Ethics & Medicine

A Christian Perspective

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E & M seeks 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 *E & M* is intended to draw together those with a common concern for a distinctively Christian approach to medical ethics.

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COMMENT

From the Editor

Is there a future for medicine?

Is there a future for medicine? Of course, it all depends on what we mean by 'medicine', but the question is not as facetious as it sounds. Medicine is part science, part art, a whole collection of disciplines. Yet its coherence and special character lie in something rather different: its system of values. Professionals in health care are united in their common calling to a uniquely ethical enterprise. Ever since Hippocrates this has been so. Trust, confidentiality, service, the interests of the patient – these are the by-words of our medical tradition.

For medicine as technique (whether ancient or modern) is but an adjunct to medicine as a vocation to care and to serve. That is why there can be medicine even where technique is primitive or limited; and why it is still recognisably the same enterprise when resources and technology are abundant. The essence of medicine, if we may so put it, lies not in the ability to care and cure, but in the determination to do so. At heart it is a matter of human values. Medicine can survive any crisis of resources and skills. The threat to its future lies elsewhere, in the crisis of our common values.

The problem is compounded since we are confused, for two things are happening at once. Technology is advancing rapidly, producing its own special problems in resources and their allocation. At the same time, values are in flux. The moral basis of our society is uncertain, and an ethical pluralism has taken the place of the ancient consensus. Whether or not we welcome this new pluralism, we cannot doubt that an historic change has altered the moral landscape of western society.

This point has been strikingly made by the American ethicist, Stanley Hauerwas, in his recent book[1], *Suffering Presence*, Hauerwas asks the fundamental question whether medicine can survive as a 'morally intelligible' discipline in the situation of moral anarchy in which we now find ourselves. The difficulty is that medicine has developed around its own values. Often they have not been articulated, and partly for this reason there are many who cannot see their significance. But the logic of medicine is not technical, it is moral. Shorn of its moral ground, what is left is mere technique; it is not really 'medicine' at all.

An illustration of this process lies in the development of techniques which have given us greatly improved information about fetal development and health. Ultra-sonic scanning is perhaps the most significant of them all. But why? What end are these techniques to serve? Ultra-sound was pioneered by the late Ian Donald, Professor of Midwifery in Glasgow, who in later years was distressed to find it employed in screening for possible termination of pregnancy.

The ambiguous status of the fetus (a person? a patient?) is now contributing to growing conflict between fetal and women's rights. On the one hand, we have liberal abortion; on the other, we know more about the health of the fetus, so the possibility of surgical and other intervention in the fetal interest grows. Yet we are perplexed to know how to weigh the relative interests of mother and baby. In a different form, the same issue has arisen in the United States: how much should maternal conduct during pregnancy be accountable in law?

In all of these cases, technology and the information it brings are playing a curious role. An impression is given at the most superficial level that technological change is itself responsible for the change in medical values: abnormal pregnancies are terminated since ultra-sound makes it possible to select them. Yet in fact it is not so simple. Technology is certainly forcing new choices upon us, and in so doing it probes and tests our values. Yet it does not provide its own. Since our generation has witnessed a shift in general moral values (from which medical values are derived), we are much less well able to face the ethical problems that result.

We may very well doubt whether any definable medical tradition will be able to re-emerge from the flux of moral pluralism. No doubt medicine will survive, for a time, as the caring, confidence-keeping enterprise we know, serving the interests of the patient; but the question will keep looming larger – where do those interests truly lie? And, who shall determine what they are?

In the Hippocratic tradition the answer to these questions has been short, but plain. The physician's responsibility extends to healing where possible, and, where it is not, to providing care and comfort as best he or she may. The sanctity-of-life ethic, with its caveat of 'first do no harm', leaves any other 'interests' of the patient out of account. The integrity of the patient's life is inviolable, and while this does not solve all the ethical problems (especially at a time when resources are under pressure) it firmly limits the number of questions which can be asked. The advent of liberal abortion, with its life-not-worth-living analogues in some paediatric and geriatric practice, has made every question proper, and in the process made decision-making much more complex for the conscientious professional.

The irony is that in a morally fragmented society it is only the sanctity-of-life ethic which can make consensus possible. For not only is this the voice of the religious-ethical tradition, it is the only reasonable resting-place of civil rights, human rights, patients' rights and respect-for-privacy arguments. The sanctity of life is the medical corollary of respect for the individual, the only basis for individual rights and dignity in a pluralist society. Perhaps, if it can be recovered, medicine will have a future. But it looks increasingly bleak. The triumph of medical technique would seem assured, yet the seamless dress of medical values is unravelling around it.

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1. Stanley Hauerwas, *Suffering Presence. Theological Reflections on Medicine, the Mentally Handicapped, and the Church*, Notre Dame, Indiana, 1986; Edinburgh, 1988.

The Unfinished Debate on Euthanasia:

a perspective on the 1970s discussion

THE REVD DR HUGH TROWELL

We are pleased to reprint here the final chapter of Dr Trowell's book, The Unfinished Debate on Euthanasia *(SCM, 1973, reprinted by kind permission), which he wrote after serving as chairman of a BMA committee on the subject. A distinguished physician who was ordained in the Church of England and served as a hospital chaplain, Dr Trowell was instrumental in the establishment of the Institute of Medical Ethics. He now lives in retirement in Hampshire.*

In January 1971 the British Medical Association issued a report condemning voluntary euthanasia on many grounds, and a leading article in the *British Medical Journal*[1] reviewed the numerous arguments set forward in some detail in this book. The report did not discuss the legal and ethical objections; it stressed the impossibility of providing adequate safeguards and pointed out that legislation would lay a serious 'oppression on the confused, sensitive and perhaps weakened minds of apprehensive suffering patients', especially if they were elderly. In the same issue of the journal, by a felicitous coincidence, Sir George Pickering, formerly Regius Professor of Medicine at the University of Oxford, wrote: 'I reject euthanasia – killing people is not what doctors should, or could, do'.[2]

On the whole the report was well received in the national Press and in the medical journals, except possibly the *Medical Tribune,* whose editor was known to favour voluntary euthanasia. He had contributed a masterly essay on the history of suicide and voluntary euthanasia in a book which advocated legislation[3]. He had indeed been able to write an editorial article condemning the report even before it was published[4], thereby displaying an unusual degree of foresight. An article by a Huddersfield general practitioner in that same issue of the journal advocated that people should opt for death at, say, 75 rather than peter out in increasing dependence on others; ... the day will come when we should be able to say, cheerfully, without incurring the distaste of our fellows or the interference of psychiatrists: 'I am expecting to die next year', exactly as today we say: 'So-and-so is expecting to give birth in the near future'.

In another medical journal[5], which rather enjoys acting as an able critic of the medical establishment, a woman journalist who was not medically qualified wrote with considerable perception and sensitivity about the problems raised in long illness. She professed her point of view, if not her creed, when she stated: 'I believe in voluntary euthanasia', and added: 'The literature of the Voluntary Euthanasia Society contains all the legal aspects and expert opinions for and against the reform I want to see'. She most forcefully accused the doctors of complete failure to discuss the matter. it is hoped that this book of mine has at least broken the silence; but only at considerable cost, for many reading this book will conclude that death can be at times a grim affair, and it is absolutely certain that portions of the book will be lifted out of their context, quoted and misquoted by a few of those who support legislation on voluntary euthanasia.

Having said this, I feel I must state once more that in all my dealings with the Voluntary Euthanasia Society, and in every public debate with their officers, I have been offered every courtesy. These are very high-minded persons, genuinely moved by the fact that mortal illness is often a tragic affair. I venture to observe that it can only be transformed by the amazing deepening of the spirit of the dying person. I have been very conscious of this on several occasions in my 30 years of medical practice. This, after all, is the only thing which can redeem a dark situation, a point to which I wish to return at the end of this chapter. The officers of the Society are genuinely concerned at the amount of suffering that is present. After careful and sincere thought they consider that legislation on voluntary euthanasia would provide the best solution that it is not always the best solution is shown by a statement made to me by Lord Raglan after we had debated the issue at the University of Sussex in 1970, one year after he had introduced his Bill into the House of Lords. He said he would not endeavour to introduce a similar Bill on any subsequent occasion, but was glad that he had ventilated the matter. This highlights the difficulties of solving the problem by legislation.

To my mind it is a pity that the few doctors who support the Society are not more vocal in its support. In my reply to the woman journalist just quoted, I challenged the respected members of the medical profession who are said to support the proposal (of voluntary euthanasia) with the assertion that 'they never give us facts and figures on the number of persons requesting euthanasia on which to base our opinions. I repeat never'. No doctor took up the challenge. I went on to challenge any doctor to say whether he supported the practice of voluntary euthanasia for the categories of persons mentioned in the 1969 Bill, since 'it can be safely asserted, without fear of medical contradiction, that the majority of middle-aged persons have at least one, and often several, incurable physical disorders which are likely to cause severe distress if they live for several more years'. All of these could have qualified for voluntary euthanasia under the 1969 Bill. No doctor took up the challenge, and the only local member of the Society, a doctor of outstanding skill and impeccable ethical standards, has found himself too busy on several occasions to discuss the matter with me.

The Voluntary Euthanasia Society considered the report of the British Medical Association and in due course issued a carefully stated rejoinder. It contended that the B.M.A. report denied the right to self-determination'. Perhaps this could be stated more succinctly as the right to 'self-termination'. This book has argued that there is a personal liberty in England and Wales to commit suicide, but there never could be any legal right to suicide, for that would make it obligatory on the state to provide means to ensure that this legal right could be exercised. However, many doctors had objections, by reason of conscience, to administering euthanasia, the state would have to find persons who would co-operate in administering euthanasia, be it some

specially appointed doctor, or some other non-medical person, given special training in euthanasia. All this would place an intolerable burden on the state to ensure adequate safeguards. The reply of the Voluntary Euthanasia society was:
If the safeguards proposed (including agreement between doctor and consultant) are not considered adequate, it should not be beyond the powers of the medical and legal professions to produce others which would be acceptable to the community.

In the light of what is written in this book, one of the first books in recent years to discuss at all fully the problem of voluntary euthanasia, it will be interesting to see what proposals are set forward. Truly, there is an inherent dilemma here.

Safeguards

Safeguards are essential in any legalisation of voluntary euthanasia, but their content has never been discussed. The bare minimum is that in every case of voluntary euthanasia there should be a statement by two doctors, one being the general practitioner and the other the consultant, that certain diseases are considered to be present, that they are incurable and causing distress, that the patient appears to have a steady determined wish to die, that they consider him to be sane, and that he understands the nature of his request. These facts should be communicated to the appropriate authority. Further, in the interests of justice and future applicants for euthanasia, the patient should state that it is desirable for the facts concerning his illness to be checked at a post-mortem examination, which should follow every voluntary euthanasia, and would disclose which diseases actually were present. This knowledge is absolutely essential as a safeguard for the applicant, for the relatives, and for the community. Relatives have a right to know whether the recommendation was made on a correct estimate of the disease present. It should be clearly recognised that, at the present time, no legal action could be taken by relatives, or any other person, of errors in diagnosis had occurred, provided reasonable care and skill had been employed.

Doctors, too, as a part of their scientific discipline, should also insist on the collection of these facts and the publication of scientific papers determining the degree of correspondence of the ante-mortem diagnosis, which constituted the medical basis to justify voluntary euthanasia, and the post-mortem findings to test its accuracy. Unless such a procedure is instituted there would be a tendency to cover up any deficiency of knowledge. If a body of scientific knowledge were built up in this way, facts would emerge such as, shall we say, an excellent correspondence of the ante-mortem and post-mortem reports in cancer, but a very low correspondence, as at present, in the diagnosis of a stroke (cerebral vascular accident). Armed with this knowledge doctors, relatives and prospective candidates would feel reassured if cancer was present, but more cautious if a stroke had occurred.

Yet any administrative procedure such as this would be certain to kill the practice of voluntary euthanasia, for doctors would be slow to disclose the areas of ignorance. It was explained earlier in this book that errors are often present in any clinical diagnosis, and the latter is often revised from time to time, until finally the patient is dying and now in a sense the diagnosis does not matter. When the patient is dying, it is usually too late to institute curative measures; it is too late to set the machinery of voluntary euthanasia in operation; it is too late for the patient to have any informed wishes in the matter.

It may come as a shock to many members of the general public to realise that doctors do not always understand fully the nature of any serious illness, or may not be able to detect all the unsuspected complications, but this is true. Let me give one example. It may be reasonably certain that a man has cancer of the lungs; he has been a heavy cigarette smoker, the X-ray appearance is conclusive, a small piece of cancerous tissue has been removed at a special examination called bronchoscopy, during which the surgeon has actually seen, through a long instrument, the tumour mass in the air-tube (bronchus). Having established the diagnosis, there is however no point in performing other examinations to see if there is arthritis of the hip, or any developing diabetes. The cancer is perhaps far too large to allow for any operation. So it is considered to be merely a question of time before the patient dies. A mild analgesic drug is taken and pain is relieved after only one tablet, but then a week later the patient has rather more pain, and his wife thinks that the doctor has said that the dose could be increased safely to two tablets if necessary. She gives two tablets, and the patient dies half an hour later. She will probably fear that she has killed her husband. A post-mortem examination however then reveals the two tablets in the stomach, almost undissolved, but also quite unexpectedly some coronary thrombosis, the commonest cause of sudden death in a man in the prime of life. Everyone then agrees that all has been for the best and the wife is immensely relieved. Neighbours, however, who have heard the story of the double dose, have already perhaps started a rumour that the doctor and the wife had agreed to terminate the life of the patient dying with cancer. In my experience, once a story like this starts in a village – and I was a village priest for ten years – the truth never catches up with rumour, never kills it. Even after the results of the post-mortem examination are known, people still nod their heads and wink at one another.

Do doctors practice euthanasia?

This brings us to the discussion of whether at the present time doctors are practising euthanasia, the termination of the life of a person. It is frequently alleged that this occurs, same say not infrequently. It is the basis of much that is written by those who support legislation on voluntary euthanasia. Certain opinion polls, which never define what they mean by euthanasia, or even voluntary euthanasia, have asked doctors to state if their colleagues are performing it, but never, as far as I am aware, have they asked if the doctor is practising it himself.[8] The alleged results of these misleading opinion polls might lead us to believe that doctors are frequently performing euthanasia. In more than one medical journal I have challenged the doctors who support legislation on voluntary euthanasia to tell us how often patients in the prime of life ask in a determined, sane manner for termination, but as far as I am aware, no single doctor has produced these figures. I would like, in all confidence, to ask them how often they took the law into their own hands, acting, I have no doubt at all, even if I cannot agree with their decision, out of motives of charity and compassion. I have offered to travel and meet these doctors, I have not succeeded in gaining an

audience with anyone who admits that he practised voluntary euthanasia, except with a few doctors who admit to something which, in my opinion, is fundamentally and completely different, as I will discuss immediately – the administration of maximal sedation, to the restless body of a person whose mind is already dead.

In modern hospitals it should be possible to see that patients have little pain during the last stages of mortal illness. I do not say that this always occurs; there are failures, which will be discussed later in this chapter. Given the staff, the knowledge, and the compassion, all three being absolutely essential, no-one should die in a modern hospital with much pain. I am satisfied both as a doctor and as a hospital chaplain that a painful death is seldom unavoidable. When it does occur it reflects some shortage of nurses, or some inexperience and lack of knowledge on the part of junior medical or surgical staff, some lack of experience or even some lack of sympathy.

On the other hand, in the difficult down-town sections of our modern cities and in the wide stretches of the countryside, personal observation shows me that people still die in their homes, sometimes in lamentable conditions. Let me say straight away that I think it is right and natural, if possible, for a person to die in his own house, surrounded by those who care for him and the surroundings of hearth and home. Some people insist on dying at home and some spouses insist on nursing those whom they love until they break under the load. I am fully satisfied that in a small proportion of these patients there comes a time when the person has died but the body goes on living. The person is dead: he can no longer speak, or hear, or talk rationally; his whole personality has broken up long ago, leaving only a shell of the former self. Eyes are blind, ears are deaf, lips are silent or mutter senseless phrases. The last intelligible words have been spoken long ago. The person is dead, yet there lies his body, perhaps panting for breath, gurgling in the throat, passing water into the sheets. Limbs may twitch and there is the indescribable odour of the chamber of death in a small room of an ancient building. The district nurse calls as often as she can, and so does the doctor. In the end the relatives can be quite beside themselves with the burden of nursing someone dearly loved, but who has long since departed, so that they have only this travesty of an animated corpse left in the bedroom.

Legislation on voluntary euthanasia could never settle the issue in this case; indeed, it would hopelessly complicate and delay it. I am fully satisfied , speaking as a common man, on the basis of our common humanity, that on rare occasions, in these cases, there comes a time when the nurse asks, 'Why change the sheets again, for the second time this evening? He may get a bedsore, but he will almost certainly die first'. And the wife says, 'Why go on trying to get these motionless lips to swallow the tea that has been vomited up three times already? He has gone away already – he is not here. He is not thirsty any more; I am putting down the feeding cup and will just go on holding the hand of him who was once the person so dear to me'.

Then, occasionally, but in my experience rarely, a good doctor with the full knowledge of the nurse and the approval of the spouse., decides that everyone, including the patient, should have a good night's rest, come what may. I have known occasions when a very large dose of a sedative has given everyone 12 hours of solid sleep and the patient has had a reasonable night and is still alive, even more vigorous, 24 hours later, and needs another sedative. I have also known other occasions when stupor and sleep deepened into death, but no-one could tell how much it was the large dose of sedative, how much it was the disease and its complications, and how much was the lack of food and drink that allowed that unconscious body to cease to function. This I am fully satisfied occasionally happens. I regard it as perfectly good medical practice and I am fully satisfied that whatever is the state of the law on the books that no doctor performing his duty and his charity to some-one who has ceased to be a person not only in his own eyes as the medical attendant but also in the eyes of the nurse, and even more in the eyes of the spouse and the relatives, need fear any police inquiry, any prosecution, or any conviction. This is, in my opinion, a wicked bogey, conjured up by some of the supporters of legislation on voluntary euthanasia. Instead this doctor is esteemed in the sight of all men. He has already been weighed, tested approved, and praised in the judgment of those most deeply concerned, the spouse and the family, the nurse and perchance other doctors who may have been involved.

Justice, charity and skill have been shown forth in circumstances that are truly exceptional, and which are becoming less frequent in the modern world where more and more people die in hospital. This certainly cannot be called voluntary euthanasia: the person as a thinking, rational person was already dead, he could no longer choose death by euthanasia. It cannot even be called the termination of the life of a person: the person died long ago; one was left with a mindless, poorly functioning body. Even after the body did eventually die, and heart and brain ceased to function, the blood would still be alive; it could be used for a blood transfusion. One cannot say that the person is still alive just because the dead corpse has living blood in it, or that it is murder to move the body until all the blood cells are dead. The hair follicles will go on living for several days after the death certificate has been written, even after the person has been buried. Similarly, occasionally, just occasionally, even before death of heart, lungs and breathing have occurred, doctor and friends can say that the person, as a person, has died and decisions on his behalf must be taken by those who kept faithful covenant with him in life: wife, children, nurse, doctor, solicitor and minister.

Even in hospital, we are faced on very rare occasions with unusual circumstances best left to the care and conscience of competent doctors and nurses doing openly in the sight of all men whatever is best for the patient, as a person with whom they covenanted to keep faith. There are not many such occasions, but they do occur. One example will be given, known from personal experience. in one of the most respected of the London hospitals a child had been operated on for a tumour of the brain; a malignant form of tumour had been found, but proved inoperable. Soon after the operation the child started to develop mental signs and became unconscious, for the brain was being destroyed. Serious repeated fits occurred. The child became noisy and violent, quite unable to speak or to recognise her parents. It was impossible to control the noisy shouting and groans without

continuous sedation. This was attempted for several days, but the other children in the ward became frightened on hearing these sounds. The child's body could only be fed through a tube and eventually after a medical consultation it was decided to stop feeding the child. But still the body just would not die; the brain was almost completely dead, but the young heart and lungs were extremely healthy. The parents and staff became worn out tending this shouting, mindless, animated corpse. Then the senior physician, after asking the parents' full permission, in the presence of the ward sister, and other members of the staff, increased the sedative until the body which had lost mind and soul many days before ceased to scream and twitch. The chaplain had been informed and was present with the parents in the adjoining room. The full dose of the sedative was written on the treatment sheet by the consultant, who signed with his own initials. The parents the day before had given verbal permission for this treatment in the presence of three members of the staff. Everyone felt that the child had ceased to be a person many days before and that they were merely preparing the body for burial. This is not voluntary euthanasia; the child had ceased to be a person who could express any wish many days before. It would not be aided but impeded by legislation on the matter. I wish to repeat that this is a very exceptional case in which an honourable doctor did that which he felt was most in the interests of the dead body.

No-one likes this kind of event, and that is right. Indeed, it would be a terrible day for the medical profession and for any hospital if this ever became a common event. It is best kept in check by this feeling of abhorrence. This is one of the reasons why, in 40 years' association with various hospitals, I have only heard of two occasions on which this occurred. A doctor knows that a malicious relative or nurse could perhaps cause a serious scandal by noisome rumour in the wrong quarters. This keeps the practice in check and this is right. The occasion must be truly exceptional: the person should be dead as a person in the judgment of the family and all members of the staff, all of whom must signify their approval. This is no argument for voluntary euthanasia; in fact the law on the books keeps this practice to a bare essential minimum, which is the main reason for refusing to tamper with the existing law. it protects against abuse; nothing else can do so.

It is quite common for a medical practitioner to be approached by the spouse or other member of the patient's family with a request that the patient shall not be allowed to suffer agonies, to undergo severe suffering to no purpose, and that nothing should be done to prolong life that is a sheer misery to all concerned. The doctor, realising how limited are his powers to prolong life, how ineffective are the antibiotics in the terminal stage, can usually completely reassure these anxious relatives. They rarely state bluntly that they want the patient to be killed, and would be horrified at such a suggestion, especially as almost invariably they have never discussed this request with the patient concerned. The relatives have been told the dread diagnosis and the gloomy prognosis and, little realising how limited are the powers of the doctor in the terminal stages of incurable illness to prolong life, they take the doctor on one side and beseech him to do nothing to prolong the agony, which is also their agony. They ask very rightly that the patient shall suffer no unnecessary medical or surgical interference. they can be completely reassured on both these points. It is very seldom that the relatives bring it upon themselves to discuss all this with the patient himself. Indeed, a large part of the anxiety of relatives in these cases is due to the fact that they usually are quite unable to share all this with the person concerned. He has been kept all too often in complete ignorance of his fate. This is one of the reasons why relatives take the doctor aside and beseech him to do all in his power to mitigate the sufferings.

Suicide as a personal decision to die

In severe progressive illness, especially if it is accompanied by severe pain, I have known several instances where the patient has terminated his own life by taking a large number of sedative tablets. Often a note is left explaining matters and asking that no resuscitation should be attempted. I have never met one of these notes myself, but I have heard of them. If I found such a note by someone who had an incurable complaint, I would respect his wishes, and I think this would be the attitude of the large majority of doctors.

As far as my personal experience goes, I think that most of those who commit suicide because of an incurable complaint have not been able to discuss this step with their relatives. This seems to be a pity, but is perhaps understandable. It therefore usually comes as a great shock to the family and friends. The blow is mitigated by the knowledge that there was an incurable complaint, but there are often regrets that the decision could not have been shared, that the farewell was so abrupt, even furtive. It leaves a sourness in the mouth and a distaste in the memory.

Suicide is however in a sense the only honest method in which to terminate one's life because of some mortal, incurable, painful complaint. In this a man exercises his liberty to end his own life. He has lived with this liberty all his life; now, in the light of what he knows about the nature of his illness, the certainty of his fate, the probability of severe pain, or declining powers, or loss of human dignity, a man decides that, on balance, life is not worth living. It his decision and many would say it is his life. This is where a man's basic outlook on life comes out. From one point of view, it might be said that it was his own life and therefore that he was free to decide whether to live or to end his life. He did not make his own body, fashion his own mind, make his own personality; he could not say as the outside agent: I made this, I own this, it is mine. On the biological level he received life from mother and father, they from their parents, and they in turn form a stream of ancestors. The individual may have his own genetic code, different from every other person that was, and is and is to be, but every cipher in that code came from some ancestor or other, way out and long back for a thousand and more generations. Perchance he has handed on half of his genes to meet and mingle with an equal number from his mate. These genes meet and mingle in their own dance of love that heralds a new genetic number, a new individual, a new fertilised ovum.

On the human plane a person knows he is not alone. Fate and fortune have joined his life to that of others. so it is a false simplification for a man to speak of 'the life that I have', and to say, 'I can decide, by myself, to terminate my own life'. The

hallmark of suicide is that a man must do it alone; he can seldom discuss it with the nearest and dearest. Perchance they will not agree; perhaps they will attempt to resuscitate him. It is most exceptional for anyone who is contemplating suicide to discuss it rationally with his friends. Dark hints may be made, threats can be uttered, a cry for help may be heard, but in 40 years of professional life I have never met a suicide who has been able to discuss the matter calmly with a friend, gain his approval and his co-operation. Doubtless, since circumstances and human nature being both so varied, there are occasions when a rational human being desires death, takes counsel with kith and kin, and wins their approval. This approval is signified by encouraging the suicide to terminate his life in circumstances known to them, and they make no effort to prevent it, or to rescuscitate him. All this may happen, but it must be extremely rare.

Occasionally perhaps someone committing suicide makes some one person party to his intention; he can hardly make him a party to the action without involving the risk of a charge of manslaughter, if not murder. Notes may be left exonerating his assistant in the act of suicide, but the main actor will have been removed by death; he can no longer speak in defence of his assistant, who may be charged with homicide. Dimly realising all this, almost all those contemplating suicide, for whatever reason, will take counsel of none, nor ask any man for assistance. the same will be true of any decision to terminate one's own life because of incurable, distressing, mortal sickness. these people are most unlikely to take counsel of anyone or to ask assistance of their fellow men.

Even if the Suicide Act (1961) were modified in England and Wales so that it ceased to be illegal to assist suicide in someone suffering from severe, incurable, distressing illness, it seems unlikely that this would often occur. Even then, the person who assisted the suicide might be exposed to the charge of homicide, unless it could be proved that assistance had been requested. There is at present no evidence that in Scotland, where it is not an offence to assist suicide, this relaxation has solved the problems posed by incurable, distressing illness. If legislation were introduced in England to cover this contingency then it would prove necessary to define incurable illness, and one likely to cause severe distress. So we are back again once more at all the difficulties that would attend the certification of severe, incurable, distressing illness by two doctors, as envisaged in the Voluntary Euthanasia Bill of 1969. Would then a potential suicide have to obtain two certificates in order to exonerate his assistant from the possibility of any criminal charge?

Unless due cause can be shown to modify the existing law, it is best to leave it as it is, and allow any mitigation to proceed from leniency in enforcement. strange as it may seem, in this deeply human situation of life and death, there seems to be everything to be said for keeping the laws in the books exactly as they are, for they are guardians against abuse and protectors against foul play. If there are any exceptions to these laws, then the common man recognises them to be exceptions and not precedents. Life seems to demand certain clear-cut rules and conventions, which everyone knows and respects. One should drive on one side of the road, assuming that everyone on all occasions will do the same. We can then proceed along the road at speed and in comparative safety. This is not to say than on very rare occasions we may not choose to vary this rule, but only under the most exceptional circumstances, which we may be called upon to justify in a court of law. Matters will not be improved by legislating for the exceptions to the Highway Code. In a similar way there is one rule for medical practice: that a doctor keeps faith with a patient as the guardian of his life. Exceptions there may be; let them be as few as possible and answerable always in the courts of the land and within the conscience of all men.

When all this has been said, the problem posed by legislation on voluntary euthanasia still stands: too often people linger on in pain and distress that is hard to bear and loathsome to behold. It has been submitted that legislation on voluntary euthanasia can never solve this problem and it has been argued that assistance in suicide would also prove ineffective. What remains?

Rare occurrences

It is first necessary to consider the last red herring, which is that doctors do occasionally perform euthanasia in an unobtrusive manner, as a great mercy. My inquiries, for what they are worth, do not support this contention. Undoubtedly there are a good many rumours and stories to this effect. I am not impressed by these tales. They are the kind which are told over a round of drinks in a bar, or at the dinner table. I was regaled quite recently by one vivid account from an eminently respectable hairdresser, who gave graphic details of a brother dying in agony; then the doctor gave a final shot and that was that. It was a good story until he spoiled it by saying that he was one of five brothers, and that three of them had departed thus, in the same cathedral city, at the hands of the same doctor, all being nursed at home, and all dying of cancer. Now cancer is not the commonest form of death: it is very unlikely that three brothers would die of cancer, all in the same city and all under the same doctor, all being nursed at home. I might have believed the single narrative, but not the embroidered triplet.

Those with experience in geriatric wards and units for terminal care know how often words spoken to anxious relatives are misinterpreted. A doctor is asked by a relative not to let the agony go on much longer; he gives an assurance that the patient will get a good sleep this very night. Some injection or pill is given; death occurs during the night; the relatives are much relieved, nod to one another and agree to say nothing. But they know, they say, that the doctor ended the life. Many genuine examples of this misunderstanding come to my personal attention, and I have confirmed that it occurs frequently in special units for terminal care.

Another source of misunderstanding arises on the numerous occasions when it is decided to withdraw active medical treatment during the last stages of terminal illness. Thus, an elderly person may be dying of heart failure, and requires some regular injection of, say, digitalis to slow the rapid, irregular pulse. The time comes when the person is obviously dying and has only a short time to live, and a decision is made to stop all active medical treatment that is not relieving pain. The regular injections of digitalis are stopped; actually at this stage they are almost useless. Death occurs a few hours later. The doctors attribute this to progressive heart failure, but relatives may

speak about the decision to stop useless treatment as terminating the life of the person; they may call it euthanasia. The doctor, they say, stopped the injections that they had regarded as indispensable to life. This is not correct; they had become quite ineffective in a dying person. Digitalis does not work if the heart is near to death, so why continue the useless injection?

Another frequent source of misunderstanding arises over the use of sedatives, a misunderstanding not confined to the relatives; it may even arise in the mind of the nurses, and is often present in the mental background of the doctor. Thus, suppose a person is dying from an advanced cancer and has had a fair amount of pain. At first this would be well controlled by tablets, later on injections of a narcotic drug would be started, eventually the dose would be increased, and this would occur more than once. Eventually, as the end approaches, some doctors may feel that it is so important to offer more relief at night, and for the relatives to know that this will occur, that they may increase the dose yet once more, but only slightly so. If the patient dies the first time that the dose is raised, then human nature being what it is, many a junior doctor will have scruples, he will fear that the dose proved too much. He may even be so unwise as to say this to the nursing staff. The relatives may be much relieved and may thank the nursing staff for ensuring that relief was given; the nurse may reply somewhat cryptically that, after all, 'It was for the best'. Nothing more is said, but the relatives are certain that an injection sufficiently large to ensure death was deliberately planned and administered. Nothing could be further from the truth.

As far as I can ascertain, and I have spoken to many doctors about this, it is extremely rare for a conscious, rational patient to ask deliberately for death at the hands of his doctor, and for the doctor to agree to terminate his life days or weeks before death would naturally have occurred. This is voluntary euthanasia, the matter that is under debate, the situation for which some consider that legislation is required. Persistent inquiry concerning this type of case suggests that this occurrence is extremely rare.

It is a different matter when death is very near to hand and its arrival is manifest to all, for a person to express a desire to die. indeed that is right and natural, it represents the patient's acceptance of death. Many must feel this, even if they seldom bring themselves to voice the secrets of their hearts. At first the idea may present itself as a great fear, with which a man must contend as with a mortal foe. Later, the adversary may be tolerated, even accepted. Finally, shortly before death, the prospect is welcomed. Such is the lot of most men confronted in the prime of life with the face of death. The elderly and the infirm have come often to accept death in a most natural manner. They speak of their decease in a disconcerting, matter-of-fact way; often they think of it in terms of meeting again those who have gone before. they may come to desire death and speak about it openly. This again is right and natural, however much it disturbs those who visit them. In an even, flat voice they announce in a matter-of-fact manner that they want to die. This, indeed, is a trump card to which there is no reply. I am firmly convinced that in the large majority of cases these elderly persons do not want to have life terminated. If one of the disconcerted visitors produced a few tablets and said, 'Take these: they will send you to sleep and you will never wake again; isn't that what you want?', the tablets would seldom be taken. if the tablets were left by the bedside they would be there next morning. indeed, if they had disappeared and the patient had departed one would be left with the haunting fear that they had been swallowed only in a mental muddle, which is such a common feature in a person of declining powers. Had they dozed off early in the evening and woken, seen some tablets, taken a couple, dozed off, woken still more muddled and settled for the balance, one by one, as a mechanical, drugged automaton? Things like this have happened many times with elderly persons.

Whichever way we look at this problem, it does not appear that legislation will solve the issue, or indeed will aid the solution. There are many problems which cannot be solved by legislation. Those who choose to exercise their liberty to died ought to do so by acting as their own arbiter, as at present, playing their part as a man, not delegating decisions to a medical tribunal, not pushing their indecision on to others. Perhaps some of them will lay by a store of tablets against a rainy day. Anyone who is firmly of this opinion should treat the matter in this cold and calculated manner. they could even deposit them in the security of their bank, and give instructions for them to be sent, should occasion arise. If this procedure was not encouraged by the banks, following a few publicised cases of euthanasia, it must be asked whether some public-minded body should not ask people to register with them, pay a small fee, buy some lethal tablets, address the package to themselves, then leave everything in the central office until they sent accredited instructions for their dispatch by recorded delivery. Should some body, possibly called Suicides Synonymous, be set up, even endowed by former recipients?

Death is not robbed of its sting by stupid quips. Those who support voluntary euthanasia have a strong case: there is a problem here, even if it will never be solved, but only vexed beyond reason by legislation. It will only be mitigated by recognition. At present it suffers far too much by neglect. Too many are frankly hypocritical and say that there is no problem here; then they are admitted as a spectator to a private box and death is on the stage, at their elbow, and the chief actor is a loved one, bowed out under a burden of flowers and tears. They are appalled, even bitter; they never dreamed that death could be so devastating. They thought that death was merely falling asleep; alas, they are completely shaken.

Increased recognition of the problem by the medical profession

Much has to be done by the medical profession. I can only record to my shame that although I taught medicine to medical students for about 25 years I never remember that I did anything at all to help then to understand the human issues that are involved in dying. Perhaps I did something in my attitudes. I hope so; but this is not enough. Granted that the medical students are not mature in their profession, but at least they can watch what one does. In my own student days at St Thomas' in the 1920s, the consultants seldom seemed to have time to discuss matters with the patients and their relatives. Having said this, I wonder whether my medical students, when I taught them medicine in

East Africa, often saw me stay to discuss matters with the patient or his family.

Doctors must face up to this problem far more than has occurred in the past. The increase in the modern methods of resuscitation only intensify the problem. As every new method is produced it must be tried on all manner of cases, it cannot be offered exclusively to young persons. Within the past few decades it has been demonstrated, for instance, that even elderly persons can often benefit by operations which would not have been contemplated years ago. People over 80 years of age, who are in constant pain from osteo-arthrosis (arthritis) of the hip, and unable to stand for any length of time because of severe pain, can be transformed by a modern operation to restore the hip joint. The arthritis would never have killed them; modern surgery often transforms their lives. In a similar manner, elderly diabetics are now treated with insulin, although in 1946 a doctor on the Isle of Wight consulted with me whether to treat my father, aged 72, for his diabetes and decided that at his age this was not desirable. Had it been possible to give him insulin, as it would today, he would have lived to achieve the great ambition of his life; it would have proved possible for him to travel in the congested post-war transport to stay with his only daughter, a doctor, married and with her husband and family waiting for him in Australia. I shall always keep, just as a reminder, his last note to me, in which he stated his unfilled wish, lest we talk too glibly of keeping useless old folk alive with unnecessary medical treatment.

It is impossible to keep long-stay patients in any number in a modern teaching hospital, and the respected heads of the medical profession seldom see this kind of patient, at least for any length of time. Medical students, too, are naturally concerned with curative medicine and surgery, they are seldom attracted towards any consideration of the treatment of incurable illness. only those of a mature temperament can see that all this is a real part of the practice of medicine. Most doctors pick up in a desultory and unsystematic manner the skills involved in the medical care of those slowly dying of an incurable and painful illness. The doctor feels committed to them as patients and persons with whom he keeps faith, even when their deterioration mocks his clinical skill. The knowledge of the correct use of drugs is not easy to pick up in a desultory manner, and this may explain why some doctors still exhibit only a modicum of skill. There is great need for all medical students as part of their medical training to visit units of terminal care. There is also great necessity to increase facilities for special short courses of instruction at these units, when all aspects can be fully discussed with practitioners anxious to increase their skill, not only with modern drugs, but in the psychological, social and personal aspects of good care of those dying from incurable, progressive illness, especially if it is accompanied by severe pain and considerable disability.

Great credit is due to those who have emphasised for a long time that this has tended to be one of those neglected areas of modern medicine. At present there are only 200 consultant geriatricians in Britain; as the number increases, this branch of medicine will improve. Geriatric units have revolutionised the approach in many parts of the country, but I know from personal experience other parts of the land where facilities are poor. There may have been for many years no senior appointments in nursing, in medical care, or in geriatric skills. These are all needed if this problem is to receive the attention that it requires. it is marvellous what has been done, in spite of the shortage of money. It pained me as a vicar to visit the elderly folk of the parish in one institution, a modified Victorian workhouse, striving to do its best under impossible conditions, where the dead hand of public finance flattened the face of everything.

The only thing which will keep the problem of euthanasia alive, past the corrosions of time, will be the eternal, unsolved, problem that will abide with us till time is no more: people who are persons in their own right, dying with powers of body and mind diminishing, always with some measure of distress, at least mental distress, often with some disability, always with much weakness, usually with some pain, dying and knowing usually that they are dying, going away, leaving those they love and places that they have known. To the end of time let us hope this calls out human sympathy and human devotion: without these, all other provision, be it never so costly in money, so marvellous in its scientific design, is a mere nothing. those who have escaped from a great fire can return to teach us how to be wise; those who have escaped drowning can return to insist on better safety precautions, even endow lifeboats, but those who are dying can never, never return to teach us how we should have done it better. This, like so many problems concerning death, is built into the situation, unaltered by any discovery of science, uninfluenced by any legislation of parliament. those who think we can escape by some voluntary choice on our own part are deluding themselves into the belief that death is like any other situation in life. It is completely different.

Death is death. I have watched it in the face of the aged African peasant, dying in his mud hut, to be buried soon in the tilth of the banana groves; he knows in a deep sense that he is going home to his fathers. As the scene darkens and the senses fail, i have marvelled at the quiet spirituality, the naturalness of it all: acceptance, peace at the last, going home, the human spirit rising above all its temporalities and trivialities, facing the eternal verities. I have watched it as an African mother weeps and wails over the dead body of her malnourished child, dying of the nameless disease that we never understood until a mere yesterday, and concerning which, if I need any epitaph, let it be: 'He wrote the first book on kwashiorkor, the disease of the world's poor malnourished children'. I have seen death in the hospital beds of the English hospital, where I stood hopeless, helpless and dumb, as the chaplain, while everyone else was doing something useful. I stood for the relatives, who feel they can do nothing but stand and wait. That is part of our human lot, that we are almost helpless and hopeless in the face of death. We must all stand in the shadow of this cross.

Yet I have learned that there is another side to the picture, for as the strength ebbs from the faces and spirit of the helpless relatives, so it seems to deepen and strengthen in the spirit of the patient. That is the eternal miracle about so many dying persons, particularly those who are not too much marred by disease or muddled by sedatives or weakened by age.

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Reproductive Technologies in the Light of Vatican Instruction

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Authors' Abstract

Technology applied to the procedures of procreation is part of a broad project that questions the relationship between love and life without procreation, between person and nature within the individual, between freedom and responsibility toward future generations, between ethical values and technological values in human behaviour

The Vatican Instruction indicates three fundamental values involved in the techniques of artificial procreation: 1, the life of the human being called into existence; 2, the special nature of the transmission of human life in marriage; 3, the unity of the family.
In order to safeguard these values, the task of scientists is to offer only those techniques that could serve as simple aid to conception and completion of the conjugal act.

Introduction

In recent years the new techniques of artificial procreation have become widespread and an increasing number of patients are seeking it and receiving treatment. But undoubtedly this practice implies ethical considerations, because many values that require protection are involved. There are various bases for the evaluation of an ethical position; thus, they can appeal to immediate utility, religious authority, or self-fulfilment and autonomy, etc.[1]

The aim of this paper is to emphasise and, if possible, to obtain a thorough knowledge of some ethical motivations that inspire the indications and responses of the Vatican *Instruction*[2] about the problems raised by technologised parenting. We think that these indications and responses of the Vatican can have a value that goes beyond the mere value of religious authority, because they are founded primarily on criteria of the human person integrally considered.

As a methodological approach we would like to make a preliminary statement on the cultural context in which the new ways of artificial human procreation are established.

Technology applied to the procedure of procreation is part of a broad project of inestimable importance that could be defined as the project of *anthropotechnics*. This project questions the relationship between love and life within procreation, between freedom and responsibility toward future generations, between ethical values and technological values within human behaviour.

The cultural context

We have analysed the Vatican Instruction keeping in mind three factors that, in our opinion, constitute the crux of the matter and represent today three risks of human and cultural catastrophe. We think these factors should be made known in order to understand fully the prophetic value of the Vatican document.

The first factor is the attempt to *destroy* or *confuse* the concept of the human person.

Today the term *person* is no longer being used as a transcendent boundary between the human and non-human universe: in fact, when applied to the embryo, it is used in a discriminatory way, that is, between two phases of its development on the basis of merely biological, psychological or sociological criteria. Thus, for some, new human life does not come into being when there is life in an early human embryo but when the newly developing body organs and systems begin to function as a whole.[3] In other words a person is the newborn child or maybe the fetus, but not the embryo. The person is not considered as such for what *he or she is*, but for *what he or she can do or appears to do*.

The second factor is the attempt to *dominate* and *control* the procedures of procreation and of the procreated life. With artificial procreation the beginning of human life appears as the result of an external casualty, extrinsic and different from the conjugal act. A biologist and not the parents 'makes' the embryo and keeps control over it, e.g., in pre-selecting the sex or in deciding which must be implanted and which not. So that tyranny, which is deplored in the political world, is transferred to the biological field, and once it is there it is impossible to drive it away.

The third factor is the very manifest attempt to establish *utilitarian ethics* or '*ethics of social consent*' to justify the intervention in procreation and the family. There are many philosophical arguments against utilitarianism and we agree with others[4] in rejecting even the most attractive versions because it can introduce a dangerous right to have a child 'at all costs', destroying any ethical value connected with the anthropology of the person or that of nature.

The values endangered

The Vatican Instruction, confirming some of the issues already defined in previous pronouncements and presenting ethical indications as a safeguard for the truth and liberty of the human person, underlines three fundamental values involved in the techniques of artificial procreation: 1, the life of the human being called into existence; 2, the special nature of the transmission of human life in marriage; 3, the unity of the family.

1. *The life of the human being called into existence.* Development of the practice of *in vitro* fertilisation requires, even today,

innumerable attempts at fertilisation and the destruction of many human embryos. Only few are transferred into the genital tracts of the woman; the other embryos, generally called *spare*, are destroyed or frozen; on occasion, some implanted embryos are sacrificed for various eugenic, economic or psychological reasons. In general, the results of IVT/ET *are very poor as presented in the retrospective data of the first Report of the United States Registry*[5] of *in vitro* fertilisation/embryo transfer (IVF/ET) and related practices: only 337 (14.1%) out of 2389 IVF cycles with embryo transfer in 1985 and 485 (16.9%) out of 2864 in 1986 resulted in clinical pregnancy. And if we consider the pregnancy outcomes, the number of liveborn children goes down respectively to 177 (5% of cycles) and 312 (6% of cycles). We wonder what the destiny of the other 95% or so of fertilized embryos was, i.e., of 95% of the human beings produced *in vitro!* This is a clear sign of domination of one human being over another which is contrary to the respect of life and can lead to a system of radical eugenics. From the time that the ovum is fertilised, in fact, a new life which is neither that of the father nor of the mother has begun: it is rather the life of a new human being with his own growth. It could never be made human if it were not human already.

Modern genetic science brings valuable confirmation of this perpetual evidence. it has demonstrated that, from the first instant of fertilisation, the genetic programme is fixed as to what this living being will be: a man, this individual man with his characteristic aspects already well determined. Right from fertilisation the adventure of a human life has begun, and each of its great capacities requires time to find its place and to be in a position to act.[6]

The zygote resulting from fertilisation has the biological identity of a new human individual, and the Vatican document disagrees with the authors, who do not believe that the beginning of the individual development of an embryo is at the moment of fertilisation. The Warnock Report, for example, recommends that no live human embryo deriving from *in vitro* fertilisation, whether frozen or unfrozen, may be used as a research subject but *only* beyond 14 days after fertilisation. In this case the reference points in the development of the human individual are the formation of the *primitive streak* and the end of the implantation stage[7]. In another case, taking such a time limit is consonant with the views of those who favour the end of the possibility of the zygote separation and formation of identical twins.[8]

Others consider that a new human life comes into being when there is a newly developing body of organs and systems that begin to function as a whole and not when, they say, there is 'merely cellular life' in a human embryo (3). This argument is related symmetrically with the death of an existing human life, which occurs when its organs and systems have permanently ceased to function as a whole. So, these authors believe that a new human life cannot begin[9] until the development of a functioning brain which has begun to co-ordinate and organise the activities of the body as a whole. But the primitive streak or functioning brain is only a point of sequential process: in fact, once fertilisation has occurred, the subsequent developmental processes follow one another continually in a systematic and structured order.[10 11]

In the case of the production of two genetically identical individuals (identical twins) the development of the second twin is the result of natural cloning and does not take anything from the other embryo's individuality.

The conclusions of science regarding the human embryo provide a valuable indication for discerning, by the use of reason, a personal presence at the moment of the first appearance of a human life, and it is spontaneous to wonder: 'How could a human individual not be a human person?'(2)[12] Therefore, all human beings are to be respected and treated as human persons. The human embryo has the same status as a child or an adult and the fundamental right to life, furthermore, to kill the life of an innocent is an especial moral outrage.

2. *The special nature of transmission of human life in marriage.* Procreation is licitly sought when it is the result of a conjugal act which is *per se* suitable for the generation of children. but from the moral point of view artificial procreation, since it is done through a technical act, corrodes the unity of the human being and the unity of body and spirit: the conjugal act, by which the couple mutually express the gift of themselves, at the same time expresses an opening to the gift of life; it is an act which is inseparably corporal and spiritual.

An act of procreation without bodily expression deprives this act not simply of the biological factor, but rather of the personal communion that can be expressed only through the body in its plenitude and unity. The characteristic of sponsal love is the totality of the gift of the two persons.

The reproductive technologies in seeking procreation which is not the fruit of a specific act of conjugal union, objectively effect a separation between the 'goods' and the 'meanings' of marriage: by safeguarding both these essential aspects, the unitive and procreative, the conjugal act preserves, in its fullness, the sense of true mutual love and its ordination towards man's exalted vocation to parenthood.

Reproductive technologies degrade and reduce the conjugal act to a technical act. And a technical act constructs the object (the embryo) and the object remains ontologically non-homogeneous compared to the subject, and the subject that constructed the object can dominate it.

On the contrary, the full conjugal act expresses the subject to another subject, of whom he or she respects the equality and with whom the free expression and communion of this act is allowed, and another subject (the embryo) is the fruit of this personal act.

Therefore, according to this point of view, all artificial procreative technologies are condemned by the Vatican document not only because they imply the interruption of human life in its origins, but also because life and love are separated in the conjugal act, even in homologous artificial procreation (the so-called *simple case*). There is instead acceptation for those

medical interventions in which the technical means is not substituting the conjugal act but serves to facilitate and to help, so that the act attains its natural purpose.

3. *The unity of the family.* Through heterologous reproductive technologies there is the introduction of a third party into what ought to be an exclusive relationship. The 'third party to procreation' contributes in a variety of ways: sperm donation, egg donation, embryo donation or surrogacy. These various 'services' do not always find a precise definition even in the legal field, and in any case they are held to be morally wrong in themselves, whatever the motives of those involved in this planning of a child's birth may be. Furthermore they are also seen as a threat to the relationship and to the family which is based on them, because that is contrary to the unity of marriage and constitutes a violation of the reciprocal commitment of the spouses and a grave lack in regard to the essential properties of marriage. Finally, heterologous procreation deprives the child of a filial relationship with his parental origins, and brings about and manifests a rupture between genetic parenthood, gestational parenthood and responsibility for upbringing. What threatens the unity and stability of the family is a social source of dissension, disorder and injustice in the whole of social life.

Conclusions

We think, according to the conclusions of the Vatican Instruction, that the task of bioethicists is to urge scientists and doctors to continue their research in order to cure sterility, seeking true therapies and offering those techniques that could serve as simple aid to conception and to completion of the conjugal act. In addition, scientists and doctors should study new methods for the prevention of infertility.

We are sure that what appears as 'prohibition' today can turn into 'prophecy' tomorrow. We think that reflection upon the Instruction can be an incentive for everyone to rediscover and reaffirm plenary humanism (*i.e.* all the human values in every man) that is threatened by the technological myth and by the excesses of technology applied to man without respect for the 'human' characteristic.

What is needed is a new humanism harmonising technological values with the values of procreation.

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Note: This is a fuller version of a paper delivered at the 1988 Leeds Conference on Philosophical Ethics in Reproductive Medicine (see *Ethics & Medicine* 4.3.1 Ethics Committee of the American Fertility Society. Ethical considerations of the new reproductive technologies. *Fertil Steril* , 1986; 46: 1S-94S (Supplement 1)

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Dying and death can only be transformed and its dolours mitigated, by those who have thought out their position with regard to death. It is the unthinking man who cannot face the dark night. In the modern world Western man, adrift from his moorings, projects his fears and uncertainties on to the question of death. It has become and it will probably remain a taboo subject, to which, however, he is existentially linked. it will end all his hopes: he will meet it one day, came what may.

This situation needs to be transformed; it has to be redeemed. This is what the Gospel is all about: it is quite literally Good News. It is received like all the good things of life, like the act of love, like birth, death, and eternal life, in faith and trust, like a child, who is beginning to know, however slightly and inadequately, the one who is Father, the one who is God. He gave life to us, when there was no life; to him we yield our lives in death to be held safe and secure. As the arms of the nurses lift us on to the last journey, we trust that underneath are in very truth the Everlasting Arms.

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Medical Ethics and the Family

J. H. SCOTSON, MB, ChB

'The family is the natural and fundamental group unit of society and is entitled to protection by society and the State'. (International Convention on Civil and Political Rights 1966)

Purpose of ethics

In order to put into effect the medical dictum 'primum non nocere', one must understand what constitutes good and evil, so that good may be pursued and evil avoided. Socrates said 'Medicine is a *techne* like oratory, which can be practised well or badly, depending on whether or not one practices it philosophically'. We need a clear philosophy in addition to technical and scientific knowledge.

Ethics, which is derived from the Greek word ethos, meaning custom or habit, is a branch of metaphysics which studies what is beyond the physical, beyond what can be perceived by the senses (meta means beyond). As medical practitioners, we must be scientific in order to practice good medicine but our knowledge and understanding cannot be confined to physical reality alone. Technical knowledge, however great, does not resolve ethical problems.

In common with all branches of learning, ethics is a discipline which requires adherence to certain unchanging and unchangeable norms of morality, contained within the Natural Law as ordained by God the Creator – to quote an obvious example of the Natural Law, it is wrong to destroy innocent life or to deliberately harm another person. In relationship to medical practice, most people of good will would agree that medical science should always be for the good of the patient and never for hurt or destruction; in other words, medical science is to be used always in the service of the patient. Medical ethics is a twofold discipline – a discipline of learning and a discipline of application.

These values are not specifically Christian. They have been recognised by those pagan philosophers who lived before the time of Christ, including Aristotle (384-324 BC), Plato (428-348 BC), Socrates (470-399 BC) and the father of medicine, Hippocrates (460-377 BC). One sentence from the Hippocratic Oath which illustrates the meaning of the Natural Law is 'I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous'.

Summary of medical ethics

Medical ethics can be encapsulated in a sentence taken from St Luke's gospel (5:31) and reiterated in St Mark's gospel: 'It is those who are sick, not those who are in health, who have need of the physician'. Most breaches of medical ethics have occurred because medical expertise has not been used exclusively for the benefit of the sick – its powers have been used for the manipulation, incarceration or destruction of the healthy, for example, the chemical destruction of physiological function, detention of the healthy in psychiatric hospitals for political or other motives, and *intra uterine* child destruction.

The aim of the physician is to be the attainment of health by his patient which is declared in this statement by Aristotle: 'The doctor . . . achieves a state which is such as to constitute a condition of health; and from this no condition can be produced except one which is intermediate between health and sickness. Neither the doctor's art nor any other art will create anything out of health, for either nothing would be produced, or else the opposite of health'. *(Problemata)*

I labour this point concerning the physician's function, which previous generations would have regarded as self-evident, precisely because it is no longer self-evident and most medical abuses have occurred because the reason for the existence of medical science has been unheeded or ignored.

Two American authors (P. Appelbaum and J. Klein) reviewing the American way of putting Hippocrates into a broom cupboard commented on 'the abandonment by the medical profession of an unambivalent commitment to the treatment of the ill'. It, therefore, behoves all of us in the medical profession not to abandon the primary purpose for our existence as doctors. The simple question must be asked and answered – for what purpose does a doctor practice medicine? He should certainly be neither a destroyer of health or of human life.

The family

Before considering medical ethics and the family, it is necessary to understand the family as the small, unique, irreplaceable community which is essential for the well-being of society as well as its individual members. It is a divine, not a man-made institution, and is therefore not amenable to reorganisation and alteration of its structure – what it needs is a respect for what it is, a community of stability where authentic human and spiritual values are transmitted. 'Family become what you are' is one of the most significant phrases used in the Papal encyclical *Familiarus Consortio*.

It may seem strange to a society which is constantly seeking improvement through reorganisation and money, that what is needed in the case of the family is an understanding of its meaning, structure and function – it needs support to fulfil the reasons for its existence.

One cannot consider the family without marriage or marriage without the family. Some regard marriage as an outdated burdensome institution, possibly because of a lifetime's commitment to one partner. However, temporary arrangements are not consistent with stability, security, and the good of either the spouses or the children.

All medical practitioners will know of the increased morbidity and mortality amongst the divorced, the neglected, and children from 'broken homes'. The health of the individual depends far more on family love and stability than on medical expertise. The institution of the family is, by its nature, inseparable from its

function of bringing offsprings into being. The Latin word for marriage, matrimonium, puts the emphasis on motherhood as though to convey that a married woman has a specific responsibility. The present climate of opinion gives the impression that a woman should avoid this responsibility and doctors should help her to take avoiding action. This is an anti-life attitude which manifests itself in contraception, sterilisation, and abortion.

Specific medical ethics in relation to the family

To respect the integrity of the family, one must respect the integrity of the individuals who constitute it. The definition of integrity according to the O.E.D.: 'the condition of having no part or element wanting – unimpaired or uncorrupted state'.

There has been a widespread attack on the integrity of the individual and the family by recourse to chemical, mechanical, and surgical destruction of normal, healthy reproductive functions. This practice has gained widespread acceptance and is incorrectly known as family planning. In ethics it is important to use words according to their true meaning and the author would maintain that family planning is a misnomer and constitutes either the plan for no family or for its strict limitation. Those clinics known as family planning clinics would be more correctly described as contraceptive clinics, since this constitutes their main work.

The conversion of the normal to the abnormal or the physiological to the pathological is the state achieved when chemicals are administered to render a person unfertile. The chemicals achieve a lot of undesirable effects but their administration is designed to create a state of infertility. The true purpose and meaning of medical science is abused. Instead of a state of health being achieved, a pathological state is created. This has been acclaimed as preventive medicine because of the prevention of 'unwanted pregnancies'. However, the elementary fact should be recalled to mind that pregnancy follows intercourse during the fertile phase of a woman's cycle and is not achieved merely because contraceptives are withdrawn or withheld. The administration of chemicals is obviously not the only method by which a woman remains in the non-pregnant state.

Young people and the family

In the medical management of the young, doctors should understand that the majority will wish to become parents when they reach adult life and that they are potential formers of future families. Nothing should be done to them which might impair this capacity. The desire of a girl to become a mother is a deep-seated natural desire and to render her incapable of realising this wish is an act of cruelty. The love of a small girl for her dolls and pram (which still exist despite external pressures to abolish such toys) is a manifestation of a natural maternal instinct. The provision of contraceptives for children has had a threefold damaging effect:–

(1) It has substituted chemical control for self-control, thereby retarding sexual maturity.
(2) Encouraged promiscuity which has resulted in an increase in sexually transmitted disease which itself can result in infertility and ectopic pregnancy, due to damage and occlusion of fallopian tubes.
(3) Chemically induced infertility has dissociated sexual intercourse from possible child-bearing which has encouraged cohabitation without marriage. Family formation is either delayed or does not take place.

Respect for life within the family

Within the family, all its members, from the youngest, who may have just been conceived, to the eldest, have an equal right to life. The child, born or unborn, must be respected and recognised as equal in personal dignity to those who have given him or her life.

It is the weak and defenceless who have the first claim on medical help and expertise. It is a travesty of justice to use medical means to eliminate the child *in utero* or to kill the chronically weak and old – Hippocratic Oath: 'I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner, I will not give t o a woman a pessary to produce abortion'.

Doctors should not allow the law to make them into killers. All human life is sacred and if the legislators say otherwise, they are in grave error.

In vitro fertilisation

The process of fertilisation under laboratory conditions is becoming increasingly popular amongst the medical establishment. its ethical acceptability has been judged according to possible consequences of the procedure but rarely has the actual act of *in vitro* fertilisation been scrutinised as to its moral worth.

When considering medical progress, it is worth bearing in mind that what is technically possible is not, therefore, necessarily morally admissible. Moreover, technology gives power to some people over other people. Therefore, each medical advance must be used for the advancement of the human person, never for harm, for destruction, or used to deny the dignity of the person.

In fact, a curious state of affairs now exists – on the one hand we are asked to have compassion on the mother with an unwanted child, to such an extent that the child can be destroyed *in utero*. On the other hand we must have such compassion on the infertile woman that no means must be spared to satisfy her desire to have a child.

The question remains as to whether the act of test tube procreation in *in vitro* fertilisation is an ethically acceptable procedure? To this, I would give the answer no, for the following reasons.

The human rights and dignity of the conceptus demand that it starts its life within the environment of its mother's womb. The process of conception in a laboratory dish transgresses these rights, putting the newly formed human life at considerable risk, both from its unnatural environment and from the judgment of technicians and scientists who have the power to determine its future, i.*e.*, whether it will be cloned, frozen, experimented upon

or transferred to a uterus which may not be that of the woman whose ova have been used in the process of fertilisation.

I.V.F. is not a cure for infertility, it is a means of procuring conception under unnatural, hostile, dangerous conditions. It is an example of technology giving the power to the strong over the weak and therefore it must be resisted as totally unethical.

Professionalism

It is necessary in understanding the meaning of professionalism. its definition according to the *Oxford English Dictionary:* 'Profession – the occupation which one professes to be skilled in and to follow'.

The professionalism of parenthood, together with its rights, duties and responsibilities have, to some measure, been ignored or not fully recognised. The well-being of the young, medically, morally, and in every other way, is much more dependent on parental expertise than any other professional help. Michael Novak has said 'the family is the original department of Health, Education and Welfare'. It is, therefore, essential to act always with parental knowledge and consent in carrying out medical procedures or giving drugs or treatment to minors. Parents cannot carry out their duties of loving and protecting a child from harm if they are deliberately kept in ignorance of procedures carried out on their children. The doctor treats the young through their parents, who are the true physicians to their own children – acting with the advice, help and support of the doctor.

An excellent example of parental involvement occurs in respect of the raising of the dead daughter of Jairus, one of the rulers of the synagogue, to life related in Chapter 5 of St Mark's gospel. Christ enters the house to perform the miracle – 'They laughed aloud at him, but he sent them all out, and, taking the child's father and mother, and his own companions with him, went into where the child lay. . . .' The miracle, of course, did not require the presence of the parents but the example had been given.

The doctor will gain the trust of the parents if he or she in turn trusts them, recognising the primacy of their role in looking after their own offspring. The parental role must be supported, not usurped, and this in turn requires a certain humility on the part of the medical establishment, and absence of arrogance and understanding that professional expertise has boundaries which should not be transgressed.

Conclusion

At this time when the well-established moral order is being spurned and overthrown, there is a great need for a moral and ethical renaissance in medicine, as well as in other disciplines. Because our work involves human life, for the doctor ethical values are of supreme importance. We need an ability to understand the eternal, unalterable Natural Law as established by God the Creator and apply the norms of this law to the medical and technical powers we possess.

'You always need to make ideals clear to yourself. You always have to be aware of them, even if there is no direct path to their realisation. Were there no ideals, there would be no hope whatsoever.' (Sakarhov)

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Position Papers, Four Courts Press, November 1988, p.328

REVIEWS

The BMA Report on Euthanasia:
A review article

British Medical Association, London, £7.95

The publication of the British Medical Association Working Party's report is an event of some significance. For some time a groundswell of opinion in favour of legalising voluntary euthanasia has been rising. The recovery in confidence of the Voluntary Euthanasia Society (following its tangles with the law during its EXIT phase in the early 1980's), the regular practice of voluntary euthanasia in Holland and the special predicament of AIDS sufferers have all played a part in this. The BMA, doubtless conscious of these pressures, has acted responsibly in commissioning a report at this time.

The final paragraph and overall conclusion of the report make heartening reading for all those who believe that the legalisation of euthanasia would be a retrograde step:

> he law should not be changed and the deliberate taking of a human life should remain a crime. This rejection of a change in the law to permit doctors to intervene to end a person's life is not just a subordination of individual well-being to social policy. It is, instead an affirmation of the supreme value of the individual, no matter how worthless and hopeless that individual may feel. (p. 69)

The report strings together a number of substantial arguments against euthanasia. It gives considerable weight to patients' autonomy but argues that patients cannot expect doctors to act contrary to the basic ethical commitments of medicine. Requests for voluntary euthanasia require doctors to act at variance with their training and inclinations, and if complied with, would alter the public view of the profession significantly. Often a request to die may actually be a patient's way of testing whether he or she is still valued and loved. And the report touches on a very important point when it says
. (p.24)

> ... if doctors intervene at a selected point to end a human life, and interrupt the unique and complex train of events and reactions that precede death, then they embark on a programme to make one of the most profound features of our humanity radically subject to human choice. Both the community and the medical profession have grave anxieties about such a move with respect to surrogate pregnancies and other issues surrounding birth, and should be equally circumspect about the role of dying as, in some sense, a 'sacred' conclusion of human li

The report contains useful discussions on such subjects as appropriate treatment of those in a persistent vegetative state and the value of advance declarations or 'living wills' that one does not want extraordinary measures taken to keep one alive when in hopeless condition. But overall the report is distinctly patchy in quality. My main reservations are as follows.

First, I feel that the report tends towards smugness about the present level of care given to the dying in this country. The Working Party is certainly justified in referring to the vast progress made through the hospice movement which is having increasing spin-offs for the general standard of care in Britain's hospitals. But cases where patients do suffer and die in great agony, such as the Voluntary Euthanasia Society is inclined to cite, need to be taken more seriously. Moreover, the refutation of charges of widespread pain which are found where the report considers active euthanasia contrasts strikingly with the admission that 'for some patients life as a whole is an intolerable burden; they are, despite counselling and support, in pain, distressed, incontinent, upset at their insight into the fact that they are severely deformed or disabled, or becoming demented' when the report justifies withholding medical treatments in certain cases. Again, while the report calls for better communication between medical staff and patients it seems too easily satisfied with the 'tacit' approach which is common U.K. practice, where medical staff rely on an *intuitive* appreciation of patients' wishes about whether to use cardio-respiratory resuscitation or drugs to prolong life.

Second, I agree with the report that there is a valid distinction which normally holds good, morally speaking, between actively intervening to terminate life and not prolonging life by all measures at doctors' disposal. But the point needs to be made more clearly that non-treatment is also morally reprehensible, and should indeed be classed as euthanasia, when it happens with patients who are handicapped or acutely ill as opposed to terminally ill. In this respect, it is disturbing that the report views with equanimity the practice of not performing corrective surgery on Down's Syndrome babies who have duodenal atresia. The Working Party's *detailed* judgments on this and Lorber's criteria for selective treatment of spina bifida children (which they broadly endorse) actually seem to run counter to their *general* sentiments which speak warmly of respecting the lives of the handicapped. (I have written further on this area in my article 'Life, Death and the Handicapped Newborn: A Review of the Ethical Issues', *Ethics and Medicine* 3:3,1987).

Third, the report neglects some important areas in marshalling the case against legalised euthanasia. It does not discuss the practical problems involved in carrying out euthanasia; nor does it discuss the ambiguous feelings (notably those of remorse and guilt) which might afflict the relatives of patients who have requested euthanasia. It does not delve at all deeply into the family, cultural and social context in which the euthanasia issue is being debated. The superficiality of comment emerges when the report discusses developments in the Netherlands. It is said that Dutch society is sharply polarised, displaying contrasts between strict Calvinism and an ultra-permissive liberal humanism, and that this leads to a 'fairly reflective' standard of ethical discussion which is different from this country. But does polarisation necessarily lead to a high degree of reflection and do we not have widely divergent views of a similar type in Britain? There are some odd *non sequiturs* here.

The report is not particularly well written. The order in which topics are treated often appears arbitrary, and it reads rather jerkily. There is one serious error in attributing a quotation, where an excerpt from Thomas Wood's article on euthanasia in *A Dictionary of Christian Ethics* is attributed to Professor John Macquarrie who edited the dictionary. Finally, why did the Working Party consist entirely of medics? Have we not reached the days when it is recognised that the whole of society has an important stake in key areas of medical decision-making?

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REVIEWS

Whose Life Anyway? The Right to Life

David Alton and Alison Homes
Marshall Pickering, Basingstoke, 1988,
£5.99, paperback

This is a very interesting book, from a number of different perspectives. It represents David Alton's own account of his (ultimately unsuccessful) campaign to amend the law on abortion by introducing a time-limit of 18 weeks' gestation. We are grateful to him and his assistant for the energetic labours which must have been necessary in the aftermath of that campaign to set down so much of this material.

The book comprises 'letters and commentary', with a large number of extracts from correspondents which Mr Alton received (both pro and con), some of it very telling; with a commentary on the events of the campaign and the text of some of David Alton's speeches (together with two pages of one by the present reviewer!) All in all it is a fascinating document.

A sidelight which will interest many readers of *Ethics and Medicine* is discussion of the place of prayer in a parliamentary campaign. David Alton writes: 'I found it curious that the people would normally be the most dismissive about the very idea that God even exists have been the loudest in their complaints about people praying to him. They complained bitterly that it was "unfair pressure"... at one point during the passage of the Bill there were even attempts by some disgruntled members to have the matter referred to the Committee of Privileges!'

And the curiously ecumenical character of Christian participation in the campaign comes through clearly. On the evening of the Second Reading of the Bill, a prayer vigil (moderated by Bishop Maurice Wood) moved between Church House, Westminster Cathedral and Westminster Chapel!

But the most memorable paragraphs are the (often very short) extracts from correspondence. And, of course, the poems with which the book is peppered, particularly Stewart Henderson's devastating 'We were going to be twins'. Those of us who heard this read by the poet himself during rallies in support of David Alton are unlikely ever to forget it.

Nigel M. de S. Cameron

A Dictionary of Pastoral Care

Alastair V. Campbell (editor)
S.P.C.K. (New Library of Pastoral Care),
London, 1987, £12.50, paperback

We welcome the appearance of this paperback edition of Dr Campbell's wide-ranging *Dictionary*. In fact, the range is remarkably wide, and that is inevitably both a weakness and a strength. So the opening articles cover Abortion, Acceptance, Accreditation, Addiction, Adolescence, Adoption (Agencies and Legislation / Emotional Aspects), Ageing, and so on.

It is inevitable in a work of this kind that there will be considerable difference in approach, and, indeed, value taken by different contributors, although the editor is to be congratulated on the thoroughness with which he has sought to draw together so diverse a company. The approach is substantially, though not uniformly, Christian; the editor indicates that a number of Jewish contributors take part, and that, in addition, specialists in various disciplines have been invited irrespective of their religious convictions. This serves to emphasise the breadth of the concept of 'pastoral care' with which we are working here. Many of us might prefer a more carefully defined concept, though remaining grateful for much which now lies close to hand in this single volume.

The *Dictionary* runs to 300 pages of double-column type, and whether for browsing or reference (in which connection the bibliographies are particularly helpful) there will be few professionals in the business of dealing with people and their problems who would not find this a welcome addition to their library.

In light of that, critical comments may seem churlish. There is no entry on AIDS (which reflects the time at which the project was gestating, no doubt in the early 1980s). The article on Abortion, by Rex Gardner, predictably dissents from the high view of the embryo and fetus which many of us hold. There is no entry whatever on Euthanasia (though of course there is one on Death). The article on Homosexuality accepts as fact that this is 'the natural sexual orientation of between 4% and 10% of the human race', and offers no distinctively moral or Christian comment. We could go on: there might be scope for someone to produce a self-consciously Christian *Dictionary* along these lines (the publisher notes that this is presently the *only* such work available). But it is to be commended none the less.

Nigel M. de S. Cameron