Christian doctor could not consent to abortion in this situation, the other issues facing me were these:

1. At 16 Miss B was legally able to consent to abortion.

2. It was evident that she was under great pressure from her aunt to get an abortion to prevent her mother knowing anything about the pregnancy, and it was not at all clear what her own thoughts and feelings about abortion really were.

3. To collude with this request would involve me in the deceit of Miss B's mother. It was inconceivable that she would not eventually find out what had happened, and this would be greatly irresponsible on my part since it would ruin the trust that she has in me as her doctor, that was essential to her continued well-being.

4. I had scarcely met Miss B before and didn't know her well enough to make any kind of assessment as to whether she had the maturity to handle a decision of this kind. It was therefore essential that her mother as her legal guardian, be involved in the decision.

Eventually I was able to persuade Miss B and her aunt of the necessity to involve Mrs B, who duly came to see me. She was distressed, and was also adamant that abortion was the only solution. I explained my views on that and she and Miss B went to a public clinic where they saw a doctor who consented to arrange the abortion.

Mrs B coped with the emotional distress of all this and retained her trust in me, and fortunately her continuing good health also. Miss B consulted me again a year after the abortion and freely expressed the reactive depression and guilt that she was then experiencing as a result of what had happened.

The Lessons these Cases Teach

Miss A vividly illustrates the problem of immaturity. Many 15 and 16 year olds simply cannot cope with taking contraceptive pills in the appropriate way. If it is necessary that they do (which to be realistic I fear we must reluctantly accept is sometimes the lesser evil in our present moral climate) it is essential that a parent or other responsible guardian supervises them. The increase in teenage pregnancies that occurred between 1983 (when the ruling that began Mrs Gillick's campaign was introduced) and the recent past, when it was amended, illustrates the futility of imagining that young teenagers can cope with contraception. There are lots of Miss A's in every community. Maintaining confidentiality with them about contraception achieves nothing except an increased number of unwanted pregnancies.

Miss B illustrates the potentially disastrous problems that could arise from complying with deceit of a parent. The issue of confidentiality for a family doctor does not occur in a vacuum – he always has to consider the effect of withholding information on other members of the family who may also be his patients. As this case illustrates, quite apart from the immorality of deceit that is unacceptable to the Christian doctor, it may be gross professional irresponsibility to do something which will damage the doctor-patient relationship and its potentially beneficial influence on an individual's health. Again, cases such as that of Miss and Mrs B are by no means rare or unusual, and illustrate that even those who have reached the legal age of consent require the emotional and practical support of parent or guardian to handle the issues raised by decisions on contraception and abortion.

Should doctors maintain confidentiality at any price? I answer no – not at the expense of the health and well-being of immature young people, not at the expense of the relationship between parent, daughter, and medical adviser, and not at the expense of the integrity of the family.

1 *Professional Conduct and Discipline: Fitness to Practise*, Part III, 83-85, p. 21, General Medical Council 1987.
2 HC(68) 1, HC(FP) 861 and LAC 86(3), DHSS

Confidentiality and Patient–Access to Medical Records

PROFESSOR DAVID S. SHORT, *Emeritus Clinical Professor in Medicine, University of Aberdeen.*

Since 11th November 1987, patients have had, with only a few exceptions, the right to see computer records that doctors or others may hold on them. Under the Data Protection Act, 'data subjects' (*e.g.* patients) have the right after making a written request and paying a fee of not more than £10 to be told by the registered 'data user' (*e.g.* a doctor, practice or health authority with computer records) whether any personal information about them is held on computer files; they then have a right to be supplied with a copy of that information within 40 days. Doctors are, however, permitted to withhold information they consider 'likely to cause serious harm' to the physical or mental health of the patient or another person. Manual records fall outside the provision of the Act. But now that the principle of access has been accepted, it must only be a matter of time before the provision is extended to the written record.

This represents a radical departure from previous medical practice. Until recently, in most hospitals, the patients' notes were kept in a folder boldly marked NOT TO BE HANDLED BY THE PATIENT. This principle was rigidly enforced. When patients were transferred from one ward or clinic to another, their notes were always securely enclosed within a sealed envelope.

Why has this change come about? It is, no doubt, mainly due to a widespread demand for greater openness in all areas of life: political, industrial, banking, *etc.* It is directed specifically toward the medical profession, because the role of doctors is generally regarded as having been too paternalistic and secretive. Moreover, doctors (like everyone else) make mistakes, and patients believe that by having access to their medical records they could ensure that the mistakes were corrected, and that they would be able to get at the truth. Many patients would argue: 'Whose body is it, anyway? If it is mine, then surely I am entitled to all the information that relates to it.'

All this sounds very reasonable, and certainly something to which no Christian could object. It emphasizes the principle of the dignity and responsibility of the individual, and respect for personal autonomy. It also emphasizes respect for the truth, and the removal of barriers to a knowledge of the truth. So why are so many doctors, Christian as well as non-Christian, opposed to this development?

Many patients and potential patients argue, cynically, that doctors object to it because they have things they want to hide. There may be a grain of truth in that contention, but it is very far from being the main reason. There are, in fact, very serious objections to patients seeing their medical records.

The paramount consideration must surely be: What is best for patients? Is it in their interest to see their medical records? There are two separate issues here. The first is: Is the patient better off knowing the whole truth – so far as it is known by the doctor? The second is: Is it advantageous for the patient to see the doctor's actual notes, with their symbols, abbreviations, impressions and conjectures? Let us look at these two issues in turn.

Is the patient better off knowing the truth? In general, the answer must be: Yes. Polls have shown that the majority of those who are healthy want this. This does not, however, apply to those who are seriously ill. A survey of 74 patients in a malignant disease unit in Aberdeen showed that only 15% wished to have the diagnosis and prognosis confirmed by the doctor.[1]

"The paramount consideration must surely be: What is best for patients? Is it in their interest to see their medical records?"

After 40 years in medical practice, as well as experience as a patient, I am convinced that it is not always best for patients to be told the whole of the truth. One reason is that the doctor can rarely predict the future accurately, and his prognosis is not infrequently far too gloomy. I can quote an example of this from my own family. A relative of mine had a very high blood pressure for the last 20 years of her life, and developed leukaemia five years before her death. Although she wanted to know the results of her tests, she was never told about either of these diagnoses. I am sure this was the right decision. Knowledge of her high blood pressure would have alarmed her with the constant anticipation of the stroke which she dreaded, and which finally ended her life at the age of 92. Knowledge that she had leukaemia would have worried her even more; though, in fact, it never caused her any trouble. Prognosis is an imprecise art. Many patients, alas, have no hope of immortality; and for many of them, prediction of a fatal or incapacitating illness would cause an unnecessarily dark shadow over the last stage of life.

I once heard an experienced psychiatrist state that no one could face the truth about themselves all at once. A wise doctor can lead the patient to it by degrees. For instance, I frequently had patients who needed cardiac surgery, but were terrified by the prospect of it. In my letter to the referring doctor, I might say: 'This patient is going to need a valve replacement in the near future.' But to the patient, I would often say: 'Of course, you don't need an operation at the present time'; and he would go away happy with his medical treatment. When he returned for review three or six months later, he might raise the subject of an operation himself. 'What about that operation you mentioned the last time I saw you? Do you think it would help me?' Before long, he would be pressing for it!

It is interesting that, according to an authoritative Jewish interpretation of medical ethics, 'a fatal diagnosis should never be divulged to the patient unless the doctor and/or family are reasonably confident that, far from causing mental anguish or a physical set-back, such information is likely to relieve the patient through the knowledge that his suffering is coming to an end. While the patient should always be informed of treatments or procedures to be applied, both as a matter of respecting his rights and to secure his co-operation, his prior consent is

required, and should be sought, only in cases of high risk treatments or doubtful or experimental cures, or differences of opinion among equally competent medical experts.'[2] This attitude is supported in their view by the message Elisha sent to the ailing king Ben-Hadad through Hazael, as recorded in 2 Kings, chapter 8, verse 10: 'Go and say to him "You will certainly recover"; but the Lord has revealed to me that he will, in fact, die.'

What then of the second question? Would it be a help for the patient to see the doctor's actual notes? Most medical records contain symbols and abbreviations which are completely meaningless to the layman. Moreover, no glossary could make them intelligible, because the symbols differ from one specialty to another. For example, MS to a heart specialist means mitral stenosis – a narrowing of a heart valve; but to a general physician or neurologist, it might stand for multiple sclerosis – a disease of the nervous system. The symbols and abbreviations would have to be explained.

Another problem is that common medical terms are misunderstood by lay people. For example, 'heart failure' sounds ominous to a layman, but to a doctor it is a broad category including some patients who, following treatment, will remain in perfect health for twenty years or more. Again, the patient reading his notes would sometimes come across abnormalities about which he had not been told, and would inevitably feel that the doctor had not been frank with him. For example, many healthy people have an intermittent irregularity of the heart of which they are blissfully unaware. As a rule, it is best that they should remain in ignorance of it, because once they know they have it, they tend to worry about it, however much they are reassured.

"After 40 years in medical practice, as well as experience as a patient, I am convinced that it is not always best for patients to be told the whole of the truth."

A further point, which is not generally appreciated, is that the patient's medical record is a great deal more than a mere collection of facts. It is also the doctor's rough note-book; his *aide memoire*. In addition to facts, it contains deductions, a list of possible diagnoses and alternative plans for action. Many of the comments are tentative and provisional. They include serious diseases which must be considered as a possibility at an early stage of the illness but which, in most cases, can be ruled out later. The danger is – and it is a very real one – that when patients see these diagnoses in black and white, they fear that they may be true, in spite of the doctor's categorical reassurance.[3]

For example, a patient may come to the doctor complaining of backache. He may have lifted a heavy piece of furniture a couple of weeks previously, and the resultant pain has persisted and prevented him from going to his work. If he has never had any trouble with his back before, far and away the most likely diagnosis is a traumatic disorder of the musculo-skeletal system; 'wrenching a muscle' or 'slipping a disc'. But there are other possibilities; some of them serious; all of them remote. The doctor jots them down, so as not to overlook them. Supposing the patient had a recurrence of the trouble, and thought it would be interesting to see what the doctor diagnosed on the previous occasion. He gets a copy of his records, and sees that one of the possibilities in the doctor's mind was cancer. What would he think? There is no doubt that some patients would be very worried; even if the diagnosis had been excluded on that occasion. Whenever the pain recurred, they might think: 'I wonder if it really is cancer?'; and they would be made anxious quite unnecessarily.

Some sort of private, rough note-book is essential to a doctor's work. He needs somewhere where he can record candid, uninhibited impressions, comments, speculations and reminders. If the doctor knew the patient would be allowed access to his notes, two things would happen. Firstly, the notes would cease to be frank; comments likely to be misunderstood would be excluded. Secondly, and inevitably, he would resort to keeping a second set of notes for his eye only; with all the inconvenience and possibility of confusion that this would involve. Letters between general practitioners and hospital consultants would cease to be a free expression of fact and opinion. Sensitive material would be communicated orally, with the danger that it would be misunderstood, forgotten or attached to the wrong patient.

Many patients and potential patients want to take a greater responsibility for their own health, and they want to have all the information available to enable them to do this. This is right. They know that doctors sometimes fail to provide them with important information and may make inaccurate entries in their medical records. This is true. They think that by insisting on seeing their records they would avoid these problems. This is a mistake. Patients would be overloaded with information, which their doctors would need to explain. This would take up a considerable amount of his time, particularly in cases involving specialist consultation. As a result, the backlog of new patients waiting to be examined and treated would inevitably increase.

There is a case for patients being allowed to have a statement of the facts contained in their medical records – if they really wish this. But the doctor's a*ide memoire* should remain confidential – in the patients' interest as much as the doctors'. Doctors undoubtedly need to improve their record keeping, and to be prepared to spend more time in consultation with the patient.

Notes

1. J. McIntosh, 1976, 'Patients' awareness and desire for information about diagnosed but undisclosed malignant disease', *Lancet*, ii, 300-303.
2. I. Jacobovits, 1983, in *Consent in Medicine: convergence and divergence in tradition*, G. R. Dunstan, and M. J. Seller, (eds.), London.
3. D. Short, 1986, 'Some consequences of granting patients access to consultant's records', *Lancet*, i, 1316-1318.

Persuading Pagans

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There grows in Britain today an increasingly vociferous objection to such current and contemplated medical practices as abortion, experiments on human embryos, euthanasia for the old and infanticide for the handicapped newborn. Their advocates are roundly condemned, and the morality underlying their advocacy rejected outright. Much of this opposition is led by Christians, driven by moral convictions arising from their religion, who express their concern in the influential activities of well-organised and highly-motivated pressure groups. That concern is also manifest in the appearance of journals such as this. *Ethics & Medicine* has as its declared aim the 'development of a Christian mind on the challenges posed to society by medical advances'. It takes as its subtitle *A Christian Perspective*, and over several years has considered the practices listed above from within this framework.

A Christian perspective implies as a starting point, a set of premises, which are common to Christians and serve to identify them as such. They include acceptance of the authority of the Bible as a record of historical events and as an exposition of the values and commitments which constitute Christianity. From these premises, arguments are developed to demonstrate the objectionable nature of abortion, infanticide and the like. Recent papers in this journal serve as examples. There can be little substantial doubt of the validity of these arguments. However, as any first year logic student knows, it is quite possible to accept an argument as valid, but to reject its conclusion, by rejecting the premises from which the argument proceeds. No amount of argument to the immorality of abortion from within the Christian perspective will convince one who rejects that perspective and the basic premises it involves. The very term 'perspective' is illuminating here, suggesting, as it does, the possibility of looking at the same object from some other direction, from a different 'point of view' – a feminist perspective perhaps, or a Hindu perspective, a Moslem perspective, each with its own initial premises and each yielding different conclusions. The biggest problem facing the Christian moralist today is not the demonstration of the Christian position on this practice or that, but the demonstration of the relevance of the Christian position to non-Christians. It is all very well to convince the fellow-Christian of the immorality of abortion or infanticide, but it is not enough, and is increasingly peripheral to our ever more secular society. The central concern is to convince the non-Christian: to persuade, if you like, the pagans.

Two questions arise. Firstly, why is it incumbent upon the Christian to convince the non-Christian? And secondly, how is it to be done? In answer to the first we should note that study of our society's past reveals, over the last millenium or so, an increasing separation of Church and State, while study of its present reveals its irreversibly pluralist nature. We, the British in the late twentieth century, are Christians, yes, but we are also Moslems, Jews, Buddhists, Hindus, Sikhs, Rastafarians, and more. Increasingly, too, we are pagans, rejecting Christianity and embracing no alternative. It is the growth of this last class that should alarm the Christian most of all, for the other religions generate principles and prohibitions similar to those of Christianity, and often pursued more strictly, but the lapsed Christian, the agnostic or atheist, frequently falls into a moral vacuum with no coherent moral outlook and no governing concern other than expediency. More challenging still is the articulate pagan, who is often more deliberative than the average Christian, and comes armed with non-Christian and anti-Christian arguments, be they feminist, humanist, socialist or some cocktail therefrom.

I use the term 'pagan' advisedly, for its etymology is revealing. The Latin paganus denotes a citizen, a member of society. It was only with the coming of Tertullian and Augustine that it took on its pejorative overtones, referring not simply to a citizen, but to a primitive, unenlightened citizen; a heathen. Such dismissive belittlement is nowadays both inappropriate and ineffective for pagans (meaning, simply, non-Christian citizens) abound, they have power and they deserve respect. Nor do they deserve respect merely because they have power, but because they are citizens, with all the status, duties and rights that title implies. The problem for the Christian moralist is essentially a political one: what place is there for Christian moral teachings in a liberal pluralist democracy? The society in which he finds himself has a basis in a political theory which is divorced from and at times hostile to the premises underlying a Christian society. While it is undeniably true that the whole notion of a modern liberal democracy has arisen historically from Christian thought, and in doing so has adopted and secularised many Christian presuppositions, it is equally undeniable that democracy and Christian society are not the same thing. Witness the spread of the democratic structure of government to India, Israel, and beyond: witness also the lack of democracy in many countries where the Christian church has more influence than our own, such as the Latin American dictatorships.

The essence of democracy is two-fold. In the first place, sovereign power resides in the hands of the people, the citizens, and is expressed via their elected representatives; and, secondly, all citizens are treated equally, each counting for one and none counting for more than one in both the expression of that sovereign power at election time, and the claims upon it for the protection of rights. Non-Christians of all political and religious complexions are counted equal with Christians; all are citizens with equal rights and claims upon the state and equal say in the state's activities. Modern democracy may be an institution historically impossible without Christianity, but it is now independent of it. Without a thorough appreciation of that fact Christian moralists end up either by preaching to the converted, their voices dismissed by the non-Christian mass as so much irritating background noise, or by advocating the imposition, by legislation, of Christian values upon non-Christians, thereby rejecting their claim to equal political status and representation. The former course is unproductive and insular, but the latter is worse for it is not just anti-democratic but totalitarian.

The first question above is now answered: the Christian committed to both democracy and the truth of his moral judgements has no choice other than to do his utmost to convince the non-Christian that those judgements bind him too. To do less is to accept practices Christianity finds repugnant; to do more is to renounce democracy. Now to the second question. If convince

the non-Christian he must, how is he to set about it? The immediate answer is clear enough, namely, to inform the ignorant, persuade the doubters, and debate with those opposed, through the use of reasoned argument. But all arguments must stop (or start) somewhere, and the Christian principles grounded in the Bible are the unargued premises from which the Christian attempts to derive his conclusions. These premises, however, cannot be fully justified by reason alone. To accept them requires an act of faith, a commitment not wholly governed by rational concerns. If reason alone could generate the Christian's premises, there would be no need for faith, and indeed no room for it, and the conclusions derived thereby would not be characteristically Christian. Both elements, reason and faith, are required; they combine together to produce the Christian perspective. If we grant that reason is shared by both Christian and non-Christian alike, so that the principles of rational argument are equally binding on both, we are left to conclude that faith, or lack of it, is the feature distinguishing them and distinguishing their attitude to the matters in hand. The non-Christian disagrees with the Christian's stand against abortion precisely because he does not share the Christian's faith in his starting point, his basic premises. It is pointless for the Christian to cite Scripture if his opponent rejects the Bible as valid authority, and pointless too to present theological argument about the time of ensoulment to one who denies the existence of the soul. No such arguments can reach the consistent non-Christian. In debate, therefore, the Christian is thrust on to the defensive by calls for justification of the premises his opponent rejects. He is required to argue for that for which there can ultimately be no arguing. In the wider debate an appeal for faith too readily invites a blunt rejection and an end to further argument.

Thus a dilemma arises: the Christian who seeks to persuade his opponent of, say, the immorality of abortion, must either instil faith in him, or he must use a rational argument which forgoes all reference to faith. He cannot do something in between and present as rational argument an account studded with articles of faith which lack independent justification, for the astute non-Christian will simply pick these out and dismiss them, concluding that the whole argument collapses. There is an unappealing choice, then, between evangelism with the concomitant transfer of emphasis away from the specific issues under discussion, and recourse to apparently pallid, faithless rationality, devoid of all characteristically Christian qualities.

Those who find such a dilemma disturbing will take comfort from Aquinas, whose theological and philosophical work, as expressed in the Summa Theo*logica*, is structured round the thesis that non-Christian rationality *can* yield a coherent and wholly admirable set of conclusions about how we should order our lives. Aquinas himself noted that appeals to authority are appropriate forms of argument in sacred teaching, where both teacher and taught share a common faith in the veracity of the authority concerned, but are the weakest form of reasoning in philosophy, where no such faith is presumed and all that is shared is acceptance of the principles of rational argument. The task Aquinas set himself was to accommodate the non-Christian (because *pre*-Christian) rationality of the Greeks, and most notably Aristotle, with the characteristically Christian values affirmed by the early church fathers. What this meant in moral philosophy was the integration of two lists of virtues, on one hand the Aristotelian, equally accessible to anyone who used reasoned argument, whether Christian or not; and on the other that specific to the Christians. Aquinas presented a modified version of Aristotle's list which featured, cardinally, prudence, temperance, justice and fortitude. These he termed the natural virtues, to be contrasted with the supernatural or theological virtues of faith, hope and charity. A life lived to the best expression of the natural virtues, that is, in accordance with the virtues recognised by rationality alone, was, for Aquinas as well as for Aristotle, the Good Life. One who lived such a life could truly be said to flourish to the fullest extent possible in a strictly temporal sense. However, spiritual flourishing, the approach of the soul to God, requires something else, the superimposition of the theological virtues on to the Good Life, although not in a way that modifies substantially the nature of the Good Life itself. It is as if the natural virtues delineate a kind of moral map which indicates the shape of the shoreline, the configurations of roads and rivers and the sites of cities. This map is adequate for navigation as we go about in our daily life, and it indicates the dangerous areas to be avoided, the deserts and quicksands; but it is limited to two dimensions. It reveals nothing about heights or depths, mountains, hills, or valleys. Representation of the third dimension, the spiritual aspect, is absent. We do not know in which direction to move to approach God, who lives in the heights, for we do not know where the heights are or which way is up. We can, however, get a better version of the map, complete with contours, by using the theological virtues in our map-making. It will not show the rivers or cities in different places, but it will show how best to move towards the spiritual high ground. Pagans, in rejecting map-making techniques which involve the theological virtue of faith, are committed to the two-dimensional map at best. They may not be able to join the Christian in his moral mountaineering – they may not wish to – but this does not preclude them using the two-dimensional version of the Christian's map to avoid the dangerous areas and forbidden zones with the full approval, indeed the help, of the Christian. The layout of the world that is represented in the map is, according to Aquinas, determined by God according to his Eternal Law. Natural Law is the layout and working of the world as interpreted by the human mind, using the map-making techniques common to all people by virtue of their rationality. Positive Law is the man-made attempt by any given society to enact the provisions of Natural Law by legislation.

Aquinas held to the view that non-Christians were subject to the demands of Natural Law no less than Christians, and furthermore that those demands are equally accessible to Christians and non-Christians alike, because nothing more than that essentially human attribute, rationality, is necessary to discover what they are. Christians, however, are supplied with a map showing an extra dimension, and so have a better view of the true nature of the Eternal Law of God. Only they can use that map to draw closer to him, the architect of the universe.

The practical implication for the Christian in an increasingly pagan world is clear. Argument about practices conducted by and on behalf of society at large is best confined to two dimensions, even though the Christian protagonist is equipped with the knowledge of a third. Difficult it may be, but what the Christian must do is to forgo mention of faith (even though it may sustain him) and dispassionately explore those arguments with which he is faced to point out their contradictions, implausibilities and defects in reason: and, more difficult still, he is also required to justify his own position, again solely by appropriate use of the irresistible force of reason. Only in this way can he ever be on the offensive and hope to win, in the battle for the mind, if not the heart, of his pagan opponent.

To return, finally, to etymology. The Latin pagan*us* was generally contrasted with *miles*, meaning soldier. Early Christians

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Medicine and the Bible.
Bernard Palmer (ed.)
Published for the Christian Medical Fellowship by the Paternoster Press, Exeter, 1986, 272 pp., paperback, £7.95,
ISBN 0 85364 423 3

This book is the third in a trilogy produced for CMF; the other two are Decision Making in Medicine, 1979 and The Influence of Christians in Medicine, 1984. It is nice to have the series but this book stands on its own and can be read independently. It is an important contribution to the minefield of medical ethics, upholding a conservative evangelical stance. The book is designed for reference. Whole chapters can be taken independently as each deals with an encapsulated subject. It is aimed at the caring professions but in the introduction the editor states that it will appeal to Bible expositors, teachers and researchers, and to all who see in the Bible a precept for living in the confused social climate of the 1980s. The chapters have notes and some also have bibliographies which are a source of further resource material. Each chapter is written by a separate author, a recognised expert in the field. There is therefore non-uniformity of style and presentation and also there is some repetition, but the whole book is authoritative, well written and readable.

One can divide the book into two parts. The first, and perhaps more scholarly section, deals with medicine in Old Testament and New Testament times together with two chapters on interpretative problems arising from the Bible. These are the purpose of the Levitical Code and the nature of the Biblical leprosy. The second section deals with medical and ethical matters in the light of Biblical principles and is therefore more practical.

Donald Wiseman draws on his great knowledge of the Old Testament World to produce a most valuable and fascinating account of medicine in those times. He looks not only at Israel but also Egypt and Mesopotamia, drawing interesting comparisons. Colin Hemer's contribution on Medicine in the New Testament World is a tour de force, beautifully written, well researched and intellectually stimulating. He discusses medicine and healing after an introduction on Greek and Jewish medical practice. He then proceeds to investigate the healing miracles. Then, most helpfully, he looks at the virgin birth, crucifixion death, burial and resurrection of Christ. He even explores Paul's thorn in the flesh. These 2 chapters are particularly well annotated. One only has minor quibbles with some medical interpretation, *e.g.* whether a man (Christ) could cry out if he had fractured ribs.

The chapter on the Levitical Code is smaller being a very specific subject. Averell Darling's discussion on diet, delivery, discharges, death and dermatitis is neat and the conclusion, that the code was primarily for holiness, convincing. It was good to learn the origin of quarantine (p. 86).

The late Stanley Browne's contribution on Leprosy in the Bible is masterly, as would be expected from the W.H.O. expert on the disease. It is thorough, detailed and most helpful. It is quite clear that biblical leprosy is not the disease we recognise as leprosy today. He argues the case medically and etymologically. He also underlines the difficulties translators have in finding suitable words to use other than leprosy in modern versions.

The second section has five chapters occupying slightly less than half the book. The first of these deals with the Value of Human Life. In particular it looks at life at the beginning and especially at the problem of abortion, biblically, medically and legally. Euthanasia merits only a brief mention in David Millar's chapter, but then he is a consultant obstetrician and gynaecologist.

Richard Winter's contribution on Homosexuality is well-balanced and sensible. It looks at the subject historically before turning to ethical and medico-legal discussion. He proceeds to outline Christian viewpoints on a broad front, including the Gay Christian Movement, before taking a biblical stance.

The chapter on Demon Possession by consultant psychiatrist Andrew Sims is timely and provides a warning to the inexperienced in recognising and handling cases of apparent possession. The naive should not meddle in the occult. This and the following contribution on Healing may upset some at the 'charismatic' wing of Christian practice. That is not the intention; sensible counsel is offered.

Roger Hurding's chapter duplicates some of Colin Hemer's thorough paper in, for instance, derivation of words from the Greek and some New Testament miracles. It then moves on to the history of healing right up to modern times, and includes the debate (division?) between the reformed and charismatic viewpoints.

The final chapter is on Conscience and Modern Medicine. It is by Douglas Jackson who has written well previously on the sanctity of life. He discusses biblical views of conscience before looking at Freudian and Humanist ideas. After that, some dilemmas in medical practice are discussed perhaps too briefly for satisfaction.

It is a shame that AIDS is mentioned only once and then in connection with contact with the dead (p. 95) and not in discussion of the infectivity of seminal discharges (p. 53). It is not featured at all in the chapter on Homosexuality. This is a reflection on the pace of development in these times and on the rapidity of the dissemination of knowledge. When these chapters were written two or three years ago, AIDS was not headline news.

The Index is sparse. For instance, fibroids, hepatitis and alcoholism are in the text but not the Index, whereas poliomyelitis, osteomyelitis and paranoia are in both.

However, the notes are more than ample compensation. There are again individual variations. Wiseman has 184 notes and Darling only five. Wiseman uses capitals for his bibliography, Hurding does not. There are also differences in the use of abbreviations, e.g. British Medical Journal in full but JSNT and BJRL are not. References are up to 1985 apart from one cross-reference with the book (1986). The notes section is helpfully headed with the page numbers in the text which makes for easy reference.

There are some typographical errors, including an amusing neologism, 'ophthalmophagia' (for ophthalmoplegia) on p. 29.

These errors and criticisms are minor and could perhaps be improved by tighter editing. Bernard Palmer has, however, allowed his contributors to retain their personalities and individual expression. A second edition, updated, could iron out the errors.

The book is in paperback but well bound and not expensive. It is certainly a valuable reference source and an important source of information, and will be a most useful resource book in ethical debate and discussion.

David Vernon

Human Embryo Research: Yes or No?
The CIBA Foundation,
Tavistock Publications, 1986, 232 pp., paperback,
ISBN 0 422 60600 6

Human Embryo Research: Yes or No? is a collection of ten papers which were presented in November 1985 to a study group whose aim was 'to clarify the scientific issues (in embryo research) for non-specialist readers and ... indicate(s) where medical research could benefit from the use of early human embryos and where such research might not be justified'. The contributors were drawn from the world of science and medicine along with representatives of the law, moral philosophy and theology. Each paper was followed by a brief discussion of issues raised.

Dr Anne McLaren immediately confronts us with a crucial issue of definition in her paper 'Prelude to Embryogenesis'. The term 'embryo', she argues, is a misnomer for the conceptus prior to implantation; thus she advocates the term 'pre-embryo' as more fitting. According to Dr McLaren, it is only 16 days after fertilisation that we are dealing with a spatially defined entity that can develop into a fetus and thence into

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a baby; thus she argues, the life of the individual commences at implantation.

It is easy to see why those who favour research would sympathise with such a definition: once this artificial divide is established, it is all the easier to treat the conceptus as a 'thing' without the uncomfortable human connotations implicit in the term embryo. It is a weakness of the papers as a whole that only one of the participants came near to challenging this view in the subsequent debate.

Chapter three examines the uses of IVF (applicable to about 18% of all infertile couples) and embryo research for relief of the infertile. In chapter four, Professor Edwards addresses the clinical aspects of IVF. He looks at the weaknesses of present techniques and shows where more research would benefit the practice of IVF. When questioned about research, Professor Edwards admits that there are non-invasive procedures, but 'it would be enormously advantageous to be able to study the embryo experimentally rather than having to replace it'.

In their paper on 'The Use of Human pre-Embryos for Infertility Research', Braude, Bolton and Johnson describe in detail the use of the conceptus in a) understanding male fertility; b) improving IVF as a therapeutic technique; c) investigating early pregnancy loss. When we look at the justification offered by the authors for their research on human embryos, ethics gives way to chilling pragmatism in which ends such as 'achieving a pregnancy' or simply 'research for its own sake' are supreme. The authors draw the net so wide that in practice this leaves them a carte blanche: 'A complete prohibition on research precludes not only obvious and calculable benefits but also the possibility of unenvisaged future benefits ...' How do they validate such a liberal attitude? The answer is revealing: 'We would not be asking the question raised in the symposium if no research had been done on human pre-embryos created for research purposes'. In other words, each step is used to justify the next.

Chapter six summarises present knowledge about the molecular defects of genetic disease which give rise to congenital malformation. This is followed by a prognosis of those areas linked with genetic disease likely to benefit from embryo research in the next five or ten years. Bob Williamson highlights single gene defects as a likely area (*e.g.* polydactyly) which it may be possible to find and 'switch off'. However, in his estimate of the time limit necessary for such work, he says, 'organogenesis ... for the most part occurs at between fourteen and twenty-eight days of embryonic development. It is this area of research which is central to the understanding of congenital malformation, which in my view would be most inhibited were a strict fourteen day rule to be implemented'. Once again, ethics are just a by-product of scientific 'necessity': 'to place laws around scientific experimentation could make it more difficult to use techniques of molecular genetics and reduce human handicap and illness'.

In their paper on contraception, Aitken and Lincoln argue the need for human embryos to test agents for their ability to block human IVF or check the quality of a resulting embryo. Finally, in chapter nine comes the long awaited general discussion on the status of the pre-embryo. It is disappointing. Some interesting points are raised but no one seems prepared to ask questions about the value or nature of the embryo. One wonders why the discussion was included at all.

In chapter ten, Mr Hawthorn asks 'Is there a consensus on morality?' If not, how do we establish nationwide ethical guidelines? Professor Bowker's paper gives an interesting account of the attitude to embryo research of the world's major religions. He shows how, in general, each major religion is associated with a particular anthropology which in turn affects the way the embryo is viewed.

In the final paper, Bernard Williams looks at some of the moral arguments against embryo research. He argues that they all stem from some form of 'slippery slope' fear which is, in fact, misguided. Society can in practice draw a line which, whilst it may not be reasonable in itself, is a reasonable thing to do and sufficient to prevent the much feared consequences from ensuing. However, Professor Williams is wrong to state that all those who oppose research are concerned solely with slippery slopes; a Christian view which sees God as the Creator of human life must recognise an absolute difference between man and the surrounding animal world by virtue of our ability to have a personal – and eternal – relationship with that Creator. Thus one can legitimately claim protection for all members of the human species.

One must conclude that the title of this series of papers is rather misleading. They offer not so much a discussion of the issues at hand as a rather technical account of the advantages of embryo research. The ethical component provides a gloss of respectability on a debate in which scientific terminology is used freely and in which the non scientists are clearly at a disadvantage. Some of the papers would be heavy-going for the lay person with no prior knowledge. However, there is a helpful synopsis of the contents of each paper printed at the head of each chapter, with a glossary of terms at the end of the book.

Jane Mellor

A Child at any Cost? The Secret Pain of Infertility.

Mary Mealyea,
Kingsway Publications Ltd., 1987, 160 pp., £2.25,
ISBN 0 86065 450 8

This is a very personal account written with great honesty, openness and realism. It explores the hurts and griefs suffered by infertile couples – who account for 10% of all marriages in the U.K. By tracing her own spiritual and emotional travail in undergoing the whole gamut of infertility tests, Mary Mealyea identifies many of the subtle and hidden guilts and fears that childless couples endure. From her own medical expertise as a doctor, she is able to give valuable information about the various probable causes of infertility and the kinds of medical help available. She also sensibly examines the ethical questions of how Christians should approach the new techniques available today through, for example, IVF. No two situations are the same and this book is not an identikit for the childless woman, but for those who pray and long for a child it could be a real source of practical help and comfort. Written from a mature and balanced Christian perspective, it would nevertheless be extremely useful for those of no faith, as well as for those who struggle to understand and grasp God's will for them in the isolating circumstances of childlessness. I wholeheartedly recommend that pastors, counsellors and medics give this book their serious consideration. At a mere £2.25, its 160 pages easily digested, it will afford much help in understanding the emotional trauma this problem produces in any marriage.

Ann Allen

The Foetus as Transplant Donor. Scientific, Social and Ethical Perspectives.

Peter McCullagh, Wiley Medical Publication, Chichester,
1987, 215 pp., £25.

The publication of this major study is particularly timely, in the light of the gathering storm over the transplant of fetal brain cells. It represents a comprehensive assessment of the state of discussion and practice, within an ethical framework which readers of *Ethics and Medicine* will find stimulating.

Dr McCullagh writes from the Department of Immunology of the Australian National University at Canberra, and his name will already be known in Britain as well as elsewhere since he has been quoted in more than one recent public controversy. He surveys the history of fetal experimentation and the various government bodies which have reported thereon, and then runs through every area in which fetal tissue has been used for experimental and transplant purposes.

A central section is that on 'The Foetal Donor'. Two chapters are covered here. One addresses the 'Status of the Human Foetus *ex utero*: Its Implications for Use of the Foetus in transplantation'. The second discusses 'Foetal Sentience'. 'Many will find discussion of the survival of live, pre-viable human foetuses *ex utero* an uncomfortable topic', writes McCullagh (p. 104). Yet when they have not died in the womb, pre-viable foetuses delivered by spontaneous or induced abortion will be delivered alive. So (he writes) in terms of the Infant Life (Preserva-

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tion) Act of 1929, the criterion of 'capable of being born alive' would 'encompass foetuses of any gestational age'. Thus in two reported series of fetuses of a wide range of gestational ages, the average time taken for heart activity to cease was around three hours (p. 103).

It is in this chapter on 'Foetal Sentience' that Dr McCullagh makes his most telling comments:

> A foetus selected as a transplant donor will be exposed to noxious stimuli capable of evoking pain in the process of termination and extraction from the uterus. In the absence of adequate foetal anaesthesia (which is likely to require the maintenance of substantially higher levels of *maternal* anaesthesia than that necessitated by maternal considerations) the stimuli associated with procedures such as surgical or suction dismemberment or the generalized spasm of smooth muscle in response to prostaglandin will unarguably be noxious. Additionally . . . the very specific requirements for freshness if tissue is to be transplanted will necessarily direct preference towards termination techniques which minimize the likelihood of foetal death appreciably in advance of expulsion. Misapplication of the adult criteria of death . . . is likely to render the donor liable to surgical intervention at a stage when sentience remains, perhaps partly diminished by hypothermia.
>
> I believe the consistent application of the general approach outlined earlier in this chapter to evaluation of sentience in subjects of any species or stage of development incapable of communication will inevitably raise the likelihood that the first trimester foetus has started to acquire sentient capacity perhaps as early as six weeks, certainly by nine or ten weeks of gestation.

He concludes the chapter thus:

> The significantly deferred development of regulatory structures capable of 'closing the gate' to perception of pain implies that the first trimester foetus may be more susceptible to pain than slightly older subjects. These possibilities carry varying degrees of likelihood at different gestational ages. However, it is surely inherent in any acknowledgement that the gratuitous infliction of pain on a sentient creature is unethical to allow that the burden of proof in the case of any subject devolves upon those claiming that sentience is absent. If this is not allowed, one is effectively denying the right to protection of non-communicating sentient subjects of any species. This would unquestionably be a retrogressive step. (pp. 131, 2)

These cool tones are characteristic of this extremely readable but equally scholarly work, and they give its most unpleasant arguments a credibility which other kinds of treatment would deny them. It is much to be hoped that the price and seemingly specialist interest will not prevent this most important book from receiving wide notice. Any intelligent lay participant in the debate about medical ethics should try to see a copy. For doctors and medical students it is surely compulsory reading. Start saving up now!

Nigel M. de S. Cameron

Should the Baby Live? The Problem of Handicapped Infants.
Helga Kuhse and Peter Singer,
Oxford University Press, 1985, x + 228 pp., £3.95

Those who know the names of Kuhse and Singer might surmise they knew the answer to the question posed in the title without reading the book, and, alas, they would be right. The authors do not keep the reader waiting long. The Preface begins as follows: 'This book contains conclusions which some readers will find disturbing. We think that some infants with severe disabilities should be killed'.

The reason the Preface is so blunt is that it is intended to reassure the reader who might jump – from 'a hasty reading of our book' – to the conclusion that the views of the writers imply 'a lack of concern for disabled people in our community'. Far from it: 'affluent nations should be spending far more than they presently allocate to assist disabled people'. Well, perhaps. But the question is not whether Kuhse and Singer are sincere: it is whether their logic holds. 'It is one thing to say, before a life has properly begun, that such a life should not be lived; it is quite different to say that, once a life is being lived, we need not do our best to improve it. We are sometimes prepared to say the former: we are never prepared to say the latter.' These are of course different things, but so much turns on their distinction that it needs to be closely examined. The reader of *Should the Baby Live?* will need to have his eyes kept wide open. And, here in the preface already, we are meeting the weasel phenomenon of language used to obscure rather than express meaning. For one thing, how many questions are begged by speaking of a life that has not 'properly begun'? According to biology, law and the ethics of a hundred generations of medicine it has begun with every appearance of propriety.

Of course, this is the fundamental issue. Kuhse and Singer do not shirk it. They confront the ancient principle of the sanctity of human life, and they reject it. They argue that it can be maintained only on particular religious presuppositions, that in a secular and pluralistic society we must be freed from such particular religious-ethical regulations, and that in its place some other criterion must be employed to decide when killing is wrong and when it is right. The sanctity-of-life position depends upon the confusion of 'member of *Homo sapiens*' with the kind of 'morally relevant characteristics' that we generally associate with 'humanness', but which are in fact absent in the cases of certain biological humans: either because they have not yet developed them, or because they are deformed. 'Since the boundary of our species does not run in tandem with the possession of the morally significant capacities, the species boundary cannot be used as the basis for important moral distinctions' (p. 123).

This kind of argument raises a series of objections. Who says what is 'morally relevant'? Is it not relevant that this human being and that are either immature or handicapped members of this same species which typically and in maturity produces all the capacities of which writers like Kuhse and Singer make so much? And so on.

What cannot be denied is that there is a candour and a freshness in a book like *Should the Baby Live?* that one seeks in vain in most apologies for the new medicine and its values. Here we have an open breach with the tradition, a vaunting of deep-seated disagreement with the sanctity of life, and an enthusiastic welcome for standards which would be disowned by most medical practitioners even today. But this is not an exercise in science-fiction, it is the work of two of the high priests of the new ethics. Reading Singer and Kuhse's chilling prose is an obligation if we are to engage the brave new world.

Nigel M. de S. Cameron

(continued from page 29)

saw themselves as *milites*, soldiers for Christ, opposed to the mass of pagan citizens about them, with whom their conflict was all too brutally physical. The conflict today is verbal and philosophical, but no less fierce, and the modern Christian *miles* needs a weapon. His faith is his shield, effective in defence against the persuasive power of pagan arguments. It can rebuff and deflect their blows, but it is of limited value in striking back, and its deployment commits the bearer to a posture unsuitable for attack. It needs to be supplemented by an offensive weapon. Polemic suggests itself, and it has its uses, though they are few. It is a bludgeon of an instrument, effective at times when in strong hands, but generally crude and awkward. The rapier of reason, wielded well, is much the better choice. It is flexible, lethal, and can seek out the chinks in the opposition's armour.

Quality and Life: A Christian Perspective

a symposium
on the ethics of resources in health care

Saturday November 12th, 1988
10.30 a.m. to 4.00 p.m.

Royal College of Physicians
9 Queen Street, Edinburgh, EH2

Chairman:

Dr George L. Chalmers, *Consultant in Administrative Charge, Glasgow East District Geriatrics Service.*

Contributors:

Luke Gormally, *Director, Linacre Centre, London.*
Dr Richard Higginson, *Tutor in Ethics, Cranmer Hall, St John's College, Durham.*
J. Douglas Hague, *General Manager, Northern Regional Health Authority.*
Professor Alan Maynard, *Centre for Health Economics, University of York.*
Dr Murdoch Murchison, *Chief Administrative Medical Officer, Grampian Health Board.*

Subjects include:

The QALY measure: a critique of its presuppositions and uses
Love, Justice and the Allocation of Resources
Is it Ethical to be Efficient?
Health Service Priorities

How should we best allocate resources in medicine? Medicine has helped raise life expectancy. Advances in many areas of medicine have helped feed the steadily rising cost of medical technology. Yet growth may not be unlimited. As more resources are constantly in demand, fewer may actually be on offer. Doctors, administrators and politicians are asking increasingly systematic questions about health care spending priorities.

Yet this debate is taking place in a society shorn of the moral consensus bequeathed by the Christian tradition. The old certainties of life and death are certain no more, and it has been argued that the values of western medicine have never been in a state less fitted to answering these new and fundamental questions. In place of the stress on the sanctity of life, ideas of 'quality' are now at the centre of discussion.

In this Symposium we shall seek a Christian understanding of the debate about resource allocation.

Booking Fees : Normal £24, to include light refreshments and lunch. Reduced Fees: Ministers and retired persons: £14; Full time students (including light refreshments only): £8. Please make cheques payable to Rutherford House. N.B. 50% refund on cancellations prior to Symposium

Space is strictly limited. Please book promptly by sending fee to: The Conference Secretary, Rutherford House, FREEPOST, Edinburgh, EH6 0JR.