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COMMENT

From the Editor

The Embryo Bill

The Government's long–awaited Human Fertilisation and Embryology Bill has just been published, and proves to be a major disappointment. In a number of areas we find cause for concern in what we believe to be one of the most important pieces of legislation to come before Parliament in modern times. We discuss them in the paragraphs which follow before going on to review the recent *Lancet* article written from the Regional Office for Europe of the World Health Organisation, in which the current state of clinical *in vitro* fertilisation is assessed. Finally we reproduce an English translation of a government bill presently under discussion in the West German parliament. Whatever the final status of its proposals in West Germany, they read in striking contrast to those of H.M. Government in the Human Fertilisation and Embryology Bill.

First we draw attention to problematic aspects of the Bill *seriatim. The promised alternative clauses permitting and forbidding embryo research.* This unprecedented offer by the Government has been cleverly mutated into a provision of alternatives within Clause 11, which deals with the Scope of Licences to be granted by the proposed Human Fertilisation and Embryology Authority: either licences for treatment, storage and research, or licences for treatment and storage only. This is no mere quibble: by cloaking the major point of contention in the bill as a detail of the licensing scope of the Authority, the bill as drafted defiantly declares this to be a matter not of fundamental principle but of detail. Aside from all else, this takes no account of the fact that seven members of the Warnock Committee itself (one less than half its number) signed dissents opposing either all such research or all research on embryos created for that purpose. Moreover, should Parliament vote against the licensing of research this approach is plainly designed to make it as simple as possible for such a prohibition to be overturned.

Yet our central concern is the *protection* of the embryo, and the Bill says nothing about that – addressing instead the licensing of the abuse of the embryo. The distinction is rather important, and our concern is echoed in two further instances.

The Bill speaks of licensing 'projects of research'. Such projects, if Parliament permits them, will need to be spelled out on the licence. There is no corresponding reference to 'courses of treatment': the other possibilities are given simply as 'treatment' and 'storage'. Why *projects of* research, and not simple 'research'? The explanation may be innocent, but we shall need to have it; for this is the plainest indicator of the failure of the Bill to provide even an option for an embryo–centred approach to the new technology. If we seek appropriate protection for the human dignity of the human embryo we must demand positive provision for the protection of the individual embryo from anything other than use in (if Parliament so decrees) treatment and storage. It is by no means clear what views the courts would take of deleterious use of the embryo which could be held to come short of a 'project'. We must seek a re–fashioning of these provisions to ensure that, if there is to be 'treatment' and 'storage', it must be in terms which as far as possible uphold the dignity of the individual embryo.

But *what is an embryo*? We might have taken for granted that the entity at the heart of these discussions could at least be biologically described in terms with which we could all agree: in layman's terms, as the product of fertilisation. Yet that is not so, and the Bill introduces a most contentious definition of the embryo as 'for this purpose' not existing until 'the appearance of a two cell zygote'. Until then, according to the Bill, there is no embryo, and so no need for licensing, no possibility of a 'project of research', and so on. Again we must ask why.

And *what is pregnancy*? The opportunity is taken to beg some further questions. 'For the purposes of this Act, a woman is not to be treated as carrying a child until the embryo has implanted.' That of course reflects the widespread legal assumption that abortifacients which operate before, or by preventing, implantation of the *in vivo* embryo are not abortifacients at all – in law.

The Human Fertilisation and Embryology Authority

The proposals for the working and composition of the Authority raise a clutch of further concerns. First there is the question of its composition. Its members are to be appointed by the Secretary of State, and their number is unspecified. According to the Bill, its Chairman and Deputy Chairman must be 'lay' – neither doctors, nor scientists working in this field. So too must be at least one–third of its members, but fewer than half. That is to say, the majority of the members of the Authority must be doctors or medical scientists. What is more, its 'licence committee(s)' which perform its work of licensing 'shall include at least one person who is not authorised to carry on or participate in any activity under the authority of a licence and would not be so authorised if outstanding applications were granted': that is to say, the 'licence committee(s)' of the Authority are obliged to include only one member who is not actively engaged in embryo treatment, storage and (it may be) research, him or herself. That is almost total self–regulation, and this stipulation in respect of licence committees implies that the lay minority on the Authority itself is expected to take a back seat.

Secondly, *the Authority has a double brief. It is also to act as a kind of standing Warnock Committee.* One of its responsibilities is defined as follows: to 'keep under review information about embryos and any subsequent development of embryos and about the provision of treatment services and activities governed by this Act, and advise the Secretary of State, if he asks it to do so, about those matters'. On the surface this seems harmless, but it is potentially highly damaging to our future prospects of morally coherent public policy in the whole area of 'embryos and any subsequent development of embryos'. Why? Because the licensing responsibilities of the Authority are largely an administrative function. They could equally well be exercised by the civil service (much as the Home Office licences animal experiments). The logic of the Authority as a licensing authority is largely political – it sets this highly contentious area of medical scientific activity at one remove from govern-

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ment. Indeed, in this respect its domination by distinguished members of the medical–scientific establishment is a political necessity, anchoring its responsibilities elsewhere than in the arena of direct parliamentary accountability. From a practical perspective, its members must plainly understand the medical and scientific aspects of their remit, and it would hardly be prudent for them to disagree fundamentally with one another about the ethics of aspects of their work. It would be truly astonishing if members were appointed to the Authority who were fundamentally out of sympathy with the whole development of *in vitro* fertilisation.

Yet if we are to have a 'standing Warnock' it is essential that it should represent just such a diversity of opinion. It was a major weakness of the Warnock Committee that even here the diversity was strictly limited, and no known critics of the fundamental direction of the new reproductive technology were appointed. Yet Warnock was at least claimed to be representative of a wide range of (religious and other) opinion, and were such a committee appointed again the pressure would be strong for its diversity to be significantly greater than Warnock's. Yet here, before our very eyes, a standing Warnock is being set up – in passing. If the Authority is constituted as the Bill proposes and with the double role envisaged, it will help ensure that the future direction of public policy in this area is in the direction desired by the medical–scientific establishment and their collaborators in the upper reaches of the Department of Health,

Experimental IVF?

It is widely assumed in this discussion that the clinical practice of IVF, though a technique of recent development, has proved itself. In the Lancet of October 28th Marsden G. Wagner, of the Regional Office for Europe of the World Health Organisation and Patricia A. St Clair, of the University of Washington, Seattle, ask some probing questions which are plainly not the kind of questions which those involved in clinical IVF are accustomed to ask. They offer in brief compass an audit of the IVF story so far, and anyone seriously interested in this discussion who has not already seen their paper should get hold it one and read it. That presumably includes our Parliamentarians, who – whether they like it or not – have been invited to take a very keen interest in these questions during the next few months.

The Science Correspondent of The Times summed up the article in this sentence: 'Test–tube baby techniques carry substantial risks for both mothers and infants and should still be looked on as experimental, the World Health Organization has said' (October 28th, 1989). Let us quote some statements from the article.

> No new technique should become standard until after rigorous evaluation. Until then, it must remain experimental, guided by the principles covering research on human subjects. Evaluation involves assessment of efficacy, safety, and costs, including indirect expenditures on treatment of side–effects. This information can then be used to establish whether the new technique is appropriate in view of national policy and economic constraints. IVF/ET and related assisted reproduction technologies have not been scrutinised in this way. Most research has focused on perfecting the procedures. With few exceptions, efficacy rates are reported for single clinics or for data from clinics that participate voluntarily in pooling. There is a lack of randomised trials to ascertain the efficacy of IVF/ET compared with more established treatments for specific classes of infertility, which seriously hampers evaluation . . . .
>
> With success defined as biochemical pregnancy related to ET cycles, efficacy rates may be as high as 35–55%. If, instead, the numerator is the number of clinical pregnancies or livebirth pregnancies, efficacy rates are modest. The best population–based study to date, of all IVF/ET units in Australia and New Zealand, reported efficacy of 15.5 clinical pregnancies and 11.1 livebirth pregnancies per 100 ET cycles.
>
> . . .
>
> Efficacy is even lower when these outcomes are related to all stimulation cycles, since the ET stage is often never reached. The Australian and New Zealand register reported 11.6 clinical pregnancies and 8.3 livebirth pregnancies per 100 stimulation cycles.... There are no reliable data on the number of healthy babies per stimulation cycle, although it is estimated to be 4-5%.
>
> 'Despite these sobering figures, some argue that any chance of successful reproduction is better than no chance at all. This would be a compelling argument... if not for the observation that many candidates would become pregnant without the intervention. Studies of women accepted for IVF/ET programmes show that 7–28% conceive naturally either before receiving treatment or within two years after discontinuation.... A clinic in Australia received notification that 450 spontaneous pregnancies had occurred in couples on a waiting list for IVF/ET between 1980 and 1985. These date call into question the validity of all reported efficacy rates since no such rates reflect the difference between the results for women receiving treatment and those for non–treated, comparable controls or controls receiving conventional therapy.' (References omitted.)

These are but samples of this stimulating review and the hard questions it poses. The writers go on to discuss safety aspects, both for child (in Australia and New Zealand, 17% of singletons are of low birthweight, some three times that of the population; neonatal mortality is twice, and perinatal mortality four times the population rate) and for mother (aside from all else, Caesarian rates are very high). Then they discuss cost (estimated at 40,000 Australian dollars per livebirth, plus additional obstetric expenses and so forth). Finally they turn to an appraisal of the current position and discuss how we face the future. They conclude: 'Until full appraisal of the short–term and long–term risks and estimation of efficacy, IVF/ET must be considered experimental, and public and private insurance funds for health services should not be used for IVF/ET.

The West German Bill

This government bill has been presented to the West German Parliament. The translation is unofficial and has been commissioned by LIFE, to whom we are grateful for permission to reproduce it here:

Section 1

Abuse of reproduction techniques

(1) Punishment of imprisonment of up to three years, or a fine, shall be imposed on persons who

1. Transfer to one woman an unfertilised egg cell deriving from another woman, unless there is no possibility of fertilisation of the transferred egg cell,
2. Undertake to fertilise an egg cell artificially for a purpose other than to cause the pregnancy of the woman from whom the egg cell derives,
3. Undertake to fertilise more egg cells from a woman than should be transferred to her within one cycle,
4. Take an embryo from a woman before it becomes lodged in the uterus, in order to transfer it to another woman, or to use for a purpose other than its maintenance, or
5. Undertake to carry out artificial fertilisation in a woman who is prepared to hand over her child to third parties after the birth (surrogate mother), or to transfer to her a human embryo.

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(2) *Punishment shall also be imposed on persons who*
1. Artificially cause a human sperm cell to penetrate a human egg cell, or
2. Artificially transmit a human sperm cell into a human egg cell,
without intending to cause the pregnancy of the woman from whom the egg cell derives.

(3) *The following shall not be punished*
1. In the cases in paragraph 1 no.1, 2 and 4, the woman from whom the egg cell or embryo derives, and the woman to whom the egg cell is transferred or to whom the embryo is to be transferred, and
2. In the cases in paragraph 1, no.5, the surrogate mother and the person who wishes to look after the child permanently.
(4) ***In the cases mentioned in paragraph 1 and paragraph 2, attempts are punishable.***

Section 2
Abuse of human embryos
(1) Persons who alienate an extracorporeally produced embryo, or a human embryo taken from a woman before it lodges in the uterus, or persons who give away, throw away or use an embryo for a purpose other than its maintenance, shall be punished with imprisonment of up to three years, or with a fine.

(2) Persons who cause a human embryo to be developed extracorporeally, for a purpose other than causing pregnancy, shall also be punished.

(3) Attempts shall be punishable.

Section 3
Improper sex selection
Persons who undertake artificially to fertilise a human egg cell with a sperm cell which has been selected according to the sex chromosome contained in it shall be punished with imprisonment of up to one year or with a fine. This does not apply if the selection of the sperm cell by a doctor serves to avoid a sex-specific hereditary disease in the child to be produced, and if the disease threatening the child has been recognised as serious by the medical centre competent according to provincial law.

Section 4
Unauthorised fertilisation and unauthorised embryo transfer
(1) Persons who undertake to fertilise an egg cell artificially without the woman whose egg cell is being fertilised, and without the man whose sperm cell is being used for the fertilisation, having given their consent, shall be punished with imprisonment of up to three years or with a fine.
(2) Persons who undertake to transfer an embryo to a woman without her consent shall also be punished.

Section 5
Artificial modification of human germ cells
(1) Persons who alter the genetic information in a human germ cell artificially shall be punished with imprisonment of up to five years or with a fine.
(2) Persons who make improper use of a human germ cell with artificially altered genetic information shall also be punished.
(3) Attempts shall also be punishable.
(4) Paragraph 1 does not apply to

1. Artificial alteration of the genetic information of an extracorporeal germ cell, if it cannot be used for fertilisation,
2. Artificial alteration of the genetic information of another intracorporeal germ cell which has been taken from a dead unborn child, a human being or a deceased person, if it is impossible for
   (a) this to be transferred to an embryo, fetus, or human being,or
   (b) a germ cell can be obtained from it and
3. Inoculations, radiation, chemotherapeutic or other treatments with which alteration of the genetic information of germ cells is not intended.

Section 6
Cloning
(1) Persons who artificially cause a human embryo to be formed with the same genetic information as another embryo, a foetus, a human being or a deceased person, shall be punished with imprisonment of up to five years, or with a fine.
(2) Persons who transfer an embryo described in paragraph 1 to a woman shall also be punished.
(3) Attempts shall be punishable.

Section 7
Chimera and hybrid formation
(1) *Persons who undertake*
1. To combine embryos with different genetic information, using at least one human embryo, to form a cell union,
2. To combine with a human embryo a cell which contains genetic information different from the cells in the embryo, and which is able to further differentiate with this, or
3. To produce a differentiable embryo by fertilising a human egg cell with the seed of an animal or by fertilising an animal egg cell with the seed of a human being,
shall be punished with imprisonment of up to five years or with a fine.

(2) *Persons who undertake*
1. To transfer an embryo produced by an action according to paragraph 1
   (a) to a woman or
   (b) to an animal, or
2. to transfer a human embryo to an animal
shall also be punished.

Section 8
Definition
(1) Embryo, within the meaning of this Act, is defined as the fertilised human egg cell which is capable of development, from the time of nuclear fusion onwards, and also any totipotent cell taken from an embryo and capable of dividing and developing into an individual if the further conditions required for this exist.
(2) In the first twenty four hours after nuclear fusion, the fertilised human egg cell shall be regarded as capable of development unless it is established, before the end of this period, that it is not capable of developing beyond the single cell stage.
(3) Germ cells within the meaning of this Act are defined as all cells which lead in one cell line from the fertilised egg cell to the egg and germ cells of the human being preceding it, and also the egg cell from the time of introduction or penetration of the germ cell until fertilisation terminating with the nuclear fusion.

Section 9
Berlin Clause
This Act shall also apply in the State of Berlin, according to Section 13, para. 1 of the Third Transitional Act.

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From Dr PEKKA REINIKAINEN, Helsinki

A Debate on Fetal Tissue Use in Finland

In the summer of 1988 the widely circulated Finnish daily newspaper, *Helsingin Sanomat* (HS), published an article in which the Professor of Neurology of the University Hospital of Turku explained that the university is going to start brain cell transplantation in a few months' time. At first brain transplants will be used to treat patients suffering from Parkinson's disease, but soon a 'youth clinic' will be opened to treat Alzheimer's dementia. The Professor stated that the tissue to be transplanted will be obtained from dead human fetuses. He went on to say that he saw no reason why this procedure should cause any ethical discussion. After all, according to Professor Urpo K. Rinne, use of cadaver tissue from dead fetuses is no different from use of tissue from the deceased adult.

However, a few dissenting comments appeared in the press. Two physicians stated their doubts about the utility of the procedure and a lay columnist expressed horror at this new kind of medicine where the weak, unborn child is sacrificed to relieve the sufferings of a patient. A theologian's viewpoint also appeared in a journal of Parkinson patients, where the theologian fully accepted the use of aborted fetuses. By this time two journalists from the Finnish National Broadcasting Company (YLE) became interested in what was going on, and they made a radio programme on the subject. Professor Rinne was interviewed in the programme, and he quite openly told the Finnish public that problems in this kind of brain tissue transplantation were mainly technical, *i.e.,* that the abortion technique should be modified so that better quality tissue should be obtained. This caused a furious reaction from some listeners and the Finnish Medical Board, the government regulatory body for medicine, suspended the planned brain tissue transplantations, because no permission had been asked, and there was no legislation on the subject.

Two Finnish physicians, Paivi Rasanen and Pekka Reinikainen, author of this comment, started to do some deeper research on the subject of fetal tissue use, and from the materials collected a book was written with the help of Dr Nigel Cameron from Rutherford House and two Finnish theologians, Niilo Rasanen and Leif Nummela. The book, *Uuden laaketieteen uhrit (Victims of the New Medicine),* caused an unprecedented uproar in the Finnish press as far as questions in medical ethics are concerned. The first reactions were those of disbelief and denial. The book was outright labelled as untrue by leading medical professors and ethics experts. However, the hard facts were there. Finnish researchers had, beyond doubt, been involved in dubious research with living human fetuses, as the following quotes clearly indicate:

In order to evaluate the early development of receptors for pharmacological doses of arginine, it was injected directly into the carotid artery of eight human fetuses weighing 45 to 600 grams (approximately 10-23 weeks), while the placenta remained in utero.[1]
Eight human fetal heads, obtained by abdominal hysterectomy at 12-17 weeks' gestation, were perfused through the internal carotid arteries.[2]
For in vivo experiments each fetus immediately after removal from the uterus was injected with approximately 100 ci . . . all injections were made into the umbilical vein. . . . During this period the heart continued to beat and spontaneous movement was seen.[3]
Fragments of pancreas were obtained from seven fetuses ranging from 9 to 20 weeks within 1-2 minutes following hysterectomy.[4]

Despite such convincing evidence systematic denial continued. Even the Medical Board declared having investigated reference 2 and found no irregularities. However, it is widely known that such experimentation has been widely practised in many countries. Swedish researchers B. Westin, R. Nyberg and G. Enhorning have even published a technique for perfusion of the pre-viable human fetus.[5]

The issue received wide coverage in the press and on national TV networks. Parliamentary groups pressed for urgent legislation on the subject. The abortion dilemma also surfaced. In Finland the number of abortions has been steadily declining from the high of 1973 when 23,000 abortions were performed (40% of pregnancies) to the present low of 13,000 abortions per year (Finland's population is 5 million).

A seminar on fetal tissue use was organised by the ethical board of the Finnish Ecumenical Council and the Finnish Christian Doctors' Association. Bishops, hospital pastors, and a few MPs attended the seminar. The churches organised also a discussion behind closed doors to ventilate the problem. Strikingly, not one lecturer volunteered from the University of Turku, which had caused the uproar in the first place by its planned brain transplantations. The seminar reached the conclusion that urgent legislation is needed.

The debate on fetal tissue use in Finland showed clearly that a control system based on hospital ethical committees is inadequate. The one obligatory lay member of an ethical committee is usually at a loss, and cannot understand scientific details. The same dilemma was mirrored in the working group set up to establish guidelines for legislation. Two of the group's three members were, in fact, medical researchers in the particular field in question, so the working group's objectivity could legitimately be questioned.

The debate covered quite extensively the issues of amniocentesis and villus biopsy, and the right to abort malformed fetuses. The moment when human life actually begins was widely discussed. One could clearly see that the implications of the Hippocratic Oath are being discarded and that the Judaeo-Christian view of medical ethics is being supplanted slowly by a purely utilitarian approach. Two nationally known ethicists have even started a column titled 'After Hippocrates' in a lay medical journal. The Finnish Medical Association has removed the obligation of respect for human life from the moment of conception from its newly published set of ethical directions. It was interesting that even the Finnish consumers' union published a statement requiring interdiction of use of

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human material in cosmetic products after it was found out that beauty products contained placenta and embryonic extracts of unknown origin. The manufacturers maintained that only animal placental tissue was used.

The debate was clearly needed, and the following problems came up which require further evaluation. Society should no longer tolerate the socio-economic distress of which abortion is thought to be the only solution. The problem of fetal death needs to be addressed because of the different physiology of the fetus *ex utero* – there is no simple analogy with later human death. The question of permission for the use of fetal tissue is not clear. It is evident that the woman undergoing the abortion should not say to whom the fetal tissue is to be transplanted, and neither can the doctor who performs the abortion. And the moment of fetal death is closely associated with the pain the fetus eventually may experience.

Finally, a midwife from the city of Turku reported to the press in September of 1989 that fetal pancreatic tissue had, for several years, been secretly harvested from aborted fetuses. A major TV network made a programme on this recently (October 1, 1989), and it proved to be a big embarrassment to the government Medical Board that had just stated that no such things could happen in the country. It was, however, distressing that despite this major scandal using fetal tissue without the woman's permission only one evening newspaper published the facts.

The ethical discussion in Finland has been monopolised by a handful of 'experts' who are always quoted by the press, and it has proved almost impossible to publish an adequate statement of dissenting viewpoints lately. What is even more worrying is that there was no reaction at all to the clandestine use of fetal tissues from feminist groups. It is, therefore, of the utmost importance that the European nations address themselves to the need for precise guidelines on the protection of man's genetic integrity and the use of embryos and fetuses in research. The Council of Europe, with its wider representation than just the EEC, has already made an encouraging start.

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3. Gaull, G., Sturman, J. A., and Raiha, N. C. (1972), 'Development of mammalian sulfur metabolism: absence of cystathionase in human fetal tissues'. *Pediatric Research* 6, 538-547.
4. Laitio, M., Lev, R. and Orlic, D. (1974) 'The developing human fetal pancreas: an ultra-structural and histochemical study with special reference to exocrine cells'. *Journal of Anatomy* 117, 619-634.
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The Spiritual Care of the Dying Patient

G. RAYMOND SELBY, Milverton, Somerset

It would not be easy to hazard a guess about the relative number of people who die in their homes, or who die in hospitals and nursing centres. What can be said with reasonable certainty is that far fewer people die in their own home than was the case forty, thirty or even twenty years ago. Far more people die in the hospitals and nursing homes in which they have been patients. This factual situation precipitates the physician into the centre of an area of life and death which, hitherto, was not a primary concern; that is the spiritual care of the dying patient. In the smaller communities of the past, where the majority of people died at home, it was the physician and probably the local nurse, who were the visitants, whilst the priest, minister or rabbi, although he too would come and go, was more able to give, not only the impression, but also the reality of his continuing presence. Because of the demands of their respective ministries, the physician of the soul was far more likely to be present with the patient throughout the process of dying, than was the physician of the body. Nowadays the situation is largely reversed.

In my own ministry in a small town where the local community hospital has recently closed through lack of financial resources, many of the local people, in critical or even in serious condition, are taken to the large, modern hospital fifty or more miles away. When a short routine visit to such a patient, because of travel, problems of parking, locating the patient in the vast hospital complex, and waiting for a convenient moment to enter the patient's room, during the temporary abeyance of medical procedures, can take almost half a day, the difficulty of spiritual ministration to the dying patient by his or her own pastor is immediately apparent. Only if the patient is returned home to die is such a final ministration more easily possible. Contemporary medical philosophy, however, very often militates against this happening.

This means that some elements of spiritual care of the dying patient have to be exercised, if they are to be exercised at all, by someone other than the person with whom the patient has had a pastoral relationship during his or her daily life. Most large hospitals have resident chaplains, and, no doubt, they perform a remarkable and valuable service; but they too, endeavouring to minister not only to the large number of sick people in the hospital, but also to the medical and ancillary staffs, are only a little less visitants to the dying patient than is the local pastor. The people who are in loco familiae, as it were, are the physicians, and their medical and nursing colleagues. It is very often only they who are physically in a position to provide the background of any kind of spiritual care for the dying patient. Many will feel that they have no responsibility in this area . 'They often do not wish to become entrapped in tough questions about death, meaning, absurdity, destiny, futurity, and trust in God.'[1] 'Modern physicians, despite exceptional technical competence, are especially vulnerable to frustration in the presence of death.'[2] What is more it would not be surprising if many practitioners in the medical field responded by asking the challenging question, 'What is spiritual care?'

In order to attempt to answer this question it has, first, to be recognized and accepted that both our society and our culture are now pluralistic. Although the roots of this nation are deeply embedded in the Christian tradition, its evolution has seen the advent of not only a large representation of the Jewish faith,(the members of which, in many ways, have a similar spiritual ethos to that of the descendants of the original Christian settlers,) but also of millions of others of many different faiths and of none. This cannot but add to the difficulty of the provision of spiritual care to the dying patient. It cannot help the dying patient to have the spiritual integrity of his or her faith impugned by the ignorance or the insensitivity of the ministrant, whoever that may be.

It would seem, therefore, that some definition or description of the 'spiritual' is a pre-requisite for all involved in the care of the sick and dying. In a world dominated, if not by materialistic philosophies, at least by materialistic assumptions and practices, is it possible so to define the spiritual that it may have application to all patients, without reducing it to platitudinous generalities? I believe it is, but first it is necessary to relegate the 'ghost in the machine' understanding of the spiritual to a more secondary place. This concept may still be valuable but it is far too narrow an understanding to serve, virtually universally, in the present situation.

The definition of the spiritual must, fundamentally, be related to the person and the personal. That is why the title of this article, (not chosen by its author) is such a perceptive one. It points to the concrete actuality or to quote William Cowper 'the unbound soul in bonds' of the body of the person/patient, and not to some abstract description of an allegedly general entity described as 'the dying'.

It is sometimes said, today, that medicine in general is moving to a more holistic understanding of the patient. The philosophy of holism is the theory that a living being has a reality other than, and greater than the sum of its constituent parts. Few, even of those who have no religious faith, would wish to deny that the living person is ' greater than the sum of the body's constituent parts'. Each person has a 'personality' which is different from every other personality. Each personality is unique, and, although manifest through and by the body, transcends the body. It is not easy to find words to describe, adequately, this transcendental element, but few words are more apt than the word 'spiritual'. If there is a human element which has a continuation with a life other than the existence we know in this world, it must be related to the element, so elusive of description, which we may call the spiritual. It may be claimed, therefore, that human beings are seen 'spiritually' when they are seen as 'living wholes'; holistic living beings. This understanding of the nature of man is certainly in accord with that of the Old Testament. It is this wholeness, this spirituality, which is essential and fundamental to human life. It remains until the process of dying is virtually complete, and the physical body may rightly be described as a corpse when it ceases to manifest that spirituality. It is to this holistic human being that spiritual care has to be rendered, not least as the person approaches death.

Gregory the Great, who wrote a great classic work on the spiritual/

pastoral care of the person,[3] has claimed that the physician of souls had a more difficult task than the physician of the body. In a very real sense this is still true, because the physician of the soul, in dealing with the whole being, has to deal with so many intangibles. What is more, human minds, human wills and human emotions do not have the patterns of regularities that human bodies have, and the sicknesses of human minds, wills and emotions are even more complex than the sicknesses of that very complex phenomenon, the human body. Nevertheless, inspite of St Gregory, the task which nowadays so often faces the physician and his colleagues, to minister holistically, is of immense difficulty, especially when it is realized that, frequently, if some spiritual care is not provided by the medical fraternity, it may not be provided at all.

There are, however, formidable barriers in the way of this spiritual care to the dying patient, and in the creation of an atmosphere in which such spiritual care may be given. For those whose training and outlook are contained totally within the context of contemporary medicine, the first barrier, as has already been mentioned, is the re-action, 'This is not my job.' The acceptance, universally, of the concept of holistic medicine has a long way to go before this entirely understandable reaction of the medico and his colleagues will not be present. This reaction, however, is not the only, nor necessarily the steepest barrier. There are several others. For example, the whole ethos of the physician's profession, and of his training for that profession, is and has been directed towards an analytical view of the individual. Indeed, it is difficult to see how the physician could do his job without this analytical, critical and clinical approach. There has to be a strong element of *impersonal* objectivity in the diagnosis and treatment of disease. But spiritual care requires a *personal* objectivity.

Furthermore, the physician's whole career is spent in fighting disease. It is not surprising that, within the context of what must often seem a situation akin to all–out war, death is the great enemy. The empirical fact that death is always the ultimate victor in this war does not change this; on the contrary, it often induces in so many physicians an almost Churchillian determination to fight death at all costs, and to the bitter end. This leads to another barrier: the often unspoken and sometimes unrecognized belief, that each death is a failure. Almost inevitably, this frequent acquaintance with apparent failure, can demand, psychologically, an even greater impersonal objectivity, which again raises the barriers to conscious spiritual care and concern.

The fundamental point and fact is that in so much of the present day's medical circumstances, only the medical staff can create and permit the growth of conditions which will allow for realistic spiritual care of the dying patient. And the first step in the creation of those conditions must be the conscious and sub-conscious acceptance of the fact that death is not the great implacable enemy, but that it is an essential and natural part of every human life. Of course, the medical profession will rightly continue to work with selfless commitment, to resist and overcome disease, but it must not be at all costs. The line will be a fine one, and even a shifting one, but there must be such a line, at which point death is accepted and not unreasonably resisted. Otherwise the opportunity for spiritual care is reduced almost to the point of non-existence.

Almost all that has been said so far has been concerned with the background, the circumstances, in which spiritual care of the dying patient has to be exercised. It is time now to turn to the more positive aspects of this care.– Arising from our definition of the spiritual, it becomes apparent that, first of all, the 'person' of the patient has, continually, to be kept in mind, and hence also the dignity which the nature of that personhood demands. Illness, to a greater or lesser degree, can always be an assault on the dignity of the person, and it requires maturity on the part of the sick person, to face that assault, and retain natural human dignity. Modern medical techniques, however, so often, and inevitably, provide a further, and sometimes a very powerful assault. When those techniques are necessary, care needs to be taken, sometimes at the cost of speed and efficiency, to pay due regard to the dignity of each spiritual person. It is distressing to see the loss of dignity which some chronically sick elderly patients suffer in some nursing homes. If it is distressing to the observer, it must be so to the patient.

Secondly, there must be some evident acceptance of the mortality of the patient. A professor of orthopaedics wrote to me recently, 'the dying accept their mortality - the living won't even accept someone else's mortality.' The acceptance of mortality, which is the acceptance of reality, is a pre-requisite of spiritual health, and this is especially so for the dying patient. It must be a great and additional burden to many physicians to be faced with the requests, or even demands, for the bestowal of a kind of immortality upon a dying person by anxious and grieving relatives. And yet the physician and his colleagues, because they are so intimately associated with the life and death of the patient have a crucial and critical role in creating the environment which accepts human mortality.

I have known of patients whose approach to death has been so distressing and spiritually damaging because of the knowingly false optimism which has been engendered, and by which they have been surrounded throughout their terminal illness. In such an atmosphere, the care and treatment is inevitably accompanied by a tissue of lies and falsehoods. For a person who has lived by the canons of honesty and truth, it is a violation of all their principles to be met with this dishonesty and deceit as they approach death. Of course this is not to suggest that a patient should suddenly be told 'you are likely to die from this'. There are strong medical and psychological reasons for the patient's reassurance, in so many cases, in order that there may be possibility of improvement, and the hopes of restoration to a more normal life. The patient so often needs to muster all their energies and courage, to benefit from the treatment received, and nothing should be imposed to detract from the will to live.

On the other hand, there are frequently situations when the patient, the physician and the pastor know that the illness is terminal, and the prognostication for any lengthy survival is grim. It is difficult to see how, in such circumstances, a conspiracy of pretence, or even of silence, is conducive to the spiritual health of the dying patient. Whilst it is probably never appropriate for the physician, either of soul or body, to say to the patient 'You are dying', for no physician of either kind knows absolutely, it is better that there should be no attempt to conceal from the patient the gravity of their illness, and the time may come when it is the pastor's responsibility to gently advise the patient of the gravity of the situation.

Without an atmosphere of the acceptance of mortality, and without a readiness to admit, on the part of the medical staff, the probability that the patient is dying, spiritual care can be prohibited. I vividly remember being called to the local hospital where an eighty year

old man, a devout and lifelong member of the church I was serving, was in extremis. I was forbidden entry into his room until after his death, in spite of the fact that resuscitation attempts had been going on for many hours, and it must have been apparent that the probability of their success was, to say the least, doubtful. In that instance 'physical care' would not give way to 'spiritual care', even for a moment.

Perhaps, even more importantly, in a number of instances, the refusal to accept the mortality of the patient, and the failure to admit the probability that the patient is dying, prevents the individual from obtaining the spiritual care that the patients themselves know they need. It is not unusual for there to be a strong sense of guilt in the mind of the dying person. This needs to be recognized, brought out and absolved, if the patient is to die in spiritual peace. It is here that the skills of the patient's own priest or pastor, or those of the resident chaplain are needed and can be used. Indeed just as when people more often died at home, the family and the minister provided the back–drop for the 'specialist' visits of the physician of the body, so now it may be that the medical staff have to provide a similar kind of back–drop for the visit of the physician of the soul. This situation may seem to demand a reversal of recognized roles. However, in earlier, and perhaps psychologically more realistic societies, the visit to the sick person by the physician of the soul was recognized as very important because sickness so often ended in death. With the development of more successful medical treatment the visit to the home by the physician of the body acquired an importance of almost awesome dimensions. It ought not to be a case of hurt pride on the part of the medical staff, if, for certain periods, the otherwise paramount importance of their roles is reduced.

All too often, in major hospitals, the visiting minister has to face an atmosphere of medical omniscience, omnipotence and omnicompetence. His appearance is sometimes seen as an intrusion into a world where he is an inconvenient nuisance which has to be tolerated, or as an anachronistic amateur in this highly sophisticated and scientific professional world. On the other hand, the inexpertise of some ministers poorly trained in spiritual care, or from a far too limited understanding of spiritual need, can provide justification for such an attitude. It hardly needs to be said that such an atmosphere is not conducive to spiritual care.

There are other spiritual problems which arise amongst dying patients in addition to the problem of guilt. Not infrequently is found the belief that the present suffering is, in some way or other, a punishment for past sins. Both this belief and the guilt feelings can produce the abusive patient. Other patients suffer from anxieties about their death, whilst yet others have feelings of personal inadequacies as they face death. These are the problems which need to be treated by the visit of the 'specialist' physician of the soul, in an unhampered atmosphere, the possibility of which can only be created by the sympathetic physician and medical staff.

Both physician of the body and of the soul need to remember that their knowledge of the process of death, no matter how experienced they are, is 'second-hand'. The dying patient knows, existentially, more than either of the two kinds of physicians about the experience. Whilst both kinds of physicians come to provide their respective kinds of ministry to the dying patient, the frame of mind should be a receptive one. Each approach to death can be a learning process, and of reciprocal benefit to both patient and physicians.

It is important that the physician and medical staff be sensitive to the needs of the 'non-church' and apparently non-religious person. This is the person who may not have received a visit from any local pastor, and, until the awareness that this illness is terminal, will not have made any real contact with the hospital chaplain. As death approaches, however, it is often this kind of person for whom the need for some spiritual care becomes acute. It may never be offered if those who are ministering, medically, do not lookout for this kind of need. Not infrequently, in spite of appearances, this person has a simple, uncluttered religious faith, which apparently has been sufficient during normal life. But the approach of death reveals its limitation, and further help and assurance is sometimes desperately needed. It is the experience of the present writer that even the nearest relatives can be totally unaware of these needs, and the patient may be especially shy of expressing this need to his kin. But the need may be acute, and only those who are ministering to the body may be in a position to diagnose this need of the spirit.

It is paradoxical that, during life, we are so concerned with the education of the mind, with good emotional development and with moral and ethical growth, all of which are part of the spiritual nature of the human being. In terminal illness, however, these aspects of life are almost entirely ignored. And yet there is no doubt that the body, which is absorbing almost all attention, will die, and it is equally apparent that if any of the elements which compose the spiritual person will live in a different dimension of life, it is precisely these aspects of life which are usually expected to be put into abeyance. Of course, physical weakness and physical pain may prohibit most of the activity of the mind, emotions, or conscience, but probably less frequently than is often thought.

The physician Alfred Worcester wrote, 'We are always dying; instantaneous death is rare and even when sudden the minutes seems hours, and there is usually ample warning that death is imminent.... The process of dying is progressive, not a simultaneous failure of vital functions. It usually proceeds from below upwards.... Remarkable recoveries of consciousness occur at the last, and the loss of consciousness is usually gradual. Long after whispered words are inaudible the patient may signify assent or dissent by movements of the head. Still later only the eyes may speak....'[4] If this is true, it adds to the justification of the argument of the previous paragraph concerning the care of those more spiritual aspects of life, which are so often ignored in terminal care.

Finally, one great problem of our human life is that death always happens to someone else; always, that is, until it is our time to die. The difficulty of the acceptance of 'my death' in life, is a considerable part of this problem. This is essentially a spiritual problem both for the patient and for the physicians of body and soul. Unless the physician accepts the appropriate spiritual significance of his own 'my death', he will not truly appreciate the spiritual significance of the dying patient's 'my death', but will himself unwittingly constitute a barrier to the full spiritual care of the dying patient.

Notes

1. *Pastoral Theology.* Thomas C. Oden, Harper and Row, 1983, p. 294
2. *Op cit.*, p. 295
3. *Pastoral Care.* St Gregory the Great (Ancient Christian Writers), The Newman Press, 1950.
4. *The Care of the Dying.* Alfred Worcester. In Emerson L.Eugene's *Physician and Patient: Person Care.* Harvard Univ. Press, 1920.

Rescuing the Innocent:

An Inquiry into the Ethics of Operation Rescue

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Operation Rescue represents an important development in the fight against abortion in the United States. The pro-life movement has grown dramatically since the 1973 U.S. Supreme Court decision, *Roe v. Wade,* which effectively legalised abortion on demand. In the past, civil disobedience occurred, but it was seldom widespread, organised, or central to the intentions of pro-life demonstrators. Now, however, Operation Rescue has made civil disobedience an important focus.

On July 3, 1989, the Court handed down a ruling in *Webster v. Reproductive Health Services,* which did not overturn *Roe,* but is largely seen as a pro-life victory. Though the implications of *Webster* are still being debated, it is understood as inviting the individual states to regulate abortion. Thus, though the battlefield seems to be shifting from federal to state venues, the struggle to save the unborn continues.

The strategy of Operation Rescue is simple: demonstrators peacefully block the entrances to abortion clinics. Writing in *Policy Review* (Winter, 1989; p. 82), Randall Terry, the founder of Operation Rescue explains:

> These acts of civil disobedience, which we call rescues, are designed to save lives by preventing abortionists from entering their death chambers, and to dramatise for the American people the horrors of the abortion holocaust. By going to jail, by using tactics such as refusing to give our names to the courts, we seek to focus attention on the nameless victims of abortion, the children who are sentenced to die without the protection of our justice system. We also seek to persuade the other victims of abortion, the mothers about to lose their children, to rethink their decision and choose life.

My Thesis

I stand with Operation Rescue in opposing abortion, but I have serious questions about the strategy it employs. My reading of Scripture leads me to conclude that its civil disobedience is without biblical warrant. I wish to do nothing that might weaken the pro-life movement, but my concern is that our thinking and behaviour resonate with Scripture.

I will not argue that civil disobedience is always contrary to Christian ethics, since the Bible clearly condones it. Daniel, for example, defied the king's edict which outlawed prayer (Dan. 6:6-10). And the apostles would not cease preaching when they were commanded to do so (Acts 5:27-29) – 'We must obey God rather than men' was their unequivocal response.

Nor will I argue that civil disobedience is unwarranted except in cases involving religious liberty, as in the foregoing examples involving prayer, or preaching. We are commanded to rescue the innocent who are being dragged off to death (Lev. 20:2-5; II Kings 24:4; Ps 106:38-40; Pro. 24:11-12). The concern for justice is central to discipleship, and to limit this to 'religious' struggles is to dishonour the one who is Lord of all. Rather, the question I am seeking to answer from Scripture is this: Are there limits placed on our civil disobedience in the fight against injustice and, if so, what are they? And how do these limits specifically apply to Operation Rescue?

The Civil Disobedience of Operation Rescue

Randall Terry prefers to speak of biblical obedience rather than civil disobedience. 'Although it is not necessary to be religious to be involved in the rescue movement', he has written, 'most of our members are following what we believe is a biblical mandate' (*Policy Review,* Winter 1989; p. 82).

A professing Christian, Terry is convinced that his strategy is a prudent effort in the public square. 'I am convinced that the American people will begin to take the pro-life movement seriously', he continues, 'when they see good, decent citizens peacefully sitting around abortion mills, risking arrest and prosecution as Martin Luther King, Jr, did. Political change occurs after enough social tension and upheaval is created' (p. 83).

Mr Terry understands civil disobedience in non-optional and even religious terms. 'America's survival as a nation, and our future as a church', he is quoted as saying, 'depend largely on rescues. They are the repentance necessary to invoke God's blessing, and the upheaval necessary to produce political change. You won't see this country saved without them'. *(The Berean Statesman,* November 1988, p. 7).

In other words, since human life is at stake, Operation Rescue considers it legitimate, even necessary, to engage in civil disobedience to seek to rescue unborn infants about to be killed. Demonstrators break just laws of trespass (or similar statutes) in an attempt to non-violently prevent abortionists from plying their legal but immoral trade.

Biblical Case Studies of Civil Disobedience

One of the primary justifications for Operation Rescue is an appeal to Scripture. Mr Terry argues that God commands his people to struggle for justice 'even if that means violating man-made law. Indeed, numerous examples from Scripture show the importance of peaceful disobedience to civil authority in order to save lives or to remain faithful to Higher Law' (*Policy Review,* p. 82).

I am deeply appreciative of this mindset. When we examine the illustrations of civil disobedience in Scripture, however, we find they do not parallel that of Operation Rescue. More specifically, the Bible does not show the people of God resisting injustice by breaking just laws to coerce the legal activities of neighbours, even when those activities violate God's moral command. Let's briefly examine the biblical case studies:

1. When the apostles (Acts 4) were instructed to cease preaching in the name of Jesus, they refused to obey. They continued to declare the gospel because God's Word commanded it. This was certainly civil disobedience, but it hardly parallels the strategy of Operation Rescue.

2. Obadiah was 'in charge' of Ahab's palace, thus working directly for an evil king. Still, he 'was a devout believer in the Lord' (1 Ki 18:3), and acted when queen Jezebel started slaughtering the prophets of God. He resisted by hiding one hundred prophets in two caves, supplying them with food and water. This was civil disobedience in order to rescue lives, but involved resisting the unjust edict directly, not coercing the activities of others.

3. This queen risked her life to rescue her people from death (Est 4). A law was in place which forbade unsolicited approach to the king. Normally, appeals were brought to trusted messengers who had access to the throne. Esther's decision not to take this route was courageous, but once again does not parallel the civil disobedience under scrutiny.

4. The Hebrew midwives in Egypt refused to kill male infants at Pharaoh's command (Ex 1). Then, when he questioned why his edict was ignored, they claimed the Hebrew women gave birth 'before the midwives arrive' (v 19). This justifies Operation Rescue, the argument goes, for laws against speaking non-truth to magistrates (perjury) surely are just laws.

There are three problems with this interpretation. First, though we are told what the midwives said to Pharaoh, we are not told whether it was a lie. It is equally valid to assume that God in his providence had provided a way of escape. More importantly, the midwives were obeying their own conscience, not imposing their standards on others. And third, as I will show, though I believe it is reasonable to assume they lied, it is not improper to extend this illustration concerning speaking non-truth to breaking laws of trespass.

5. A similar case is that of Rahab, who hid the Israelite spies (Josh 2). It is clear from Scripture that Rahab acted in faith (Heb 11:31), and that she refused to cooperate with an unjust law by lying to save lives. What we can conclude is nothing more than this: we need not fear divine retribution if we choose to lie in resisting an unjust law in order to save the life of another.

This Scripture is important for the insight it gives us into the nature of truth and falsehood in a fallen world. The ninth commandment reads 'You shall not give false testimony against your neighbour' (Ex 20:16). The emphasis is not on speaking the truth, *per se*, but on using non-truth to hurt others.

Truth implies responsibility, and can be used in hurtful ways, just as non-truth can. Speaking truth in certain situations is equivalent to giving a weapon to another who will misuse it to kill. In a fallen world, we are allowed to choose to refrain from giving that weapon. This does not, of course, turn a lie into truth or weaken the importance of truth-telling. It merely faces up to the horror and depth of the Fall, and the nature of truth and non-truth in a fallen world.

In other words, to sacrifice myself for the truth is something I must be willing to do for the glory of God. To sacrifice another for my truth-telling is not, however, my prerogative. The same thing applies to the story of the Hebrew midwives or to German Christians lying to the Nazis about hiding Jews. Rahab's story may have direct application to a health professional in the hospital, but it does not parallel Operation Rescue.

6. Jesus cleansing the temple (Mt.21; Mk.11; Lk. 19; Jn.2) may, at first glance, suggest a whole series of just laws were broken by Jesus' action: trespass, disturbing the peace, destruction of property, and possibly assault as he coerced the behaviour of others to follow the dictates of what he deemed morally correct. But this analysis misses Christ's own commentary on his behaviour: "How dare you turn **my Father's house** into a market!" (Jn.2:16, emphasis added). It was not Jesus who trespassed, but the merchants. It would be similar to my returning from vacation to discover strangers had transformed my house into a shop. I would gladly throw them out as lawbreakers who had no proper access to my home.

7. The law of God stipulated that only the priests were to eat the holy bread in the sanctuary, but David asked the priest to give it to him and his hungry men (I Sam.21). But this involved ceremonial law, not civil. And, as Jesus emphasized when he discussed this incident, laws such as keeping the Sabbath holy were always to be understood in life–enhancing ways (Mt.12; Mk.2; Lk.6). There is much to learn here, but once again it does not justify the strategy under examination.

My conclusion is that the case studies of civil disobedience in Scripture do not parallel the civil disobedience of Operation Rescue. Even in those passages involving the rescue of lives, those engaging in civil disobedience resist the unjust laws directly and never seek to coerce the legal though immoral actions of their neighbours. A lack of biblical precedent does not prove Operation Rescue is wrong, of course, but it should prompt us to carefully examine whether there is biblical principle to justify such civil disobedience.

Obedience to the State

The Christian has a biblical mandate both to resist abortion and to obey governmental authority. Paul's word to us in Romans 13 must be obeyed, and we dare not ignore it because there is injustice in society. It is worth noting that the government in power when Paul penned these words was brutal and in many ways deeply unjust. Rome not only allowed abortion, it permitted a host of practices which were abhorrent to the Christian conscience. The number of issues for which the apostle could have allowed the breaking of just laws to coerce the behaviour of others is numerous. But nowhere in Scripture is there command for us to follow such a course.

There are biblically mandated limits to civil disobedience. In legal terms, Christian civil disobedience is limited to instances of direct coercion of religious-based conscience. In *Public Eye* (Summer 1989; p.4), Ken Myers defines the limits this way:

> The breaking of civil statutes is permitted on biblical grounds only if Christian obedience requires it. In other words, we are only permitted before God to disobey those laws which, if obeyed, would involve sin. Laws which can be obeyed without sin must be obeyed. It is not permissible to disobey a just law in order to mitigate the effects of other unjust laws, or to mitigate the effects of sin.

But Human Life is at Stake!

A valid question at this point is whether upholding trespass laws when babies are being killed is really that important. The answer is that obedience to God's Word is always important. Further, trespass laws in our Western culture are not societal whims, but are rather rooted in the eighth commandment.

God's commands cannot be played off against one another, and his law is a series of non-conflicting absolutes which form a unity. Christians believe God's moral imperatives are all equally rooted in his holy character. Arguing that the eighth commandment is less vital than the sixth is to adopt a stance unknown in the Scriptures. To do so is to postulate an ethical hierarchy which makes autonomous man sit in judgement over God's law. Further, if the sixth commandment takes precedence over the eighth there is no reason why it cannot take precedence over any of the others.

We must not disobey God's law as we resist injustice. It is sometimes argued that Rahab's story provides an exception to this principle, but this is mistaken. Rather than an exception it is an insight into the nature of truth in a fallen world. We can follow Rahab's example without terror of divine retribution, but to do so except under duress is to go beyond the limits of the text. And the text does not include forcing neighbours to abide by our conscience when they are doing nothing illegal.

Undercutting Civil Order

The ethic of civil disobedience of Operation Rescue, if applied consistently, would undercut order in society. There is balance in the Bible concerning resisting injustice and obeying the state, and it is this balance which provides a basis for civil society. Our resistance to injustice need not result in anarchy, and our obedience to the government need not result in acquiescence in evil.

If each citizen has the right (to say nothing of 'necessity') to disobey just laws to coerce others if they believe unjust laws are on the books, the result would be lawlessness. Once this door is opened, there are no effective limits except for the subjective judgements of each individual.

I am not suggesting Operation Rescue is without limits in its lawbreaking. I am arguing that the principle it espouses ultimately results in lawlessness. Any pluralistic society which adopts such a standard is on the road to anarchy. Besides, bombing property and blocking entrance to property are simply two variations of disobeying the eighth commandment.

'Just war' theory argues that action in defence of life and liberty is justified if it meets certain criterion. Since that is true, it is argued, surely non-violent civil disobedience at abortion clinics is a proportionate response. But 'just war' theory never purports to give individuals the right to coerce others. Rather, it is the criterion to determine whether a war declared by a state is a just one.

Another argument raised is that since we would gladly trespass or coerce behaviour to stop a murder, we should be equally eager to do so to stop an abortion. When a citizen acts to stop a murder, however, that individual acts as an agent of the state. United States law has provisions which say the action of the rescuer is not to be defined as criminal trespass, even if he physically entered another's private property in the process. But *Roe v Wade* means the state does not recognize abortion as murder. Ken Myers notes that 'Christians are properly outraged that the state does not regard abortion as murder,' but warns that' there is a great temptation to allow righteous indignation to degenerate into sinful vengeance.' Breaking just laws, he continues, to resist unjust laws, 'follows the logic of terrorism' (*Public Eye*, February 1988; p.3).

Working for reformation does not mean we can flirt with revolution. The democratic experiment is a fragile affair, and sweeping aside the laws in the name of morality may not increase morality at all.

Some of the rhetoric I have heard in defence of civil disobedience comes perilously close to that of revolution (if not anarchy). Repeatedly it is asserted that civil disobedience is called for 'because if America doesn't repeal abortion then it isn't worth saving.' Those are strong words indeed, and perhaps they are said primarily in the heat of the argument. Still, this is a call to revolution. And if this is what is intended, there is no reason to stop with non-violent civil disobedience.

I believe this is unnecessary and dangerous talk. The Christian mind, with a bit of effort, can certainly be more carefully nuanced. A concern for civility requires it.

The pro-life movement in America has insisted that it has both morality and legality on its side. It has argued that it is immoral for pro-abortionists to call it a 'fetus' unless the parents decide they want to have the 'baby.' And it has argued that *Roe v Wade* is bad law and finally unconstitutional. 'It would be ironic and tragic,' Jeremy Jackson has commented, 'if lawless conduct by pro-lifers spawned understandable misgivings in the electorate and their national officers' about the wisdom of repealing *Roe v Wade*.

Operation Rescue appeals to the civil rights movement of earlier decades to further justify its civil disobedience. But this overlooks the fact that the manner in which a movement is portrayed to society is crucial in determining the response it engenders. Civil disobedience can as easily provoke a backlash as it can a more favourable response. The power brokers of American society, particularly the media, were sympathetic to the civil rights movement, but are largely antagonistic to pro-life efforts. More importantly, the civil rights movement by and large did not take to the streets until after *Brown v Board of Education*, the Supreme Court decision which said 'separate but equal' was unconstitutional. The marchers resisted illegal local laws which attempted to maintain segregation. The local officials were the lawbreakers.

Impatience and the Ways of God

The fact that abortion is such an emotional issue can give rise to an impatience at working for justice, and for waiting for God to act. The danger is that our impatience can lead us to ignore the limits set by the Lord of life. The power to coerce the behaviour of others has not been given to the individual or to the church, but to the state. The individual and the church must not attempt to usurp it.

The Bible insists that it is normative to obey 'the powers that be' because they are ordained by God. 'This authority,' Mr Jackson notes, 'contrary to what some would have us believe, is not an evil necessity, resulting from the Fall, but a positive principle represented in the marital relation.... Marriage and the family is the basic origin and building block of society at large, and social government is only an extension of family government' (*Light and Life*, Fall 1987).

Not all reformed thinkers, of course, would agree with this view of human government. Nevertheless, agreement will increase when he concludes that 'except where a positive command of God is laid

upon you which cuts across a human law, then the responsibility for that human law falls not on you but upon the human lawgivers.' Or to put it another way, 'we are not called to bear civil responsibility for the evil behaviour of all men.'

God has not given the sword of coercion to the individual or the church, but to the state. It is horrible when the state uses that authority unjustly. But when this happens, the church and individuals do not have biblical warrant to pick up the state's coercive power for themselves.

Two types of unjust laws are possible. The first commands us to do wrong, e.g. the population control laws in Communist China which coerce abortions. The second gives permission to do wrong, such as *Roe v Wade* does in America. In either case, Mr Jackson argues, the Scriptures do not allow us to 'restrict our neighbour in his actions - assuming they do not directly harm us - if they are permitted by law. To do otherwise is to usurp the authority of the powers established by God to order civil relations between all families and persons in the state. If our neighbour were breaking a law, we might or must intervene. But if his conduct is licit, though contrary to our own conscience, our sole recourse is to change the law, change his mind and otherwise appeal to God. For God alone can and will judge both the state for its wicked laws and those citizens who obeyed it.'

It is proper to be concerned about the steady advance of the modern state into the rightful sphere of the family. But we must equally be concerned about the opposite error: to encroach upon the rightful power of civil authorities in the name of personal freedom or morality.

God's ways remain mysterious to us (Rom 11:33; Isa 55:9). He allowed Wilberforce to labour for a lifetime before the effort to stop slavery bore fruit. He allowed the covenant people of God to remain enslaved in Egypt for centuries before he raised up a rescuer in Moses. And in perhaps the greatest mystery of all, God did not coerce Adam and Eve from their fatal choice.

He has given those created in his image a most awful freedom and responsibility. The Bible reminds us we must not mistake God's ways as an excuse for impatience (1 Pet 3:8-9; Rom 2:4). The Christian's efforts against abortion must be both principled and unflagging. Choosing to fight with the world's weapons may appear to bring victory in the short run, but the victory will be tarnished at best.

Rescues will not save America. What is needed is nothing less than for people's consciousness to be changed so that they see babies in the womb as precious human beings. And this requires a declaration and a hearing of the truth.

Rescuing the Innocent

'Rescue those being led away to death,' Proverbs 24:11 says. Unfortunately, there is reason to question whether Operation Rescue stops rather than merely delays abortions. Further, Proverbs presupposes the legal system present in Israel, and thus this command applied to situations within Israel which were clearly illegal. It was not an excuse to conduct raids into neighbouring countries where infants were routinely sacrificed to pagan gods.

It is morally justifiable to save human life. It is also biblically proper for the Christian to engage in civil disobedience to that end. The issue here is whether we will conform to biblical limits in that struggle for justice. A moral end does not justify unbiblical means.

And within the limits set by Scripture, there is much we can do. We must continue to work to change the law. Perhaps more of us need to give more. Perhaps, as well, the pro-life movement could spend less of its resources holding conventions, and pour that money into a national PR campaign to educate and move the American public. Though polls show that a majority support the 'right to choose,' polls also show that a majority do not support or like what *Roe v Wade* actually allows. Sam Ericsson of the Christian Legal Society suggests rescue homes which go beyond the laudatory efforts now underway by crisis pregnancy centres. Many young girls, from backgrounds of poverty, may need help raising their children to maturity.

And whatever our efforts, they must be bathed with and backed by fervent prayer, not merely 'opened' and 'closed' by it.

In Conclusion

Roe v Wade is the most difficult kind of unjust law to resist. That is because it permits evil but does not demand it, and so we cannot resist it directly by breaking it. That must not discourage us, for the God who notices stumbling sparrows does not slumber nor sleep. Nor must our impatience become an excuse to embrace lawlessness and thus yield the moral high ground to our opponents. Nor must we forget that there is neither biblical principle nor precedent to force our neighbour to stop a legal action in order to obey God's moral imperatives.

What we have been called to is faithfulness to God's Word. That is enough, since faithfulness begins by confessing anew that the kingdom is God's, and that only the King can consummate it. And by God's grace, may the cries of the slaughtered unborn be finally silenced in our land.

Allowing Death or Actively Killing?

The legal Situation and Present State of Ethical Debate in the Nordic Countries

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This paper was presented at the Second International Symposium of Medical Ethics, September 15th - 17th, 1989, in Bad Segeberg.

The formulating of the theme for this introductory orientation has the advantage that things are called by their right name. You could put in 'passive' and 'active euthanasia' instead, but these terms do not state what is at stake as clearly as the terms 'allowing death' and 'actively killing'. As Professor Gustav Giertz from the Swedish Medical Association's ethical delegation has put it: 'To speak about euthanasia is only confusing; when the intention is 'to kill' then let us say it.' (*Lakartidningen* 84: 47, 1987, 3942).

If you stop treating a diabetic with insulin and he dies, that would be a kind of passive euthanasia, but of course quite unacceptable - even more than hastening death by giving an overdose of morphine, though that would be called active euthanasia. Yet it is difficult to get round the term euthanasia, but as we shall use it, the concept of *passive* euthanasia is reserved for the treatment of patients in the *terminal* state only. *Active* euthanasia is not in the same way restricted to the terminal state; it can be used and is used also to indicate ending the life of a person who does not suffer from a terminal or even an incurable malignancy (Righter, Eilers and Leenen in *British Medical Journal,* Vol. 297).

The disjunction in the formulation of our theme is important. It says ' allowing death or actively killing'. In this 'or' is already included an attitude to our problem; as a rule the proponents of active euthanasia claim that it is not possible to distinguish between active and passive euthanasia. They find no ethical difference between omitting or stopping a life-sustaining treatment of a patient in a dying state and causing death by active interference.

On the other hand the opponents of active euthanasia recognize the difference between active and passive euthanasia. For them the decisive step is not the one taken from continuing a life-sustaining treatment in the terminal state to stopping it. But the decisive step is the one taken from omitting or stopping a life-sustaining treatment in the terminal state to causing death by direct action, in other words the step from mercy dying to mercy killing. They admit that in certain cases it can be difficult to draw the line between active and passive euthanasia, but, as the chairman of the Swedish Medical Association's ethical council, Olle Westerborn, has said: 'The exact drawing of the line can in certain cases be indistinct. But - as physicians we should be ready to accept this possible uncertainty and not use it in advocating active euthanasia.'

Before I pass on to speak of the situation in the Nordic countries I should like to make one more point about the problem in general. Some proponents of active euthanasia tell us that it is their experience that when euthanasia is no longer taboo, more desperately ill patients do ask doctors to end their lives, and this is referred to as an argument in favour of active euthanasia. When the taboo is removed it will be easier to ask for euthanasia, as it no longer gives so much offence.

As far as I can see this fact could just as well be used as an argument against (active) euthanasia. No culture can exist without taboos. There are good taboos and bad taboos. A good taboo can be a necessary guard of an important borderline which it will be dangerous to cross, because by crossing it you enter a slippery slope. The more usual and natural it will be to ask doctors to end one's life, the more such a performance will be part of the possibilities the health service can offer, which patients have to take into consideration, and about which they must make up their mind.

By and by that will lead to a totally new situation and change the whole atmosphere in hospitals and nursing-homes. And how can you then be sure that the decision taken really is voluntary? How can you avoid the so-called 'right to die' in some cases developing into an indirect pressure to die, when an old, helpless person, who is a burden on his or her environment, knows that it is within the range of possibilities to ask for one's own death? When determining your own death is no longer entirely out of the question, how can you secure that the right to die will not interfere with the obvious right to live as long as you are alive? The Norwegian theologian, Professor Inge Lonning, speaks of an unuttered expectation-pressure in that connection (*Kirke og Kultur,* 1989. 183, 195).

Now let me turn to the situation in the Scandinavian countries. As to the legal situation, active euthanasia is not allowed in any of these countries, which is not surprising since, as far as I know, it is not allowed legally in any other country. Assistance to suicide is also regarded as a criminal act in the Nordic countries except in Sweden.

In Denmark there has been only one case about euthanasia within the last thirty years. A doctor was acquitted in 1979 of a charge of having caused the death of a hopelessly ill cancer patient; he had taken her out of the respirator and given her an overdose of morphine. The court appeared to acknowledge the doctor's right to make a total evaluation of the patient's condition and act accordingly, as it also acknowledged the so–called doctrine of double–effect (Jorn Simonsen, medico–legal Professor in *Manedskr. Prak. Lagegern*, Sep. 1987, 625). I would conjecture that a similar legal practice would obtain in the other Nordic countries. In such cases you will certainly not be given up to the hardest punishment of the law, but the special circumstances will be respected, and the judgement will be mild if not suspended or the charge withdrawn. A Norwegian judge of the Supreme Court has recently written in an article that according to Norwegian law active euthanasia is an offence, but she does not dare to predict what the outcome will be of a charge of euthanasia. It depends on the concrete circumstances as to how punishable the act will be regarded (Elisabeth Schweigaard Selmer, *Kirke og Kultur,* 1989, 3, 206f.). This statement may be representative for the legal situation all over Scandinavia. It is also characteristic that people who believe that active euthanasia could be ethically justifiable in certain cases do not find that for that reason there is any need to change the law at the present time.

There are 'living will' organizations in all the Nordic countries, but

none of them support active euthanasia. They want the 'living wills' made legally valid, which they are not in any of the Nordic countries today. In Denmark negotiations between the Danish Medical Association and the living will organization have resulted in a commission, appointed by the Ministry of Justice, with the task of surveying the legal questions about stopping or omitting useless treatment which only postpones the natural termination of life, and of considering the importance that should be attached to the consent and wishes of patients.

In 1974 the Danish health authorities announced that 'if a treatment of a patient is of no purpose, as it would only prolong the ongoing process of dying, it is not contrary to the commonly acknowledged principles of doctors' practice to decide not to start or continue measures that could only postpone the moment of death'. In my opinion this has always been good practice, and should not be called euthanasia at all.

In Sweden the ethical council of the social authorities takes the same position. It also accepts a distinction between treatment directed against the disease and care directed toward the person *(Lakartidningen Volym*, 84:47, 1987, 3940). The chairman of the Central Scientific Ethical Committee in Denmark makes the same distinction (Povl Riis in *Nordisk Medicin*, 102: 8-9, 1987, 242f.). Treatment could be omitted or stopped, but care should go on to the end.

As to the ethical debate in Scandinavia, as in other countries you find views represented on both sides of the question. In Sweden an opinion poll has recently shown that 60% of Swedes believe that incurable patients should have the possibility of active euthanasia. Most of those in favour were found in the age groups 18-24 and 65-74 years old. In Norway an opinion poll showed that 53% were for active euthanasia. I have no numbers for Denmark.

But if you asked *the doctors* there is no doubt that the great majority of them would be unambiguously against active euthanasia. All the medical associations in the Nordic countries have taken a clear stand against active euthanasia. How do you explain this discrepancy between the attitude of the population and the attitude of the physicians? I think it partly reflects the fact that the physicians know better what is at stake. Another reason may be found in the difficulty in formulating questions in such a way that the people concerned really know what they are answering. Only think of the difficulty in giving an exact and satisfactory definition of the different aspects around the concept of euthanasia. Therefore, in my opinion, you cannot attribute too much importance to opinion polls about this question.

As far as I am informed Sweden is the only country in Scandinavia where you find an organization which is directly fighting for legalizing active euthanasia. It is called 'Informationcenter Exit', founded in 1985. It is led by Berit Hedeby, a woman who as early as the beginning of the 1970's started her fight for the right to active euthanasia. When this organization had a big meeting in Stockholm, in February 1986, the organizations representing the handicapped arranged a protest demonstration outside. Did they feel that they were threatened by too much talk of quality of life? Perhaps they found that the concept itself was threatening the equality of life.

Berit Hedeby does not doubt that some day active euthanasia will be legal. 'Then', she writes in an article, 'we will be able to say to our doctor: "Help me to die!" Or we will say to our doctor, with a smile: "Now time has come for me to die." And the doctor will answer, with a smile: "Do not worry, my friend! I will help you".' The Swedish medical journal quotes this passage and makes this important comment in an editorial: 'The treacherous thing in the argumentation about 'the right to die' is that it includes 'the right to be killed', and, as the uttermost consequence, the 'right to kill'. The step from there to the 'duty to kill' is a very short one. We must decidedly dissociate ourselves from the idea that nurses and doctors should be given the role of murder-angels. In the same way we must guard the fundamental principle, that in Sweden nobody – whether individual or institution – has the right to deprive anybody else of life.'

The Norwegian professor we have already mentioned, Inge Lonning, voices a similar concern when he writes: 'A right to die cannot be adopted by a community without the same community being ready to define a duty to kill. It is not possible in any areas to define rights, which the community undertake to secure, without at the same time – mplicitly or explicitly – imposing duties' (*Kirke og Kultur*, 1989, 3, 194).

At a meeting held in September 1987 by the Danish Medical Association, the President, Jens Gotrik, made it clear that his organization could not recognize a practice of active euthanasia. Two years ago I took part in a TV programme in Denmark about human dignity in death and dying. We were twelve on the panel, doctors, lawyers, philosophers, psychologists and nurses; I was the only theologian. Only one out of the twelve advocated a legalization of active euthanasia.

Lastly I should mention a Nordic Seminar on medical ethics held in Finland in April 1987. Here there was agreement among the participants that active euthanasia was not allowed legally in any of the Nordic countries, and that there was no need to introduce rules for such a thing. The Finnish delegation told of an enquiry among a group of elderly Finnish physicians, from which it appeared that these had never met a patient who had seriously wanted the physician to shorten his or her life. It was generally agreed among the Finns at the seminar, that it was not however the duty of the physician to keep patients alive at any price.

The Norwegian delegation emphasized that besides the patient and the doctor, the relatives, the other medical staff and the community was involved in the circumstances around the end of life. The Swedish delegation accentuated the patient's right to have information about the treatment and the right to demand a treatment be ended, though a patient can never demand that medical staff actively assist in taking his or her life. It is the task of the doctor to make the patient's last days as painless and peaceful as possible, including a liberal dosage of palliatives. (By the way, a Danish specialist in geriatrics has told me that the practice of giving a liberal dosage of palliatives at the end of life is spreading in Danish hospitals, in his view may be too much.

The participants in the seminar in Finland agreed in conclusion that the word euthanasia made no sense in the health service of the Nordic countries, and that at the present time there was no need to change the law in connection with terminal care. All gave their support to a statement of Professor Gustav Giertz of Sweden that active euthanasia is a capitulation which is unworthy of a good health service.

May I round off by suggesting that 'quality of life' is a phrase that should be handled with care. History has shown that the question of whether a certain kind of life is worth living for human beings, can be changed, before you know it, to the question of whether certain kinds of human beings are worth being kept alive.

There is a famous quotation from Soren Kierkegaard, which throws some light on this dubious concept. He had a disabled cousin who had to spend all his time in an invalid chair. In a letter to him Kierkegaard wrote: 'If I should give you advice for your life, when I think of your conditions, then I should say: Do not forget the duty to love yourself; though you in a way are placed outside life, prevented from actively intervening in it, though you in the eyes of a busy world are superfluous, let it by all means not deprive you of the conception of yourself, as if your life in the eyes of an all–wise providence, when it is lived in sincerity, had not the same importance and validity as any other man's, and a good deal more than the busy, busier, busiest hurry of the business – to waste life and lose itself.'

REVIEWS

Bereavement
John & Libby Wattis.
Lingdale Papers 10
Counselling as Covenant – some Theological implications
David Atkinson
Lingdale Papers 11.

These short booklets provide practical and seminal reading for Lay & Professional Carers.

Bereavement presents Attachment Theory (developed initially by John Bowlby) as the basis for a psychodynamic understanding of grief. Normal and abnormal reactions to the severing of primary emotional bonds, which have helped create and sustain the bereaved's identity, are considered with a view to understanding and helping adjustment and acceptance of changes which are vital to the search for the new you.

For anyone familiar with counselling the bereaved there is helpful revision of basic principles governing grief but nothing new, save the theme of Attachment. The Church's valuable role as a healing community is briefly considered and bible verses are used to support points, but the focus is largely psychological rather than theological.

There is scope however for the more theologically minded to make more of Attachment as a theme in helping the bereaved, for surely God is the most important person to develop a relationship with in the search for identity. Indeed the loss of someone dear can uncover the gap which only Christ can fill and lead to new or greater attachment to God, a point unfortunately not made.

Unlike the Wattises, Atkinson takes his agenda from Scripture, integrating psychology with theology, and uses 'Covenant' as a key to developing a sketchy but stimulating theology of counselling.

Counsellor and client are in a covenant relationship which both resembles (e.g. grace, personal relation, costly love, individual responsibility etc.) and differs (most obviously in that both counsellor and client have needs) from God's covenant with man. Christ as the 'True Man' and His Spirit as the 'Wonderful Counsellor' is the context for the counselling task which is 'to facilitate Christ realisation within the client. 'Personhood' is the 'Creator's gift and our personal goal' as we move towards fulfilment in Christ.

With clarity and simplicity Atkinson brings a breath of fresh air to Christian counsellors concerned to use psychology's insights for their God given work of making people whole within an overarching Christ–centred theological framework, and especially to those who are wary of the relationship between psychology and theology.

Neil Urquhart

Choose Life. A Christian Perspective on Abortion and Embryo Experiments.
Richard Winter
Marshall Pickering; UK, 1988, paperback 136pp
ISBN 0551 01576 4

This book is exceptionally good. It is always clear, easily understood by both laymen and the medically orientated, beautifully produced in a modern format with clear headings and a large number of appropriate, marvellous, colour pictures, and I found it alarming compulsive reading.

Foetal development is simply explained and illustrated; Abortion statistics are shown; then the detail of how an abortion may be performed, followed by complications of the same, both physical and psychological. 'When does Life begin?' (Chapter 6) and 'What the Bible says.' (Chapter 7), are concisely stated and most helpful.

Handicaps, Prenatal screening and Infanticide are then considered – with alarming facts about the insidious ways in which we can be blinded to the facts behind the terminology and the mass murder which is currently masquerading as a 'responsible attitude to parenthood' A child WHEN we want one – and only a perfect one will do!

The increasingly complex area of Infertility Treatment – including Artificial Insemination, In–vitro Fertilisation, Gamete IntraFallopian Transfer (GIFT) and surrogacy, is considered and so clearly explained and illustrated that I would be happy to use it in ANY situation where the subject was under discussion.

Richard Winter is unafraid to state his own standpoint and rationale as he goes on to discuss the moral, ethical and Biblical implications for the Christian – this is invaluable. Embryo experimentation in 'Brave New World?' (Chapter 12) includes the following from an article in 'Newsweek'.

> But at the bottom, the debate over embryo research ends at much the same intractable point as the argument over abortion: trying to agree on when a tiny mass of living cells ceases to be mere biological matter, fit to be experimented on or destroyed, and instead becomes a fully entitled human.' A society that accepts the abortion of a 24 week foetus is not going to be squeamish about the few cells of an early embryo.

The implications of this may seem to extend into Science Fiction – but they are in grave danger of becoming Science Fact – unless we realise what we as a society seem well on the way towards, almost by default.

The final chapter 'Time for Action' is a challenge to us all.

> Whenever fellow human beings, of any race, culture, class, size or ability, are treated with lack of respect and the dignity worthy of those made in God's image, we are called to fight for justice for them, with deep compassion on our hearts. So for God's sake and out of love for your neighbour, pray, write, speak and act with compassion to fight for justice for the most helpless members of the human race – the newly conceived, the babies soon to be born, and the newborn whether mentally or physically handicapped or perfectly formed.

This book should be compulsory reading for everyone who is in any way involved in the whole abortion question — isn't that ALL of us?

Dorothy J. Urquhart