Ethics & Medicine

A Christian Perspective on Issues in Bioethics

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COMMENT

From the Editor

The Embryo Debate

We reprint here, with due acknowledgement to Hansard (HL, 7 December, 1989), a speech by the Archbishop of York on the Human Fertilisation and Embryology Bill currently before Parliament; together with a response from the Editor.

The Archbishop of York: *My Lords, bearing mind what the two noble Lords who have preceded me have said, your Lordships will realise that I stand before them with a somewhat ambiguous reputation in these matters. However, I am sure noble Lords will know how to make up their own minds. I too wish to start by paying tribute to the magisterial introductory speech by the noble and learned Lord the Lord Chancellor which covered the ground so well that there seems little left to be said. However, I am sure that will not deter us from debating the matter.*

Like others who have spoken, I speak primarily in a personal capacity. The much maligned Board for Social Responsibility of the Church of England produced an excellent report on this subject a few years ago entitled Personal Origins. *This has been debated in the General Synod and has received wide acclaim, but I think it is fair to say that the Church of England has not yet taken a definitive position on these matters. I therefore speak personally and I wish to express support for this legislation which I believe is necessary and which is for the most part on the right lines.*

Like others I propose to concentrate on the issue of embryo experimentation because this represents the moral heart of the Bill. If we can clear our minds about this, I believe most of the other provisions of the Bill will fall into place. The Warnock Report described questions about when life or personhood begin as not 'susceptible of straightforward answers' and such answers as 'complex amalgams of factual and moral judgments'. I think that is true, but I add the rider that a great many answers to apparently simple questions also have this complex character as amalgams of factual and moral judgments. This, however, does not deter people from giving simple answers. As the Bill progresses we are likely to hear more accusations of the kind just referred to by the noble Lord, Lord McGregor, put forward with greater and greater passion. My concern this afternoon, however, is to try to understand how and why such passionate differences arise and how they might be reconciled.

The noble Lord who preceded me has already reminded your Lordships of the two different perspectives on the way in which life develops. It needs to be stressed that both entail profound respect for human life. *Both are motivated by the desire to protect and enhance human life, and both in the case of a great many people spring out of deep religious commitments.*

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It is absurd and dishonest to label one attitude pro-life and the other pro-death. I hope that that language will be kept out of the debate. By and large a biological approach to the beginnings of life is rooted in gradualism. Scientists in general and biologists in particular deal mostly in continuities and in gradual changes from one state to another. This is true of evolution, in which the transition from the prehuman to the human took place over countless generations. There was never a precise moment at which it could have been said, 'There is a hominid and here is a man'. But this is not to deny that as a result of that process there emerged a profound and indeed crucial set of differences between hominids and men.

The same is true in the development of individual lives. They begin with chemistry and they reach their fulfilment in mystery. There is no doubt about the depth, wonder, moral worth and religious significance of personhood, but the transitions on the way to it are not clean, clear and decisive, despite the tremendous significance attached by some people to the moment of fertilisation. Biologically speaking we are looking at a continuous process. Perhaps I can make the significance of this a little more clear by giving your Lordships an analogy. Exactly 10 years ago a mathematician called Mandelbrot first discovered what is now called the Mandelbrot set. It is a set of points which can be mapped out as a computer graphic to form the most amazing, beautiful and complex structure that it is possible to imagine. It is a picture of literally infinite depth. If one magnifies the details of any part of the picture, one finds that in them are whole worlds of further detail which are always beautiful, which never repeat themselves and which always reveal more and more detail, on and on ad infinitum.

How is the Mandelbrot set made? It is made by the use of an absurdly simple equation with only three terms. The secret lies in the process. It is a process whereby the answer to one use of the equation becomes the starting point for the next. In other words, it is a cumulative process, just like evolution in which one life form builds on another and just like embryology in which the development of one cell provides the context for the development of its neighbours and its successors.

This is how unimaginable complexity can develop out of extreme simplicity. That is why it seems strange to a biologist that all the weight of moral argument should be placed on one definable moment at the beginning. What matters is the process. One might call it a value-added process. It is out of that process that humans grow. That is a biological viewpoint.

The alternative viewpoint entails looking back from the standpoint of fully developed human persons along the historical line to some point which seems to mark an individual beginning. If we are to give full moral worth to such persons, runs the argument, then we have to give full moral worth to their whole history, from its very first moment.

COMMENT

That is a fine ideal but it seems to me to rest on biological, theological and philosophical mistakes. Despite the claims of some, it does not in my opinion represent a view which is necessarily and unquestionably Christian. Christians are no more required to believe that humanness is created in an instant than we are required to believe in the historical existence of Adam and Eve. As a matter of historical fact, Christian beliefs about when the fetus should be treated as having full human value have differed widely through the ages.

The biological mistake in the ascription of full value from the moment of conception is the confusion between development and growth. As the noble Lord who spoke before me reminded the House, the mental image which some people have of an early embryo is of a miniscule baby. The language used about its smallness and defencelessness clearly reflects that view. But early embryos are not miniature babies. What is lacking in that perception is any understanding of how biologically speaking, the process of development creates the person. That biological view can be backed from a theological perspective by the understanding of creation as continuous – God continuously calling personal being into existence.

The theological mistake in that view is to suppose that because Christians claim that human beings are unique and made in the image of God, that necessarily implies the implantation of a human soul or at least of some entity carrying full human rights at a particular moment in time. One reason that is a mistake is that if that moment is thought of as the moment of conception, and if we face the fact that the majority of fertilised ova never develop beyond a very primitive stage, we seem committed to the curious belief that the majority of souls destined for eternal life will be those whose earthly life has never been anything but embryonic. To me biological gradualism makes much more sense. This world is a vale of soul-making, and the soul develops with the body's capacity to receive it.

The philosophical mistake in the belief that full and instantaneous human rights are somehow created in the moment of conception lies in the surreptitious assumption that in those very early stages of embryonic life there is some real personal entity to which our moral language can apply. For example, in a memorandum by the Association of Lawyers for the Defence of the Unborn there is a helpful recognition of the imprecision of the word 'person' when used in such circumstances. However, at the same time the lawyers seem to feel no difficulty in describing those entities which they cannot call persons as victims. Far be it from me to criticise lawyers, especially when I am about to be followed by one, but I cannot help feeling that there are philosophical inadequacies and unexamined assumptions in that kind of language.

The real strength of that continuous history perspective as I see it lies not in some dubious claim about the full moral rights of fertilised ova but in the question: what are we doing to ourselves and to our own respect for human life if we fail to be sensitive towards something so intimately bound up with our personal origins? That is a serious and a valid moral question. It is a question which can be set alongside the equally serious and valid moral question about the importance of research as itself a basis for respecting and enhancing human life.

Both questions rest upon the same kind of moral presuppositions. Both are in the end utilitarian questions. It is not a case, as some have suggested, of mere utilitarianism on one side and a noble adherence to principle on the other. We are all struggling to do the best that we can in using and controlling the new powers and insights which science, medicine and technology are constantly providing. Therefore I hope that we can come through this stage of sharp confrontation towards a consensus which acknowledges the special quality of human embryonic life but which refuses nevertheless to make claims to it which are biologically, theologically and philosophically unsustainable, and which recognises a valid place for research in this delicate area.

The 14-day rule, with all the safeguards surrounding it, seems to me to be a workable basis for such a consensus. It is no more possible to set it up as a totally clear moral dividing line than it is to do the same for the moment of conception. But to make it a cut-off point is morally and biologically defensible. The fact that it is based on an identifiable biological transition will, I believe, protect it against future argument for extending the limits of research. I therefore gladly support the Bill, including the first option in Clause 11.

The Editor responds:

The Archbishop is surely right to single out the issue of embryo experimentation as lying at the 'moral heart' of this long and complex Bill, but despite his considerable skill and the undoubted authority with which he speaks – as both a bishop and a scientist – it is less easy to agree with the rest of his speech. He begins by acknowledging that he speaks in a personal capacity, since the Church of England has not yet taken a 'definitive position' on these issues. But he leaves us facing the question: if things are as the Archbishop suggests, why has his Church not simply fallen into line behind his view – that of the majority of the Warnock Committee?

Why should so many people disagree – including (and this is often forgotten) almost half the members of the Warnock Committee itself? Those seven men and women who signed one of the two dissents on the question of embryo research would not all agree with the position the Archbishop is arguing against; indeed, it is possible that none of them would. If that is the case then the Archbishop has – no doubt all unconsciously – set up a straw man.

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COMMENT

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COMMENT

First let us look at the seemingly persuasive arguments which Dr Habgood deploys. He offers what he calls 'a biological approach to the beginnings of life', an approach which he says is 'rooted in gradualism'. And then we have an example of the gradual character of biological development, that of the process of hominisation – the evolution of *Homo sapiens* out of earlier hominid stock. 'Biologically speaking we are looking at a continuous process', we are told, however significant minor changes may finally prove to be. Well, this is a curious example, since the evolutionary idea of human origins has little in common with the process of human reproduction. Indeed, it is fundamentally disanalogous. In the one case (human evolution) we are indeed dealing with continuous process (to leave discussion of such details as punctuated equilibria to one side!), while in the other (mammalian reproduction) there is a continuous process – but the process is *initiated* by the coming together of male and female gametes, previously separate and (reproductively) inert.

The process of development begun with the fertilisation of ovum by sperm is indeed continuous, but its continuity is born of a radical discontinuity. When Dr Habgood tells us that the 'transitions on the way' to the full development of human personhood are 'not clean, clear and decisive', it comes as a great surprise to learn that he is including fertilisation among them. Of course, he must; for otherwise his emphasis on the continuity of biological process would serve not to support but rather to undermine Warnock's majority thesis that the development of the primitive streak at around 14 days marks a sufficiently fundamental discontinuity to permit deleterious research beforehand (and absolutely forbid it, on pain of imprisonment, thereafter).

Dr Habgood says he finds it 'strange' that 'all the weight of moral argument should be placed on one definable moment at the beginning'. Well, that is a somewhat tendentious assessment of what his opponents are seeking to do, though in offering it Dr Habgood makes two interesting admissions. The opponents of embryo research seek to place just enough moral weight on what Dr Habgood himself here acknowledges to be a 'definable moment' which lies 'at the beginning' – just enough moral weight to suggest that deleterious laboratory research is inappropriate after this 'moment' since that of which it is 'the beginning' is an embryonic human life.

Three mistakes?

Dr Habgood then goes on to suggest that the view he criticises rests on 'biological, theological and philosophical mistakes'. Let us look at his three arguments in turn. They are important arguments, since (presumably) Dr Habgood's support for embryo research depends on their displacing this other view, which is widely held (not least in the churches, including Dr Habgood's own) – and which Dr Habgood himself recognises rather oddly as 'a fine ideal'.

1. What is the *biological* mistake? It is 'the confusion between development and growth', 'any understanding of how, biologically speaking, the process of development creates the person'. The Archbishop seems here to be less than charitable toward those for whom fertilisation is crucially important, since their ranks plainly include biologists no less distinguished than Dr Habgood himself, and indeed some very famous names from the worlds of science and medicine. What of his substantive point? There may be confusion of 'development and growth' in some popular misunderstanding – some people may understand the zygote to be a 'tiny baby', which of course the zygote is not. The zygote is a zygote, but Dr Habgood can hardly claim that its ensuing development is not also its growth; and this zygote is a zygote of the species Homo sapiens. Dramatic changes are involved in the ensuing embryonic and fetal development, but they mark stages in the growth of this miniscule organism which is the product of human conception – all the way to adult maturity.

2. What is the *theological* mistake? Dr Habgood argues that the Christian claim that 'human beings are unique and made in the image of God' need not imply that such status is conferred 'at a particular moment in time' (whether through the implanting of a soul, or in some other way). This is a strange claim for Dr Habgood to make, for what can it mean to say that human beings are 'made in the image of God' (which Dr Habgood of course would say) if we cannot at any given stage in human development ask the question 'does this human being bear the image of God now?' Of course, we may be unsure of the answer; but, in principle, there must *be* an answer. There must be 'a particular moment in time' before which the answer would be No and after which it would be Yes – even if we do not know what that point is (fertilisation, 14 days, 6 weeks, viability, birth, first birthday, or whenever). If there is not, the belief that human beings are 'made in the image of God' is nonsensical, since we can never say whether this general statement is true in a particular case.

Dr Habgood adds 'one reason why that is a mistake': 'if that moment is thought of as the moment of conception ... we seem committed to the curious belief that the majority of souls destined for eternal life will be those whose earthly life has never been anything but embryonic.'This is not a new argument, but it is curious that Dr Habgood seems unaware of its corollary. Something like half the babies who have been born in the world have died in infancy. Does the prospect of heaven half-filled with those whose earthly life has never been anything but infant lead Dr Habgood to deny that babies dying in infancy bear the image of God?

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3. What of the *philosophical* mistake? It is the 'surreptitious assumption' that 'in those very early stages of embryonic life there is some real personal entity to which our moral language can apply'. Dr Habgood calls this an assumption; yet it is of course the fruit of argument. It is easy to use language loosely, but those who stress the significance of fertilisation as marking the beginning of human life do not suggest that in the early embryo we have a conscious, sentient, creative 'person', in terms of such a definition of what being a 'person' entails. On the contrary, the argument that has been put forward by some very distinguished philosophers is precisely that the unconscious, insentient zygote must nonetheless be treated

COMMENT

as we treat all other human beings. For that which constitutes essential human being is present already in the earliest stage of membership in *Homo sapiens*: the zygote *is* 'one of us', and must therefore be treated *as if* one of us. In terms of Christian theology, the personhood of the early embryo as of the mature adult is rooted in the personhood of God – which is part of what possessing the 'image of God' means, that image which Christians believe to be coterminous with the genetic constitution of *Homo sapiens* in defining human being.

What Dr Habgood alleges to be 'mistakes' prove harder to demonstrate than he imagines, despite the fact that he is deliberately tackling the most extreme of his opponents – those who argue that the embryo bears the image of God and should therefore be treated as fully human from its biological beginning in fertilisation. This is a powerful position which has the support of philosophers, theologians and scientists. But it does represent one end of the spectrum of opinion, and Dr Habgood is less than candid to imply that once this position has been dismissed there is no longer any reason for opposition to deleterious embryo research.

Because the case for the protection in law of the human embryo does *not depend on any such firm conclusion*. The same conclusion can be reached from very different perspectives, as is clear from the Warnock Report itself. Seven members of Warnock dissented from its principal recommendation (the 14-day rule) – by objecting either to all deleterious research, or to such research on embryos created for the purpose. They made none of the assumptions with which Dr Habgood argues, and this was most recently demonstrated by Professor John Marshall, himself a dissenting member of Warnock, in his telling *Times* interview of December 11th, 1989. His view is, in short, that the question of the nature of the embryo 'cannot be decided universally, and ... each person will have their own view. On this argument, because the entity has the potential to become a person, one affirms that it should *not* be interfered with, that *nothing* should be done that prevents it realizing that potential, and that things *can* be done which will help it to attain that potential.' The *Times* writer comments: 'This is a much more brilliant twist than his plain prose would have you believe. For Marshall is showing that the banning of experimentation could, in fact, be the more liberal course, since it accepts the plurality of possible answers to the underlying ethical issue.'

Two distinct positions are possible. We may be uncertain ('maybe the embryo should be treated as a human being – how can we be sure?'), or (with Professor Marshall) seek a way around such discussion by focussing instead on the universally agreed potential of the embryo. Neither of these widely-held views is tackled by Dr Habgood, yet both argue for caution and the protection of the embryo. Uncertainty as to whether something is right is no basis for action, and it is plain that in a matter of this importance the burden of proof must lie with those who seek to justify the experimental use of the human embryo.

The international dimension

Much of our discussion in this country has gone on in ignorance of developments overseas. Three developments are of special interest and must be allowed to form the context in which we make our own decisions. First, even in a country with such liberal traditions as Denmark there has been a moratorium declared on embryo research while further discussion takes place. Secondly, in West Germany a government Bill is to be debated which has all-party support and which seeks to ban embryo research. Thirdly, the Council of Europe – which now represents 23 European states – has promoted intensive discussion of these questions, and for several years has sponsored CAHBI, its *ad hoc* experts' committee on bioethics, which includes representatives from the U.S., Canada, Australia and elsewhere. The CAHBI is currently chaired by Dr Jeremy Metters, who was Secretary to the Warnock Committee. In its latest report (Strasbourg, 1989), the Committee recommend as follows:

> '*Principle 16*
> 'The fertilisation of ova *in vitro* and the obtaining of embryos by lavage shall not be permitted for research purposes.
> '*Principle 17*
> 'No act or procedure shall be permitted on any embryo *in vitro* other than those intended for the benefit of the embryo and for observational studies which do no harm to the embryo.'

Conclusion

Dr Habgood rightly stresses the fundamental continuity of biological processes and, in particular, of those involved in the development of the human embryo and fetus. Yet, as he himself allows, there is a 'definable moment' which lies 'at the beginning' of that process. His emphasis on the continuity of the process which follows is unwittingly subversive of the proposed 14-day criterion, to which he refers only in passing. The case is strong for treating fertilisation as the moment when personhood begins – when one of us comes into being, bearing the image of God. Dr Habgood makes no reference to the fundamental Christian argument for such an understanding of the status of embryonic human life; that it was at this point that the Son of God took human flesh, becoming incarnate *in utero* and in embryo. His suggestion that there is uncertainty in the Christian tradition on this matter takes no account of the fact that Christian theologians have sought to follow the fashions of the contemporary embryology at different points in the church's history. That is a complex question, though we may suggest that the clues offered by recent developments in embryology and genetics firmly lead us in one direction rather than another.

Yet it is by no means necessary to be convinced of this position in order to join one or other of the dissents filed by seven members of the Warnock Committee, to follow the approach taken in countries such as West Germany and recommended by the expert committee of the Council of Europe, and to decide that – whatever the state of debate about personhood and early embryonic human life – uncertainty here must counsel caution in public policy; and the extraordinary and unique potential of the early embryo must demand its protection from deleterious research.

If we accept a classical Christology we will of course want to go much further and affirm that since our Lord took human flesh first as a zygote, so in every zygote there is 'one of us' who bears the *imago Dei*.

If we accept a classical Christology we will of course want to go much further - will we not? - and affirm that since our Lord took human flesh first as a zygote, so in every zygote there is 'one of us' who bears the *imago Dei*. If the Archbishop of York does not agree, if he seeks rather to give his blessing to experimental abuse of early human embryos, he will, we hope, forgive us for being puzzled – and very sad.

This comment also available as a leaflet from CARE Trust, 53 Romney St., London SW1P 3RJ

Arguments for Abortion of Abnormal Fetuses and the Moral Status of the Developing Embryo

Agneta Sutton, Deputy Director designate, The Linacre Centre, London.

We are pleased to be able to publish here a chapter of Agneta Sutton's book Prenatal Diagnosis: Confronting the Ethical Issues, *just published by the Linacre Centre, 60 Grove End Road, London, at £10.95 (ISBN 0-906561-06-X).*

Arguments in favour of aborting abnormal fetuses may be divided into three main types. The most fundamental of these is that at the embryonic and fetal stages of human life there is not yet a person. It is argued that since an unborn human being at the embryonic and fetal stages is not yet a person, it has no human rights: in particular, it no more has a right to life than has any other non-person. The second type of argument (which usually, at least, implicitly assumes the correctness of the first argument) is based on considerations of the consequences of bringing disabled children into the world. It is argued that a disabled child constitutes an unjustifiable burden on its family, is an excessive strain on social resources at the expense of other members of society and may even pose an intolerable threat to the health and welfare of future generations. The arguments of health care economists belong to this type. The third type of argument in favour of selective abortion is based on the 'impaired quality' of life of a disabled child. It is argued that the life of a severely disabled child is not worth living.

These arguments deserve careful consideration; for they have far-reaching consequences for beings who are destined to become children and grow to adulthood (even if not all of them do so). In this chapter the first argument is subjected to critical scrutiny. An alternative account of personhood is proposed which, unlike the account defended by the proponents of abortion, obliges us to recognise a personal presence from the time a sperm and ovum come together to form a new organism. In the next chapter, the second and third types of arguments for avoiding the birth of disabled children are examined in the light of the conclusions reached in this chapter.

Some different understandings of personhood

The concept of a person specified by Boethius some 1500 years ago might well be described as the classical understanding of what it is to be a person. According to Boethius, a person is 'an individual substance with a rational nature' (*naturae rationalis individua substantia*) (Boethius *Lib. Pers. Duab. Nat.* cc. 2, 3). The ideas of individuality and of the possession of a certain kind of nature are fundamental to this classical understanding, which was accepted by St Thomas Aquinas and the scholastics and which has remained central within the Thomist tradition of thinking. It follows on this understanding that if it can be shown that already at the embryonic and fetal stages of life there is an individual being with the same rational nature as mature human beings, an unborn human being from the embryonic stage onwards is a person.

Since the publication in 1694 of the second edition of John Locke's *Essay Concerning Human Understanding*, in which the chapter entitled 'Identity and Diversity' first appeared, the Boethian concept of personhood has had to compete with another concept which differs from it very strongly. On Locke's understanding a person is:

> a thinking intelligent being, that has reason and reflection, and can consider itself as itself, the same thinking thing, in different times and places; which it does only by the consciousness which is inseparable from thinking and, as it seems to me, essential to it: it being impossible for anyone to perceive without perceiving that he does perceive (Locke 1694, c. 27).

What is important on the Lockean understanding of personhood is possession of consciousness and self-consciousness, and of those personal abilities which are associated with consciousness and self-consciousness. As philosophers in the Lockean tradition view the matter, consciousness and self-consciousness, understood as *presently exercisable abilities* and therefore as *presently manifestable states of mind*, must be possessed by any being which is to count as a person.

It is obvious that on a Lockean understanding of personhood, the fetus or embryo is not yet a person. For it does not yet possess any presently exercisable intellectual abilities associated with self-consciousness and rationality. That is to say, a philosopher in the Lockean tradition would argue that neither an embryo nor a fetus is a person, because they lack those intellectual attributes which are typical of persons [1]

Another important line of argument is that the early embryo or zygote (the first cell formed by the union of sperm and egg) fails to fulfil the conditions of personhood laid down by Boethius. It is argued that the zygote is not yet a person because it is not an individual being and does not have the right kind of nature; the zygote cannot be a person because it is not an individual being with a rational nature.

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Now, Lockean arguments which deny that early human life is personal can be shown to suffer from serious shortcomings. I shall argue, first, that a Boethian understanding of personhood (that is, one based on the criteria for personhood laid down by Boethius) is both more rational and more consistent with our intuitions than a Lockean understanding which defines personhood in terms of presently manifestable states of mind. Secondly, I shall argue that a Boethian understanding of personhood is not only compatible

with but suggests the view that the human embryo is a person from the time of conception onwards.

The argument to be advanced here, then, is that the human embryo is an individual being and has, right from the time of conception, the same kind of (rational) nature as an adult person. The argument proceeds by posing the question: What kind of being is the human embryo? And it seeks to answer this question by answering two questions suggested by the Boethian definition: Is the human embryo an individual being? and, Does the embryo possess a rational nature?

Is the early human embryo an individual organism?

Many philosophers today argue that the embryo in the early stages after fertilisation is not yet an individual human being, and so not a person. They claim that the early embryo is not yet a historically stable or single continuous being or that it is not yet an ontologically single being.

For instance, Father Norman Ford, Master of the Catholic Theological College, Melbourne, in his recent book *When did I begin?*, argues that although the zygote is a biologically human individual, when the first cell division occurs there ceases to be a single individual, and from then on until the primitive streak appears, each multiplying cell is a distinct individual (Ford 1988, 122-126, 137-138). Similarly, according to Dr Ann McLaren, of University College, London, the embryo is not a spatially defined entity until the primitive streak appears. Only then, she argues, when determinate sites for the co-ordinated development of future structures, tissues and organs can be discerned, is it possible to speak of a functional whole (McLaren 1986, 5-23). Furthermore, Ford and a number of other philosophers have argued that the early embryo is not yet an individual organism because its cells are undifferentiated and plenipotential (Ford 1988, 119-122, 125, 132-138, 151-163, 170-177; Mahoney 1984, 52-86; Dunstan 1988a, 9-17; Kenny 1987, 84-98). This is important, they believe, because the undifferentiated and plenipotential character of the early embryo's cells is a sign of the discontinuity between the early and the later embryo; for it means, among other things, that some of the early embryo's cells are destined to give rise to placental tissue rather than to become a proper part of the future fetus. In Ford's view, for instance, the fact that some of the cells of the early embryo will become placental rather than fetal tissue supports the claim that it is not yet a stable ontological individual. Finally, it is pointed out that until the primitive streak appears the organism is capable of dividing into identical twins, that is, into two distinct individuals. Indeed, it is argued – and not only by Ford and McLaren but also by such authors as Professor G.R. Dunstan and Peter Byrne, of the Institute of Medical Law and Ethics at King's College, London – that the possibility of monozygotic twinning provides the ultimate proof that there can be no single continuous individual human life (or ontologically individual life) until after that stage of development has been passed.

These arguments rest on defective presentation of the facts. First, it should be noted that it is false to say that the cells of the very early embryo are totally undifferentiated. Molecular differentiating activity in the cell or cells directed towards the formation of the fetus, the child and the adult begins immediately after fertilisation. Indeed, it starts as soon as the sperm has penetrated the zona pellucid surrounding the ovum and has entered the ovum itself.[2] There is definite scientific evidence, then, of functional unity from the zygote stage onwards. Thus the early embryo develops as a unified organism, and not (as Ford would have it) from a one-cell organism to a mass of loosely connected one-cell organisms which, at the primitive streak stage, suddenly and inexplicably unite into one organism. From the time cell-division begins, the different cells develop together in synchronised harmony as integral parts of one organism. And their development as a functional whole is teleologically orientated and so is guided by an inherent principle of life, or what Aristotle calls a soul. For the early cells could never have reached the primitive streak stage if they had not been programmed to do so and to do so in unison as a functional whole. The primitive streak stage is neither the beginning nor the end of the functional unity of the organism. It is but one of the many stages of the continuous teleologically orientated development of the embryo.

Furthermore, the fact that the early differentiating activity of the embryonic cells is partly directed towards the formation of the placenta does not disprove but rather testifies to its organic unity. That the placenta is developed precisely as an organ temporarily necessary for the life-support of the embryo shows the single goal-directedness of the differentiation and development of early embryonic life. It is a manifestation of the fundamental functional unity of the organism right from the start. And that the placenta is lost at the birth of the child has no more bearing on his individuality than does the loss of his milk-teeth at a later stage in his life.

The question remains: Does the possibility of twinning show that the unborn child cannot be an individual being from conception onwards?

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twinning does take place (0.33 per cent of live births), is that we still have no scientific explanation of the phenomenon. However, it is possible, and quite plausible, that spontaneous monozygotic twinning is genetically determined.[3] If this is so, there is some inherent difference between those early embryos which are destined to twin and those which are destined to remain single. On this assumption, twinning is due to a special genetic quality which is present from the time that the genetic blueprint of the original embryonic cell, the zygote, is determined. There is some evidence for the hypothesis that twinning is genetically determined inasmuch as it tends to run in families. Moreover, if all embryos had the same propensity to twin, it would be odd that twinning was the exception rather than the rule. If twinning is genetically determined, it follows that in the case of an embryo destined to twin there are two individual presences from the start, in the sense that two different final ends, two different life-paths, are programmed from the very beginning. And this holds true even though the original zygote is not composed of two individual physical beings in the sense, say, of housing two sets of paired gametal chromosomes instead of the one set. For its genetic blueprint contains a programme which governs two lives and two destinies. Thus we cannot unequivocally describe a zygote which is destined to twin *as a single individual being*; rather we may speak of two *individual presences* in such a zygote. Despite the physical unity of the twins immediately after conception, from a logical point of view there are already, from the time of conception, two distinguishable fates and lives, and so two beings.

If, on the other hand, twinning of human beings is not determined by genetic causes, the situation is different. In this case there is no inherent difference between embryos destined to twin and embryos not destined to twin; rather the process of division and separation must be triggered off by some other factor. Is there, in this case, a problem concerning the individuality of the original embryo or either of the twins? The answer to this question will depend on the exact nature of the process of division and separation.

One possibility, if twinning is not genetically determined, is that the process of division and separation is to be understood as the original embryo's shedding a part of itself, this part becoming, at the moment of separation, a new individual organism. On this understanding there is no problem about the continuous individuality of the original embryo from conception onwards. It is and remains the same single individual embryo after losing a part as it was before losing it. However, on this account the twin embryo who originates as a part of its sibling only starts life as a living individual organism at the time of separation. Yet, even if the younger twin only starts life as an individual being at the time of separation, there is no problem about its continuous individuality from then onwards. The lives of both twins are individual and continuous from beginning to end.

Another hypothesis, although a rather counter-intuitive one, is that at the time of division the original embryo ceases to exist and the lives of two new individuals begin. Interestingly enough, however, even on this hypothesis there is no problem regarding the continuous individuality either of the original embryo or of either of the two twins. Admittedly, the life-span of the original embryo would be a short one. But it would be the continuous life-span of a single individual while it lasted. The lives of the two twins would begin only at the time of separation but would from then on be two separate continuous individual lives.

In sum, on the hypothesis that twinning is genetically determined, there are two individual presences or beings from conception onwards in what appears to be but one. If twinning is not genetically determined, it follows that human life does not always start at conception, but that sometimes human beings begin life a little later as the result of an asexual process of generation. However, even in this case the original embryo, the zygote, is one single individual being throughout its existence, whether the process of generation be understood as a shedding of a part or as a splitting into two. Moreover, be there one or two descendants, each descendant is an individual being and remains an individual being throughout his entire life. And this is true irrespective of whether his life starts at conception or at the time of separation. Thus, all three hypotheses have one important implication in common, namely that human life is individual life from beginning to end.

In short, none of the arguments for denying the individual organic unity of the early embryo bears close scrutiny. None of them proves that the early embryo is not an individual organism. Indeed, properly understood, plenipotentiality of the first embryonic cells and the development of the placenta are manifestations of the functional unity of the early embryo. And every explanation of monozygotic twinning suggested here entails that all embryonic life is individual from the very beginning.

Does the early embryo possess a rational nature?

Some proponents of the view that the early embryo is not yet a person have argued that this is because it does not yet have the right kind of nature. Byrne has argued that the early embryo is different in nature and constitution from the later embryo, the fetus and the infant, because its cells are plenipotential rather than differentiated. On Byrne's view, it is not until organogenesis begins and twinning is no longer possible that the organism can be called a human being, or a being with potential for rational powers (Byrne 1988, 102-105). And, as we have seen, on Ford's theory, although the zygote is a biologically human individual, from the two-cell stage until the primitive streak appears there is not a single organism but a multiplicity of distinct organisms, which as a multiplicity cannot possess the nature that goes with the functional unity of more developed human beings (Ford 1988, 119-126, 132-139, 151-163, 170-177).

However, the argument that the zygote does not have the same nature as the later embryo, the fetus and yet more mature human beings is not convincing. For we have seen that – at least when twinning does not take place – the development from zygote to fetus is continuous and so must be informed throughout by one and the same teleologically orientated developmental power which at the biological level is genetically determined and which directs the organism's development as a functional unity from zygote into fetus, into a baby, a child and eventually into an adult. And even if twinning does take place, not only is the twins' shared genetic blueprint there from the zygote stage, but their development both before and after division is teleologically orientated and follows the path towards organogenesis and beyond to infanthood just as in the development of other embryos. Furthermore, if a twin did not possess the same kind of nature and the same inherent potential as

other embryos from the time its life began, it would never develop into a human being with personal powers like the rest of us. It would therefore appear that the zygote, the fetus, the baby, the child and the adult must share the same kind of nature, a nature determined by an inherent teleological principle of life which governs the formation and development of the organism.

In brief, it seems clear that all beings of human origin, all members of the species *homo sapiens*, have the same kind of nature, that is, human nature. But, it could be argued, this does not mean that the early embryo has a *rational* nature. The Lockean argument for claiming that the early embryo (or the fetus) does not yet possess a rational nature (and so cannot be a person) can be elucidated as follows:

(1) in order to possess a rational nature (and be a person), it is necessary to possess certain presently exercisable abilities associated with self-consciousness and rationality;
(2) the early embryo does not possess any presently exercisable abilities associated with self-consciousness and rationality (nor does the fetus);
(3) therefore, the early embryo does not possess a rational nature (and so is not a person) – and likewise for the fetus.

The crucial question on which this argument hangs is whether possession of presently manifestable abilities associated with rationality is a condition of personhood. And, in order to answer this question, it is helpful to distinguish between the following notions:

(1) the actual manifestation of an ability;
(2) the possession of a presently exercisable ability; and
(3) the possession of a capacity to develop an ability – or abilities – for short, a radical capacity.[4]

Philosophers in the Lockean tradition would hardly be inclined to deny rationality to somebody just because he was asleep and was therefore not actually manifesting this quality. The actual manifestation of rationality is not a condition of one's possessing a rational nature.

However, philosophers arguing on Lockean lines would insist that even if possession of a rational nature does not require that rationality be manifested all the time, it does require the possession of a present capacity to manifest rationality and self-consciousness. Hence, quite consistently, those who accept Locke's definition of personhood will be prepared to argue that just as the early embryo and the fetus do not possess a rational nature, neither does the newborn baby or the permanently comatose individual.

Most of us, however, would find these conclusions counter-intuitive. One reason why most of us would regard young children and newborn babies as persons is that, using our imagination, we can envisage their future rational abilities. As for the comatose, unless it is certain that they will never again display any signs of rationality and self-consciousness, their situation is like that of the sleeping. Moreover, and more important, even if we knew that a particular comatose person would never regain consciousness, the fact that in the past he was undoubtedly a person would make us disposed to continue regarding him as a person until his death. Thus, because they are contrary to common sense and fail to reflect the ordinary use of words, the Lockean conclusions and so their premises appear to be unconvincing.

Quite apart from the counter-intuitive character of the viewpoint being examined here, there are strong grounds for concluding that the early embryo from the zygote stage onwards possesses a rational nature. This can be shown by the following argument. Adult human beings normally possess exercisable abilities such as self-consciousness and rationality. These abilities are manifestations of their rational nature. But the possession of inherent abilities which were not always present must have originated from a capacity to develop these abilities which was inherent in the individual's nature from the outset. Otherwise the present abilities would have sprung from nothing and so would be inexplicable. *Ex nihilo nihil*: out of nothing nothing can come. That is to say, a being possessing abilities associated with rationality must always have possessed a nature inherent in which was a radical capacity to develop such abilities. It must therefore be concluded that the human zygote, which develops into a fetus, an infant and eventually an adult person possessing manifestable abilities associated with rationality, possessed from the very beginning a radical capacity to develop those rational abilities. Moreover, since this radical capacity is a capacity to develop rational abilities, the nature in which it resides must be understood as a rational nature. This nature possesses an inherent potential to manifest precisely those abilities which are associated with rationality. Thus the nature of the zygote, of the early embryo, of the fetus and of the infant must be understood as a rational nature.

In brief, we have arrived at affirmative answers to the two questions: Is the human embryo an individual being? and, Does the embryo possess a rational nature? The final question to be asked is therefore: How, then, could the early embryo not be a person?

Is the early embryo a person?

What truth there is in the Lockean understanding of personhood rests in the assertion that adult persons typically do possess and are capable of manifesting self-consciousness and rationality, and that beings who are not persons do not possess and therefore cannot manifest self-consciousness and rationality. But from the fact that (presently manifestable) self-consciousness and rationality are typically possessed by, and only by, persons, it does not follow that it is necessary to possess these characteristics in order to be a person. What is necessary is the possession of a rational nature with an inherent radical capacity to develop manifestable mental states of kinds associated with rationality and self-consciousness.

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To argue by analogy: it is typical of a lion to have four legs, a yellow coat and to feed on raw meat. Nevertheless, it is possible to be a lion and have three legs, a white or spotted coat and feed on boiled meat. The truth is, of course, that a normal healthy lion has four legs and most commonly has a yellow coat and eats raw meat. What determines whether or not a creature is a lion is its nature. Similarly, a person may lack one or several of the attributes that are typical of

personhood and correctly be described as a person. For what decides whether or not a being is a person is his nature.[5]

However, it might be objected that the suggested analogy is a poor one, for while a lion has what might be called a lion nature by virtue of its belonging to a certain species, possession of a personal nature is not tied to any particular species. Those who make this objection might argue that there is a similarity between the concept of a lion and that of a human being but not between the concept of a lion and that of a person. The terms 'lion' and 'human being' both have their places within the scientific system of biology. The term 'person', on the other hand, does not seem to belong to the scientific system of biology but rather to spheres of learning such as philosophy, theology, history, literature, psychology and law. Yet the personal abilities typical of mature adult human beings must surely depend on the kind of being they are. Just as what a lion is and can do depends on its nature, so the facts that I am a person and that I possess personal abilities depend on my nature. The concept of a person may not be primarily a biological concept, but human beings are persons because of their (human) nature. And human nature, so it has been argued here, is determined at conception. In the life of a living being of human origin abilities develop gradually and continuously by virtue of capacities inherent in that being's nature from conception onwards.

To reiterate, adult human beings normally possess exercisable personal abilities such as self-consciousness and rationality. These abilities did not suddenly appear from nowhere but must depend on previous capacities inherent in their nature from the beginning. That adult human beings normally can and do attain self-consciousness and rationality can only be explained by their possession of a certain kind of nature inherent in which, from the outset, is a capacity to develop over time exercisable personal abilities. We have termed such a capacity to develop certain future abilities a radical capacity. Human zygotes must, then, possess a radical capacity to develop personal abilities.

Moreover, a radical capacity to develop *personal abilities* must itself be understood as a *personal capacity*. And if this radical capacity is personal, so too is the nature in which it resides. The nature possessed by zygotes, human nature, must therefore be understood as personal. In other words, human nature must be personal from the time of conception; and every member of mankind must by virtue of his human nature be a person.

That human beings must be personal from the one-cell stage has been argued by Teresa Iglesias in similar terms:

> The bodily person I am now certainly began as a tiny organism of one cell, a human zygote. If this original cell was capable of developing into *me*, what capacities and potential did it have then? This is the crucial question that must be answered. The development of personal abilities (self-awareness, choice, creativity) does not come about independently of our organic development. There are no bases in reality to affirm that those capacities are 'something added' (by miracle?) at any particular stage. Thus if we are to make sense of our existence *now* as human personal beings, we must admit that whatever capacities we have now have developed from what we were from the beginning. Our present abilities are only explicable if there were *always a presence* of the inherent capacity for those abilities in the human organism from the beginning (Iglesias 1984, 35).

In short, there are strong grounds for thinking that every living being of human origin has a personal nature with inherent personal powers, and so is a person from the time his life began at conception (or possibly, if he is a twin, from the time of separation).

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Embryogenesis and developmental accidents

It might be argued that sometimes things go so drastically wrong with the process of human generation that the resulting living being, although of human origin, cannot be counted as a person. For example, it has been argued that anencephalic babies with large parts of the brain missing are not really human persons. Such a view is not compatible with the argument of this chapter. We have seen that the development of an individual from zygote to adult is intelligible only by virtue of a dynamic radical developmental capacity in the human nature of each human being. It is by virtue of this capacity that we can understand how a human zygote which develops normally can result in an adult human being with the range of abilities, including rational abilities, possessed by adult humans.

But clearly there can be failures of development at many stages. Those who argue that anencephalic babies are not human persons seem to rely on the assumption that the distinctive rational abilities of persons are ultimately reducible to brain structures and brain processes, so that if these are absent it cannot even make sense to speak of a person being present. The assumption behind the view presented here, however, is that the capacity for rational activity is not reducible to brain structures and brain processes. In order to state accurately the relationship between the two it is necessary to distinguish between a capacity or ability on the one hand, and the vehicle of the capacity on the other. This conceptual distinction has unproblematic applications. The vehicle of my capacity to stop the car is the brake mechanism; the vehicle of my capacity to rise to the top of the Empire State Building is the lift mechanism. Brain structures should be thought of as the vehicle of my capacity for rational activities. The capacity cannot normally be exercised without the vehicle, but the capacity is not reducible to the vehicle. So a failure in organogenesis to develop brain structures necessary for rational activity does not show that the anencephalic fetus lacks the radical capacity for rational activity. And it is possession of the radical capacity which makes a product of human conception a person.

In the case of anencephalic babies we have no reason to think that the product of conception is not a human being starting life with what is fundamentally necessary for human and personal development. Rather, an anencephalic baby is a human being who has suffered a gross *developmental* failure.

But what about embryos who are affected by grave chromosomal defects? They may have one chromosome too many (as in Down's syndrome) or one chromosome less than is normal (as in Turner's

syndrome). Or instead of the normal 2-times-23 chromosomes, their cells may contain 3-times-23 or 4-times-23 chromosomes. The answer is that this does not make them any less human than the rest of us. At the basic physiological level, their chromosomes retain the overall structure of human chromosomes and human gene patterns. And, at the immediately observable level, they not only look recognisably like their fellow members of the human family, but many people with chromosomal abnormalities are just as rational and self-conscious as those whose chromosomes are normal. Others may display varying degrees of rationality, self-consciousness and other personal abilities. Inherent in their nature is a radical capacity to manifest personal abilities, even if the extent to which they can actually express this radical capacity varies. In other words, these individuals share our human and personal nature.

But there are some products of conception which right from the start lack the fundamental prerequisites at the biological level for human development. There is no reason to think that these are informed by that distinctive principle of human life which we have called a radical developmental capacity for human and personal characteristics. Indeed, when things go so drastically wrong with the process of generation that the chromosomal structure and genetic base of the resulting growth predetermines it never to develop as a living being with recognisably human characteristics, it does not seem reasonable to speak of a living being at all but merely of an organic growth, the genetic origin and make-up of which is human. This is what happens when, for example, a hydatidiform mole develops from a cell originating from two gametes but possessing chromosomes of solely paternal origin. Such a growth develops into placental tissue only. And because it is functionally directed to grow into placental tissue only, even if such a growth genetically speaking is human, it is not possible to speak of it as a being possessing a human and personal nature.

In short, all human beings – and only human beings – possess a human and personal nature from the time of conception (or possibly shortly afterwards, in the case of a twin). And this is true even if no human beings are capable of manifesting personal abilities at all times, and even if some human beings are never capable of expressing any personal abilities at all.

Conclusion

It is as personal life that human life deserves to be respected and possesses a special dignity. Thus, since personal life is the continuous life of a human individual, human life deserves to be protected at all stages and not merely during those stages in an individual's life when he is capable of expressing typically personal abilities. Individual human life must be respected from beginning to end. Hence, if there is individual human life from the time of conception, as seems to be the case, human life deserves to be respected from the time of conception onwards. Moreover, since a human life hampered by disability is no less personal than any other human life, every human life, even if hampered by malformation or affected by disability, deserves to be respected from conception. Every individual human being, then, however undeveloped or defective, deserves to be respected as a member of the human family.

Notes

1 The trendsetter among modern philosophers who base their arguments for abortion on a Lockean conception of personhood is, no doubt, Michael Tooley (Tooley 1972). According to Tooley, the condition of personhood is possession of presently-expressible and self-conscious desires for long-term ends.

2 *Cf.* Begley *et al.* 1980, 90-102.

3 It may be mentioned that there is no single case of artificial monozygotic twinning of the human embryo *in vitro* reported in the literature so far.

4 *Cf.* Kenny 1975, 9-11. Kenny distinguishes between the possession of a power, the exercise of a power and the vehicle of a power and points out that there is a modern tendency to equate the possession of a power with either its exercise or its vehicle. See also Fitzpatrick 1988, 230. Fitzpatrick distinguishes between the actual performance of an activity, the possession of a present ability to perform the activity and the possession of a radical capacity to come to perform it.

5 *Cf.* Saul Kripke, 'Naming and Necessity', in *Semantics and Natural Languages*, ed. Davidson and Harman (Dordrecht 1972), 316-323. See also Hilary Putnam, *Mind, Language and Reality* (Cambridge 1975), 139-152; David Wiggins, 'Locke, Butler and the Stream of Consciousness: and Men as a Natural Kind', in *The Identities of Persons*, ed. Amelie Oxenberg Rorty (London 1969), 139-173.

A Case Against Dutch Euthanasia

Richard Fenigsen, Cardiologist, Willem-Alexander Hospital, s-Hertogenbosch, The Netherlands

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Dutch general practitioners perform voluntary active euthanasia on an estimated 5,000 patients a year; the larger figure cited of 6,000 to 10,000 patients probably also includes hospital patients. However, figures as high as 18,000 or 20,000 cases a year have been mentioned. The population of The Netherlands being fourteen and a half million, the lowest Dutch figure published would correspond to about 80,000 cases of active euthanasia a year in the United States; the highest published Dutch estimate (20,000) would be tantamount to over 300,000 cases annually for the U.S. 81 percent of Dutch general practitioners have performed active euthanasia at some time during their professional careers; 28 percent perform active euthanasia on two patients yearly, and 14 percent on three to five patients every year. In Holland, the causes of death of people suffering from AIDS are different from those of patients with AIDS in other countries as 11.2 percent of Dutch AIDS patients die by active euthanasia.

Many people in The Netherlands carry a will requiring active euthanasia to be performed on them 'in case of bodily injury or mental disturbance of which no recovery to reasonable and dignified existence is to be expected.' Recently, the paper wills have begun to be replaced by small, handy plastic cards nicknamed 'credit cards for easy death' by the Dutch press. In 1981 the number of people carrying such cards was reported to be 30,000, but is supposedly much higher now.

The law that would legalise euthanasia is a major issue in Dutch politics. Of the eleven political parties in Holland, ten have included the issue of euthanasia in their electoral platforms. Government coalitions rise and fall because of agreement, or disagreement, concerning euthanasia. Some representative headlines: 'Majority of the Lower House (of Parliament) for Euthanasia'; 'Coalition Splits on the Plan for Euthanasia'; 'No Waiting Till the Elections: Christian Democratic Alliance and VVD (the Liberals) Want the Law on Euthanasia'; 'The Parliamentary Fraction Sticks to the Euthanasia Bill of D-66: Conflict Looms Within the Liberal Party'; and 'Political Consensus on Euthanasia.'

Thus, there is considerable public acceptance of the view that life-saving treatment should be denied to the severely handicapped, the elderly, and perhaps to persons without families.

Acceptance of 'voluntary' active euthanasia by the Dutch people is growing. According to two consecutive polls, 70 percent of the Dutch people accepted active euthanasia in 1985, and 76 percent in 1986. This is interpreted by the media as a vote for human freedom (including the freedom of the individual to decide upon his or her life or death), but the reality is more complex. An analysis of public opinion reveals other, and quite different attitudes, in particular, views that oppose the individual's freedom of choice and support society's right to cut short a person's life. Thus, there is considerable public acceptance of the view that life-saving treatment should be denied to the severely handicapped, the elderly, and perhaps to persons without families. Further, opinion polls show that a majority of the same public that proclaims support for voluntary euthanasia, freedom of choice, and the right to die, also accepts involuntary active euthanasia – that is, denial of free choice and of the right to live.

In Holland, the most prominent persons on the medical scene are at the same time leading figures in the movement to legalise euthanasia. The late Prof. Dr P. Muntendam held both the chairmanship of the State Committee on Legal Reform of the Medical Profession and the presidency of the Dutch Society for Voluntary Euthanasia. The long-time president of the latter society, Dr Helen Terborgh-Dupuis, has been offered the chair in medical ethics at Leiden University. Her inaugural lecture was entitled, '*Dood wordt te negatief gewaardeerd*' (death is being judged in too negative a way). Holland's leading specialist in pediatric oncology, Prof. P.A. Voute, recently revealed that since the early 1980s it has been his practice, at times without the parents' consent, to provide some of his patients with doses of poison, enabling them to commit suicide when they feel so inclined. An opinion poll showed that 70 percent of the public approved of Prof. Voute's actions.

In June 1984, the Board of the Royal Dutch Society of Medicine (KNMG, the main Dutch physicians' organisation, with a membership of 30,000) approved a 'Position on Euthanasia' supporting the legalisation of voluntary active euthanasia. In another official statement this same Board declared support for involuntary active euthanasia. It also indirectly supported involuntary active euthanasia in the affair of the *De Terp* killings in The Hague. The Royal Dutch Society of Pharmacology (KNMP) has compiled a list of drugs to be employed in performing active euthanasia. The Health Council (*Gezond-heidsraad*, the official medical body advising the Dutch government) has issued numerous detailed guidelines concerning indications for, and the performance of active euthanasia. One of these, published in March 1987, states that requests for euthanasia submitted by minors and children should be honoured, and euthanasia performed, not only when the child's parents consent, but also when the parents protest.

Euthanasia in the Courts

Of the 5,000 to 20,000 cases of active euthanasia occurring every year, an average of eleven prompt inquiries to be made by the offices of public prosecutors. The prosecutors act under a regulation issued by the Ministry of Justice which states that an inquiry should be launched only when it is suspected that the doctor performing euthanasia did not act in a careful manner. The legal authorities encourage doctors performing euthanasia to state active euthanasia as the cause of death to avoid their making false statements. In some cases, the doctors inform the public prosecutor beforehand that

euthanasia is to be performed. The sentence passed by the court of Leeuwaarden in 1972 (one week of suspended arrest for a doctor who killed her mother) initiated the judicial trend now followed by all the courts, higher appellate courts, the Supreme Court, public prosecutors, and the Ministry of Justice. In the few cases of 'voluntary' euthanasia brought to trial, the court declares the doctor guilty but does not impose punishment, whereupon the higher court overturns the 'guilty' verdict on the grounds that the doctor acted out of higher necessity. The latter ruling is now being applied in every such case.

When a perpetrator of involuntary euthanasia is brought to trial, as in the case of the doctor who secretly committed the killings in *De Terp* nursing home in The Hague, punishment is imposed but abolished on a technicality by a higher court.

Why Holland?

The causes and origins of Dutch euthanasia seem to be complex, rooted both in the past history and the present development of Dutch society. The subject deserves extensive study. Until such study is done, however, one can only offer views that are incomplete and partly conjectural.

An important current of Dutch medical, legal, and theological thought was influenced by such German thinkers as Haeckel, Jost, Binding, and Hoche, who introduced the concept of lives unworthy of being lived, and advocated the extermination of useless individuals to relieve society of that burden. Appearing on the scene half a century after their German predecessors, after the experience of Nazi euthanasia on psychiatric patients and the handicapped, after Europe's historical experience of genocide, and at a much further advanced stage in the development of the Western concept of human rights, the champions of euthanasia in The Netherlands had to present a modified and highly refined program. They emphasised the right to die, and stressed death as a relief from suffering and as being in the best interest of those who were ill and unhappy — a program designed to appeal to those who believe in human rights. The other theme, that of the right to kill in the interest of the society, has been downplayed but never actually eliminated, so as not to discourage those who believe that the human race should be improved by the extermination of weaklings. Thus, the pre-requisite for the success of the pro-euthanasia movement in Holland has been its extremely well-constructed program.

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This program, promoted by talented writers such as van den Berg, kept gaining support until an avalanche effect occurred. Editors and publishers soon became reluctant to print or broadcast anything that went against the current. The media have been virtually monopolised by the euthanasia proponents, and a whole generation of Dutch people has been raised without ever hearing any serious opposition to it.

Several features of Dutch public life seem to have enhanced the rapid expansion of the pro-euthanasia movement. First, Holland is a very democratic, liberated, and permissive society that highly values unlimited freedom of thought and expression, and encourages the rejecting of dogmas and the overthrowing of taboos. This has facilitated open discussion of euthanasia and the questioning of the 'taboo' upholding the sacredness of human life. One possible failure (or side-effect) of the advanced democratisation and liberalism of Dutch society is popular antimedical feeling, which runs much higher here than in other European countries. There is great resentment against doctors who wield so much power without being elected, and who are seen as selfish, much too self-assured, devoid of common sense, and ignorant of people's needs. There is a strong link between this antimedical public mood, nurtured by propaganda in the Dutch media, and the rush to euthanasia. Some people would rather die soon than be left to the mercy of doctors 'and their machines.'

In The Netherlands, where Catholicism and Protestantism coexist, issues easily acquire religious connotations. As a result, the principle of the sacredness of human life has been unduly identified with, and confined to, the religious commandment. This has weakened the cause of opponents of euthanasia, as it is clear to all that the country belongs to believers and nonbelievers alike and no purely religious concept should be imposed as a general rule or made the law of the land. Secular reasons – moral, rational, and medical – for rejecting euthanasia are still unknown to the Dutch people.

Also, peoples speaking languages of the Germanic group have historically proved able to build particularly strong social structures. To maintain them requires the far-reaching subordination of the interests of the individual to those of the society. Important business, including the destinies of individuals, may and should be decided upon by public assembly, by consensus, or according to the tribe's laws and rules. It can be argued that these attitudes have determined the acceptance of involuntary aspects of euthanasia by the Dutch public.

Finally, while guilt about the Nazi past until recently precluded any serious pro-euthanasia movement in Germany, the Dutch, who never committed such crimes and, on the contrary, have built at an enormous cost to the national economy an exemplary system of care for the sick, the handicapped, and the elderly, have not been inhibited by such guilt.

'Voluntary' Euthanasia

It is the concept of 'voluntary' euthanasia, evoking the themes of the right to self-determination and freedom of choice, that is being used to influence the public, the medical profession, and legislators to open the way to the legalisation of euthanasia. However, there are, and always have been, compelling reasons for which 'voluntary' euthanasia was rejected by Western civilisation in the past, and should be rejected now and in the future.

'Voluntary' euthanasia should be rejected because its voluntariness is often counterfeit and always questionable.

'Voluntary' euthanasia should be rejected *because its voluntariness is often counterfeit and always questionable*. In Holland, doctors have tried to coerce patients, and wives have coerced husbands, and husbands wives to undergo 'voluntary' euthanasia. But it is not these flagrant incidents that matter, it is all the others. For twenty years the population of Holland has been subjected to all-intrusive propaganda in favour of death. The highest terms of praise have

been applied to the request to die: This act is 'brave,' 'wise,' and 'progressive.' All efforts are made to convince people that this is what they ought to do, what society expects of them, what is best for themselves and their families. The result is, as Attorney General T.M. Schalken stated in 1984, that 'elderly people begin to consider themselves a burden to the society, and feel under an obligation to start conversations of euthanasia, or even to request it.' Recently, the Dutch Patients' Association warned Parliament of reports showing how strongly a sick person's decision to request euthanasia is influenced by pressure from the family and the physician. It is striking that doctors who practice euthanasia have killed so many patients 'at the latter's own request' (one doctor gives a figure of seventeen), while other, more traditional practitioners have yet to hear such a request from a patient. When evaluating the thousands of 'voluntary' requests for euthanasia submitted every year in Holland, one should take into account the influence of propaganda and of the physician provocateur.

'Taïgetian' Medicine and Crypthanasia

'Voluntary' euthanasia must also be rejected because, contrary to the beliefs of some of its supporters, *it is inseparable from, and inherently linked to overtly involuntary forms of euthanasia*. The Dutch phenomenon of mass 'voluntary' euthanasia can only be understood when it is considered in the broader context of a changed attitude toward human life, together with other important manifestations of this new mentality: 'Taïgetian' medicine and the practice of crypthanasia. There is a very widespread practice of intentionally allowing certain groups of people to die out. This aim is achieved by denying these people life-saving treatment. I call such practices 'Taïgetian' because in the Taïgetos mountain chain near Sparta, where newborn babies not found strong enough by the Ephor of the State were left to die. Doctors allow at least 300 handicapped newborn Dutch babies to die every year; prevent surgery for congenital heart disease in Downs Syndrome children by refusing to give anesthesia; and refuse to implant pacemakers for heart block in patients older than seventy-five or to treat acute pulmonary edema in the elderly and single people without close families. Some doctors justify these practices by arguing that it is in those patients' own best interest to die as soon as possible, but often the explanation is that society should not be burdened with keeping such persons alive. The decisions are taken without the knowledge of the patients and against their will. Doctors who deny some of their patients available life-saving help violate thereby Rules 1, 6, and 7 of the Code of Medical Conduct adopted by the KNMG, the Medical Code of Ethics of the World Medical Association, the Declaration of Tokyo of 1975, the European Treaty in Defense of Man and the Basic Freedoms, Dutch civil law, and Article 450 of the Dutch Criminal Code. However, these Taïgetian practices are strongly supported by the public, theologians, and the medical institutions of high authority.

There is now ample evidence that 'voluntary' euthanasia is accompanied by the practice of crypthanasia (active euthanasia of sick people without their knowledge). Gunning was the first to report attempts to kill off elderly patients instead of admitting them to the hospital. In 1983, extensive information on crypthanasia became available with the publication of H.W.A. Hilhorst's well-researched book, *Euthanasia in the Hospital* (in Dutch), based on the results of a study conducted in eight hospitals. In this publication (sponsored by the Royal Dutch Academy of Science and the University of Utrecht) the author analyzed the practice of involuntary euthanasia and described cases of involuntary active euthanasia on adults and children. There followed, in 1985, reports on mass secret killings in the *De Terp* senior citizens' home in The Hague; my report about practices of crypthanasia at the internal department of a hospital in Rotterdam; estimates by Dessaur, Gunning, Dessaur and Rutenfrans, and van der Sluis that more people die in this country by involuntary than by voluntary euthanasia, and, in 1987, the discovery of serial killings of comatose patients by four nurses in the department of neurosurgery at the Free University Hospital in Amsterdam. Whenever cases of crypthanasia are revealed, attempts are made to dismiss them as abuses that have nothing in common with the regular practice of voluntary euthanasia – as exceptional, sporadic, and criminally liable acts. However, the problem cannot be discarded in this way. It cannot be asserted that crypthanasia occurs only sporadically.

Neither can it be claimed that the covert medical killings are perpetrated by some criminal outcasts whose actions are contrary to public mood and condemned by public opinion. The reverse is true. Two consecutive polls conducted by NIPO Institute showed that while 76 percent of the Dutch public approve 'voluntary' euthanasia, 77 percent support involuntary euthanasia. Thirty-three percent of the respondents showed 'considerable understanding' and another 44 percent 'some understanding' for those who, out of mercy, kill their own father or mother without his or her consent. Forty-three percent approved of involuntary active euthanasia for unconscious persons 'with little chance of recovery,' while 10 percent were certain and an additional 17 percent deemed it probable that they would request involuntary active euthanasia for a demented relative.

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Ninety percent of the undergraduate economics students polled supported compulsory euthanasia on unspecified groups of people to streamline the economy. The perpetrators of crypthanasia enjoy broad public and institutional support, and total judicial leniency. The doctor apprehended in The Hague under suspicion of having killed twenty inhabitants of the *De Terp* old people's home without their consent or knowledge pleaded guilty to five, was accused of four, and convicted of three killings. Witnesses testified that some of the victims were not ill but only senile and querulous, and that the doctor was impatient with elderly people, reluctant to treat them, frequently absent, and left many decisions to the male head nurse. The latter carried out the killings (using untraceable intravenous injections of insulin) and threatened other *De Terp* inhabitants with euthanasia. A Citizens' Committee of support for the accused doctor was formed in The Hague, and he received public declarations of support from among others, the president of the Dutch Society for Voluntary Euthanasia, the vice-president of the KNMG, and a former Attorney General at the Supreme Court, and others. In an official statement, the Board of the KNMG declared itself alarmed, not by the killings, but by the conviction of the doctor,

which could cause feelings of insecurity among physicians who help their patients to die and discourage these doctors from doing so openly and from stating active euthanasia as the cause of death. Finally, a higher court dismissed the accused doctor's guilty plea, and found him innocent of the killings, while a civil court awarded him 300,000 guilders ($150,000 U.S.) in damages.

Similarly, four nurses at the neurosurgery department of the Free University Hospital in Amsterdam, who admitted to having secretly killed several unconscious patients, received support from the hospital's Employees Council (*Ondernemings-raad*), which demanded their immediate release and reinstatement. The Council raised the question of the responsibility of the doctors working in the hospital, suggesting that by unduly delaying euthanasia these doctors may have forced the nurses to act. When releasing the nurses from custody, the Amsterdam court held that their actions had been prompted by humane considerations. The victims' parents, who only after the arrests of the nurses learned how their sons and daughters had died, thanked the nurses at an emotionally charged, televised ceremony. Thus crypthanasia is not an 'abuse' of the practice of voluntary euthanasia; it is widely accepted, openly supported, and praised as a charitable deed.

The country's highest authorities show leniency toward doctors who practice crypthanasia: Prof. Ch.J. Enschede, adviser to the Dutch government on the juridical aspects of euthanasia, informed me that 'the government and the Council of State decided to keep just these cases out of the reach of the criminal code.' Institutions that proclaim the voluntariness of euthanasia in their official platforms make use of every opportunity to promote involuntary euthanasia as well. A member of the Board of the Dutch Society for Voluntary Euthanasia pleaded for involuntary active euthanasia for the demented elderly, unconscious victims of road accidents, and (conscious) Thalidomide-impaired children, while the president of the same society publicly defended the perpetrator of the *De Terp* killings. The society's quarterly publication printed without comment the exhortation to kill all handicapped newborn children to breed a strong race. The Board of the KNMG has ordered a special committee to work out guidelines for involuntary euthanasia of such newborns. Thus in Holland, 'voluntary' and involuntary euthanasia are advocated by the same people and the same institutions, supported by the same public, practiced alongside each other and closely linked in the public mind. Both are manifestations of the same basic attitude, that is, the now widely shared conviction that people's lives may be cut short whenever there are good reasons for doing so. Those who contend that it is possible to accept and practice 'voluntary' euthanasia and not allow involuntary totally disregard the Dutch reality.

Social Implications

'Voluntary' euthanasia should also be rejected *because of the ominous change it brings about in the society*. Instead of the message a humane society sends to its members – 'Everybody has the right to be around, we want to keep you with us, every one of you' – the society that embraces euthanasia, even the 'mildest' and most 'voluntary' forms of it, tells people: 'We wouldn't mind getting rid of you.' This message reaches not only the elderly and the sick, but all the weak and dependent. Attorney General T.M. Schalken found that Dutch society has already undergone this transformation. As a consequence, some groups live in fear and uncertainty. The Dutch Patients' Association stated in 1985 that 'in recent months the fear of euthanasia among people has considerably increased.' A group of severely handicapped adults from Amersfoort stated in their letter to the Parliamentary Committees for Health Care and Justice:

'We feel our lives threatened... We realise that we cost the community a lot... Many people think we are useless...often we notice that we are being talked into desiring death... We will find it extremely dangerous and frightening if the new medical legislation includes euthanasia.'

In their fears, people do not distinguish 'voluntary' from involuntary euthanasia.

A study conducted among hospital patients showed that many fear their own families because these are people who could decide upon euthanasia or pressure them to request death. Out of fear of euthanasia some elderly people refuse to be placed in old-age or nursing homes, refuse to be hospitalised or to see doctors or take medicines. A study of the attitudes of the elderly showed that 47 percent of those living in their own homes and 93 percent of those living in homes for senior citizens reject any active euthanasia 'because later on, when they won't be in command of the situation any more, their lives, against their will, will be put to an end by others.' Pathetic attempts are made to escape imposed medical death. The 'Sanctuary Association' (*Schuilplaats*) printed 'declarations of the will to live.' This card 'which anyone can carry on his person, states that the signer does not wish euthanasia performed on him.' Thus, for the protection of their lives people no more rely on the rule of the law. The impunity of crypthanasia, established as the practice of the courts and the policy of the government and the Council of State, indicates that articles of the Statutes for Batavian People and of the Dutch Constitution protecting life and person have been *de facto* suspended.

More change must be expected if the pro-euthanasia movement, having attained the legalisation of 'voluntary' euthanasia, is to achieve the rest of its proclaimed goals. Proposals calling for euthanasia of handicapped newborns mean that doctors acting, as they do everywhere, under state supervision, will issue some newborn citizens permits to live and destroy others. To exist, a human being will have to be approved by the government – a reversal of the democratic principle that governments, to exist, have to be approved by people. Such parts of the program as compulsory euthanasia for the demented elderly and limiting the lifespan of people by denying medical help to those above a certain age, as, in general, any measures to eliminate from society large numbers of citizens, voters, life-long taxpayers, living people, are incompatible with our present system of government. This does not mean that these programs will not be put into effect, but is does mean that the implementation of euthanasia programs will involve an essential change in the system of government now prevailing in Western nations.

False Promise

'Voluntary' euthanasia should further be rejected *because its promise is false*. Euthanasia is supposed to spare the sick person the agony that precedes death or the sufferings of a prolonged illness. But this is not the case. When Wibo van den Linden filmed one patient's preparations for 'voluntary' euthanasia, about a million Dutch television viewers watched the unfortunate lady's

anguish and despair as the fixed day of execution approached. Millions die a human death, in uncertainty, fear, and hope, as cherished members of their family, of the human community, surrounded by those who won't let them go. But euthanasia causes extreme psychological suffering – the excommunication, the exclusion of a person from the community of the living while he is still alive.

Hilhorst's interviews with doctors who practice euthanasia reveal that they have recourse to crypthanasia when they have neither the courage nor the cruelty to talk openly to the patient and offer him death. Because of the cruelty of the procedure, the most prominent champions of euthanasia – Foster-Kennedy in America, Lenz in Germany, and van den Berg in Holland – did not even consider 'voluntary' euthanasia and advocated only the covert, involuntary variety.

Fallibility and Irreversibility

Voluntary euthanasia must also be rejected because of the *fundamental discrepancy between the uncertainty of human (and medical) judgments*, which are fallible, *and the deadly certainty of the act*.

Clinicians have traditionally rejected euthanasia because they realised that we all make mistakes, that diagnoses are uncertain and prognoses notoriously unreliable. Erroneous diagnosis of fatal disease remains a very real possibility.

In their efforts to improve a patient's condition or save his life, doctors often have to rely on a diagnosis that is only probable. This course of action is unavoidable and justifiable intellectually. Yet, to perform euthanasia on the grounds of a diagnosis that might prove incorrect is as evil as it is mindless. We don't know how often this happens in The Netherlands because those who advocate euthanasia and the doctors who practice it never agreed to F.L. Meijler's demand that reasons for euthanasia be verified in every case by a post-mortem examination.

Moreover, plain mistakes occur in medicine as they do in every other human activity. A doctor's mistake is always deplorable but forgivable if he made it while doing his best to improve the patient's health. The damage can sometimes be repaired. The mistake of a doctor practising euthanasia (and they do make mistakes, and even more than other doctors) is unforgivable and also irreparable: the patient is dead. It was not only a crime but an unforgivable professional mistake when an internist at a Rotterdam hospital decided to perform active involuntary euthanasia because the patient was semi-conscious, overlooking the fact that this condition was caused by the tranquilizer he himself had prescribed. At the intensive respiratory care unit of the University Hospital in Leiden, a female patient in fair condition after chest surgery died of respiratory arrest because the nurse told the physician on duty that there was an agreement not to reanimate. Later it turned out that the 'agreement' did not apply to this patient but to another lady.

'The patient's own request' is not necessarily the firm grounds for 'voluntary' euthanasia it is purported to be. Anybody may in a moment of distress express wishes that he disavows the next day. The only patient ever to ask me for euthanasia recovered from his nearly lethal illness (severe heart failure due to multiple pulmonary embolism) and during six years' follow-up never again mentioned the request he had made in a moment of despair. It is also generally known that, in reality, a request to die very often signifies something else, and can be a cry for help, for understanding, an attempt to dramatise the situation. Even when someone requests death emphatically and repeatedly, in writing or in the presence of witnesses, this does not preclude in the least that he is actually asking for help and attention.

Euthanasia is Never 'Necessary'

'Voluntary' euthanasia is to be rejected *because it is totally unnecessary*. In my many years of work as a hospital doctor, I attended thousands of patients and, much to my regret, many hundreds of them died. They needed support, relief from pain, breathlessness, or nausea. Until their last conscious moments they needed to belong, to share with all of us our common destiny, fears, uncertainties, and hopes. None of them needed euthanasia, and with a single exception in thirty-six years, none asked for it.

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It is a most demanding task of the doctor to assist his patient to the very end, one that is very different from what vocal supporters of euthanasia expect and demand. Suffering should be alleviated as effectively as possible. The drugs used to relieve pain, or the anticonvulsants used on patients who have suffered cardiac arrest, may shorten a person's life by suppressing respiration, but this is a risk we take; it should never be our intention. No treatment should be inflicted upon a patient that by itself is more harmful than the disease. When in doubt, I follow Dr Loeb's First Rule of Therapeutics: Don't allow to be done to the patient what you wouldn't allow to be done to yourself. I stop treatment when everything has failed. I also stop or withhold treatment when the patient so requests, but this point requires some elaboration. First, there are situations when the patient's refusal of treatment is ill-informed and there is no way of explaining this to him. The two examples I know from personal experience are: a patient who lost consciousness due to massive bleeding from a duodenal ulcer, having first refused to be operated on; and a relapse of ventricular fibrillation in a still-conscious patient who had already been defibrillated and refused to undergo the electric shock again. In such situations I act against the will of the patient and assume the responsibility; I would rather be sued by a living person than take a patient at his word and allow his unnecessary death.

The situation is different when there is no emergency and the patient's refusal of further treatment seems a well-considered decision. Even then, however, we should not just accept the refusal, but try to encourage and persuade him. If nothing else is accomplished, we have still made the patient feel that his doctor has not abandoned him.

Turning off the respirator is an act often discussed. However, many patients on respirators recover and are disconnected from the machine. Others die, of pneumonia, cardiac arrhythmias, or kidney failure; often their death is due to our failure to regulate the body's functions, the acid-base balance, the liquids, and the electrolytes, in a way equal to that of natural regulatory mechanisms. The very, very few patients who require indefinite respirator support should receive it. The urge 'to decide,' 'to do something' is misplaced. A society that can afford 20,000 respirators can also afford using respirators in 100 hopeless cases. What a society cannot afford is a legal and moral warrant to kill.

Fallacious Reasoning

'Voluntary' euthanasia should also be rejected *because of the flaws in its philosophy*. Euthanasia advocates base their positions on the following line of reasoning: Seriously ill people who in the end will die neither wish to nor are able to endure their meaningless suffering. This has become an important social problem in connection with an aging population and the proliferation of old-age homes and homes for the chronically ill whose residents, cut off from their families and isolated from the rest of society, lose faith in the meaning of their lives. Moreover, as a result of medical and technical progress the lives – and sufferings – of the seriously ill are extended and become unbearable. Like every important social problem, this one must be solved by society. The taboo on cutting short a person's life is at odds with a truly human attitude. A doctor who cuts short the life of a person experiencing terrible suffering acts out of higher necessity: he cannot act otherwise. People who want to die have a right to euthanasia. The individual's absolute right to self-determination must be acknowledged as fundamental.

However, rigorously applying the principle of voluntariness deprives infants, the mentally ill, paralytics who can neither speak nor write, and the comatose of the chance for a painless death. When a patient is inarticulate, but it can be assumed that if he were able to express his wish he would choose to die, euthanasia should be granted. In the case of the demented who 'are beyond making their own decisions...someone else (should be given) the mandate to take over' and decide on euthanasia. As for the comatose, they are kept alive at great effort and expense to the despair of their families. Currently, no one dares to make a decision and cut short the lives of such people. But to keep a comatose person alive is also a decision that needs justification.

Anyone who intends to change the status quo must prove he is right; when the proposed change entails irreversible consequences, the arguments must be convincing beyond doubt and the proofs irrefutable. The philosophy of euthanasia does not meet these requirements.

Of course, the essential flaw lies in the attempt to justify both 'voluntary' *and* involuntary euthanasia. 'Voluntary' euthanasia is to be justified by the individual's right to self-determination. So absolute and inalienable is this right that we must overcome the obstacles of law and tradition, our habits of thinking and instincts, and kill people who request death. However, involuntary euthanasia also requires justification and then it turns out that the right to self-determination is not so absolute after all: some people – the newborn, the demented, the comatose – do not have this right, and will undergo euthanasia though some of them (the demented) obviously wish to live and the others never expressed a wish to die.

The primary assumption that the human tragedy of confronting death and dying is a solvable problem is obviously erroneous. This problem is unsolvable and the 'solution' offered is a sham (no problem is solved by destroying the thing involved). The assertion that technical progress in medicine has created the need for euthanasia is contrary to fact. This argument was used by proponents of euthanasia in 1875 and 1899 when medicine's ability to prolong lives by technical means was almost nonexistent.

Neither can present-day euthanasia be explained by the suffering of people whose lives are artificially prolonged by machines: in Holland, most acts of euthanasia are performed by general practitioners at patients' homes, on patients treated without any special techniques. The assertion that the growing need for euthanasia is due to the proliferation of homes for the elderly, where the isolation and the meaninglessness of existence prompt people to request death is false. The homes for the elderly are not natural disasters to which, with all their consequences, we must resign ourselves. These institutions are the result of our own conscious action. They were created as places where the elderly can *live*. Had our efforts produced only opposite results, led only to people asking for death, then the logical conclusion would be to close the residences, not kill the inhabitants.

When used to justify involuntary euthanasia, the concept of killing a person in his own best interest is obviously illicit. People who feel quite happy in their lives are put to death 'in their own interest' by doctors who know better. What a person feels, desires, and values are by definition that person's subjective attitudes; no one but he can pass judgment on them and certainly no one can know these better than he. Doctors who practice crypthanasia, or deny some patients life-saving help, assume a right to judge and decide on behalf of another person that it is 'in his own interest' to die, but this is a right that cannot exist either morally or logically.

Moreover, the practice of euthanasia is often in an obvious way directed against the involved person's interest. Doctors who refuse to treat acute pulmonary edema or insert pacemakers because of the patient's age, or to administer renal dialysis because the patient was unmarried, condemned these people to a particularly painful death: rattling in mortal fear and suffocating from pulmonary edema, hitting the floor with their heads in Adams-Stokes seizures, or vomiting, bleeding, and gasping for breath in progressive kidney failure. These doctors cannot assert that dying in such a horrible manner is in the best interest of a person, even if that person is elderly, handicapped or alone in the world.

Those who use the concept of killing a person in his own best interest to justify 'voluntary' euthanasia disregard the fact that euthanasia destroys the very values in the name of which it is carried out: a dead man is deprived of all interests (and freedoms) once and for all.

The concept of 'quality of life,' frequently used in the philosophy of euthanasia, implies an objective, impartial assessment, but its very point of departure is biased. The use of this concept assumes in advance that life as such, life independent of its 'quality,' has no intrinsic value. Then, the concept of 'quality of life' is in turn used

to justify the assertion that some lives are not worth living, which is an inadmissible error of logic (*circulus vitiosus*). Such terms as 'unbearable' or 'senseless' suffering are value judgments that are inappropriate in logical argumentation. More important, reasoning that resorts to 'unbearable' and 'senseless suffering' is used to undermine the endurance, courage, and will to live of the severely handicapped or chronically ill. Such arguments are also used *instead* of adequate (and, indeed, attainable) alleviation of the sufferings of the gravely ill, thereby producing the very afflictions they decry.

'Higher Necessity'

The concept of euthanasia performed out of higher necessity was devised by the supporters of euthanasia among the judiciary and is now routinely used to justify medical killing. This is, however, an error of judgment. Higher necessity is not an independent and separate concept but depends on the actions considered admissible in a certain situation; actually it is an offshoot of those actions. Someone who has robbed a bank will find it fruitless to appeal to higher necessity (his family's poverty, impending bankruptcy of his business), fruitless because his act is considered inadmissible under any circumstances whatsoever. A doctor who kills a patient can appeal to higher necessity because his action is considered *a priori* as possibly admissible. It is the *a priori* acceptance of euthanasia that creates the 'higher necessity.'

The assertion that keeping a person alive is a decision that must be justified is based on the same logical fallacy. Only those who assume *a priori* that a choice exists, that one can kill or not kill, can define leaving a person alive as a decision. Assertions that every person has the right to decide about his own life and death ('the right of self-determination'), or that nobody has this absolute right, are value judgments that cannot be proved or disproved by logical argumentation.

Traditional social practice, as well as legislation, considered human life had value worthy of the highest protection (at least in peacetime); all other values, including freedom, must be subordinate to the defense of life. It is important to notice that laws protecting a person's life, even against that person's will (for example, forcible hospitalisation of the mentally ill who are in danger of committing suicide), are consistent with the deep belief we all share and which is a natural reaction: everyone rushes to help at the sight of a clothed person preparing to jump from a bridge into a river. Thus it cannot be argued that the right to self-determination is based on a general consensus among people. When confronted with attempted suicide, the great majority of people act in accordance with the belief that the community of people has the right and duty to intervene to save human life. Thus the individual's right to self-determination is not a self-evident one. It is a controversial concept proclaimed by many but rejected by all when ultimately tested.

This concept is, moreover, improperly used in the philosophy of euthanasia. The advocates of euthanasia assert that the right to self-determination is the basis and justification of voluntary euthanasia. Those who recognise the right to self-determination supposedly recognise *eo ipso* the right to voluntary euthanasia. The latter assertion is, however, untrue. People who recognise the right to self-determination recognise the right of each individual to decide what will happen to his own body, his own life. But 'voluntary' euthanasia includes more than that. Other people take part in the performance of euthanasia: a doctor, often nurses, and, as a rule, those who express their consent – the patient's relatives, guardians, members of the clergy, and sometimes the judiciary. The right to voluntary euthanasia (were we to recognise such a right) would thus include not only the right to exert control over one's own person but over other persons as well, over their acts and their consciences. The person requesting his own death would also have the right to make killers of other people and accomplices to killing of those who expressed their consent. He would have the right to compel society to renounce the principle of the inviolability of human life, that is, to destroy the barriers protecting the life of each person.

The right to voluntary euthanasia (were we to recognise such a right) would thus include not only the right to exert control over one's own person but over other persons as well, over their acts and their consciences. The person requesting his own death would also have the right to make killers of other people and accomplices to killing of those who expressed their consent.

The philosophy of euthanasia, to which many brilliant writers have contributed, is ultimately a miscarried piece of work. It makes incorrect assumptions and uses obviously flawed or at best controversial concepts. Its aim is nonsensical: to convince humans that they have better options than life. As for its reasoning, the very idea of using logical argumentation to justify euthanasia, or, for that matter, any basic human choice, is erroneous. The view that one may kill a person, or that one may not, are value judgments whose validity cannot be demonstrated by logical argument. They are rooted in our value system, which exists beyond logic, and are based on our traditions and, in the end, on our instincts. Nevertheless, the pro-euthanasia movement has taken on an impossible task and attempts to demonstrate logically that its choice is the right one. This inevitably results in arguments based on logical error, the vicious circle.

The Danger to Medicine

'Voluntary' euthanasia should also be feared and rejected *because of the irreparable damage it causes to medicine*. It has become obvious that the practice of euthanasia interferes with doctors' performance as observers of nature and as helpers. The high occurrence of factual errors and oversights committed by doctors in the rush to euthanasia seems to be due to the excitement accompanying the socially and officially approved legalised killing. It has also been pointed out that it is the strong motivation of curative medicine that enables a doctor to grasp and memorise a great number of facts relevant to the case, while euthanasia dispenses the doctor from this necessity.

Desisting from potentially effective therapy because of the idea of euthanasia is a well-known phenomenon that is increasingly disabling the profession. Euthanasia does not just change medicine or extend its range; euthanasia *replaces* medicine.

Trends in medical thought and research also reflect this ominous change. The Dutch medical profession that gave the world Boer-

have's clinical teachings, Jacobus Bontius's discovery of the dietary causes of beri-beri, Donders's physiology of the eye and scientific correction of errors of refraction, Einthoven's electrocardiography, and Wenckebach's analysis and treatment of cardiac arrhythmias, now exerts itself in finding more and more reasons, opportunities, and ways to put sick people, and sick children, to death, or to let them die.

Euthanasia brings about the decline of medicine also by undermining the doctor-patient relationship. The old confidence of the public in the medical profession, the old certainty that a doctor would do everything in his power to help the patient, that he would abandon nothing that could be of help, that he would never consciously do anything injurious – this certainty has vanished. Patients realise, too, that some of those doctors prepared to put patients to death at their own request will also be capable of doing it without a patient's knowledge. In the era of euthanasia, patients' attitudes toward doctors are increasingly marked by distrust, suspicion, and fear.

Doctors are plain people doing quite unique work. They may be irritable, exhausted after sleepless nights, frustrated by the failure of their efforts, or troubled due to difficulties at home. They may be, and some of them definitely are, emotionally unstable persons. Their actions, or, for that matter, the rate at which a potassium drip is administered, are often difficult to check or trace. And yet patients used to be safe in our hands; certainly safe from any intentionally inflicted harm. This derived from the particular and one-sided education and shaping of physicians. It has been imbued in us to identify ourselves, our ambitions, with the success of treatment, with improvement of the patient's health, with keeping him alive. For us, the clinical adage *primum non nocere* preserved its literal and absolute meaning.

At present, however, a generation of doctors is being raised who learn that a doctor may treat a patient or, sometimes, kill him. The thought of what's happening to the most humane profession is terrifying. Every society has learned to coexist with several dozen criminal killers. But no society knows how to live with an army of benevolent or casual killers, thousands strong.

Charitable Euthanasia?

Euthanasia is depicted as an act of charity governed by truth and wisdom. Alas, the reality of euthanasia does not confirm these claims; rather, the reverse proves true. Doctors whose actions I observed, repeatedly tried to justify euthanasia by making reference to false data – citing a nonexistent lung cancer, or a presumed, but never made, family request; or presenting a patient with a large and loving family as 'a person completely alone in the world.' A neurologist recommended euthanasia after a none-too-careful examination of the patient for he mistook a woman for a man. An internist ordered active euthanasia because the patient was semi-conscious but this condition was caused by valium the same doctor had prescribed. The same physician did not, as a rule, deem it necessary personally to examine candidates for involuntary euthanasia and relied instead on the opinion of the head nurse. Another internist intentionally allowed a sixteen-year-old physically active boy, and talented student, to die of cardiac arrhythmia because he had a congenital heart disease for which at that time surgery was not feasible.

A wife who no longer wished to care for her sick husband offered him a choice between euthanasia and admission to a home for the chronically ill; the man, afraid of being in unfamiliar surroundings and in the hands of strangers, chose to be killed.

When at a departmental conference in a Rotterdam hospital an internist was asked why he attempted (involuntary active) euthanasia without knowing the diagnosis, on a patient who was not seriously ill, he explained that it is the calling of the doctor to perform euthanasia when the opportunity presents itself, regardless of the diagnosis, to spare people the illnesses and sufferings inherent to life. Life-saving medical help has been denied to Down syndrome children, the elderly, and single people without close family, on the grounds that society should not be burdened with keeping such people alive, and that it is in their own best interest to die as soon as possible. So much for my own observations; some of the cases published in the Dutch medical and popular press are equally distressing. A wife who no longer wished to care for her sick husband offered him a choice between euthanasia and admission to a home for the chronically ill; the man, afraid of being in unfamiliar surroundings and in the hands of strangers, chose to be killed. An elderly man coerced his healthy seventy-three-year-old wife to submit to euthanasia promising to make recourse to it himself in three days, only to go off to Austria. In both cases the doctors were aware of the coercion; nevertheless, they put these people to death. A general practitioner called to a patient's home, and seeing her for the first time, immediately asked her to choose between hospitalisation and euthanasia. When the stunned patient could not reply, he gave her one hour to think it over. A chest physician told an interviewer about a chronically ill patient 'who was quite young and clung to life,' and how he treated the man for several years but finally killed him out of impatience, in an outburst of anger. According to testimony given in court during the *De Terp* trial, the male head nurse used to silence frightened inmates with the words, 'When I and the doctor decide on euthanasia, euthanasia it will be, and you better shut up. I don't want to hear a single word from you, or else...' In the hospital where Father P. Verspieren is chaplain, it is the doctors' habit to order (involuntary) euthanasia by warning the nurse, 'When I come back from the weekend I don't want to find this man here any more.'

It is the attitude toward the evil and the absurdity of euthanasia that most clearly characterises the two sides in the debate. To some, so unique is human life that even the possibility of error is sufficient reason to reject euthanasia once and for all. To others, so overwhelmingly important is euthanasia that it must go on regardless of all the nonsense, falsehood, reckless acts, and evil doings involved.

Editor's Note

As Dr Fenigsen's extensive references are largely in Dutch, with Dr Fenigsen's consent , we elected not to publish them with the article. A copy of the original manuscript with citations is available from the Hastings Report.upon request. Dr Fenigsen has discussed the Dutch experience in greater detail in his book, *Charitable Euthanasia*? (in Dutch) (Deventer: Van Loghum Slaterus, 1987).

REVIEWS

The Rites of Life

Caroline Berry

Hodder & Stoughton, London, 1987, 207 pp., paperback; £7.95 ISBN 0 340 39518 4

This book sets out to examine the facts surrounding the questions of abortion, euthanasia, caring for handicapped infants and other related issues. The book would seem to be aimed mainly at non-medically qualified readers, with fairly good explanations of basic methods of genetics, *etc.*, provided for the layman. The scope of the book is wide, with chapters covering ethical problems 'from the cradle to the grave', though the main emphasis and bulk of the book (four chapters out of seven) is concerned with problems and dilemmas surrounding human life from conception to early infancy.

Chapter 1 is an introduction to 'Man's Place in the Natural World', which discusses human origins and the origin of life. The author simply accepts evolution as a 'truth revealed by scientific study' without offering any supporting evidence for this *revealed truth.* Dr Berry, in this chapter, acknowledges that man's creation in the image of God is a spiritual image not dependent on specific skills or attributes, but the implications of this are ignored later in the book when a Christian view of the unborn fetus is discussed.

Chapter 2 deals with contraception in its various forms and also the problems of giving contraceptives to children under the age of consent. The author's view seems to be that contraception is better than unwanted pregnancies, even though easily available contraception probably increases the amount of teenage sexual activity in society. In the third chapter the issues of parenthood, infertility and measures to overcome infertility are discussed. All the methods of infertility treatment from ovary stimulation to surrogate motherhood would seem to be approved by the author.

Chapter 4 discusses abortion, when does a human life begin, and related issues. The author accepts that an absolutist view of the fetus as being a human being, from the moment of conception, is the only intellectually consistent view for a Christian. (The other intellectually consistent view being that the fetus is simply part of the woman's body until birth and she has the absolute right to dispose of it.) Having said this, the author then goes on to condone therapeutic abortions for many reasons other than danger to the life of the mother.

The issues surrounding 'test-tube babies' and experimentation on human embryos are discussed in Chapter 5. The general tone, seems, to this reviewer, to be that scientific research in this area should be allowed because of the potential benefits, at great cost, for a few couples. This view would seem to be at odds with the points made by the author concerning health care resources in Chapter 7 under the heading 'The Cost of Life'.

Chapter 6 looks at euthanasia and care of handicapped infants, adults in terminal illness or a vegetative state and the senile elderly. This chapter and chapter 7 on 'The Cost of a Life', looking at the allocation of limited resources on a national and world-wide basis, is the best part of the book. These final two chapters are much more in line with biblical principles than the preceding five. The book ends with an epilogue and useful bibliography and index.

Overall, this book, in the opinion of this reviewer, fails in its stated aim of highlighting biblical principles relevant to the issues discussed. Perhaps the author's close involvement in medical genetics has made it harder for her to look objectively at the topics discussed in the main part of the book, and this is unfortunate as the somewhat woolly and often quite secular thinking in the first five chapters overshadows the good points in the final two chapters.

On balance, this is not a book to recommend to non-medically qualified Christians looking for help in these difficult ethical areas.

Garry Sime
Glasgow

The Twentieth Century Plague

Caroline Collier

Lion, 1987, 95 pp., paperback; £1.95

This is not a useful book. Most of its faults are perhaps due to lack of space. But, even so, what space there is is not always wisely used. Most of the first two chapters, for example, are taken up with an explanation of the reasons for her personal involvement in the subject, and a sketchy history of previous plagues. Although the definition of AIDS itself is clearly given, not all medical terms are explained, which may confuse the lay reader. Books are quoted minus authors, publications and lectures without accurate references. Her tables and diagrams are not all equally valuable. Despite these shortcomings this book might still have been profitable for those with limited time, were it not for some of the views Dr Collier expresses, which seem strangely naive. On page 30 the present NHS system is referred to as a 'solid foundation' for the basis of medical care of AIDS patients. Some doctors might disagree. On page 33, referring to the possibility of segregating those infected to protect the general population, she writes 'the powerful motivation of protecting the nation will, in part, lessen the pain' of separation, as in a wartime situation. These and similar comments made it hard for this reviewer to take the book very seriously. Moreover, even statements that one would not disagree with are poorly expressed. She writes on chastity: 'Saving sex until you are married is not very different from saving money in a bank'. How appropriate or helpful is this in our present society? Dr Collier has a great deal of information about the subject, but in this short book it is not persuasively or convincingly expressed.

Janice Brown
Glasgow

The Truth About AIDS

Dr Patrick Dixon

Kingsway Publications, 1987, 250 pp., £4.95

Eleven chapters, 12 appendices, footnotes and references on almost every page – a first glance suggests that this is a responsible treatment o f the subject. Dr Dixon writes fluently and often urgently. His dominant theme is that we need to know the truth about the situation.

He begins with the American situation. 'The numbers already doomed in the USA make Vietnam look like a children's playground', he writes. He stresses the immensity of the AIDS plague, suggesting that by the year 2000 there will be seven million affected in Britain.

He holds that AIDS is just the latest in a series of epidemics spread by sex. The figure of half a million new cases of such illnesses per year in the UK is given. Thus he takes time to consider syphilios, gonorrhoea, genital herpes, and related problems. AIDS is only different in that others are infected during years when the disease is not diagnosed and, crucially, because there is no cure. His imagery is often compelling: 'If a man slept with his secretary and three weeks later was dead, and that was repeated across the UK, you would not need any health campaign, because the coffins would be the campaign'.

Dr Dixon uses the San Francisco situation to outline a horrifying scenario for a future Britain and explores the reasons why the facts are hushed up on both sides of the Atlantic and in Africa. He predicts that AIDS will dominate the rest of our adult lives.

Chapter Two explains, with a refreshing lack of jargon, the nature of the virus, why there is no cure and why one is unlikely. Further chapters detail how the disease progresses, and how different groups of people acquire it. He is concerned to make the reader examine any preconceived ideas on sexual behaviour, which may lead to complacency about how far this disease will affect the population as a whole.

REVIEWS

His fifth chapter might be subtitled 'all the questions you ever wanted to ask about AIDS, including those you felt were too ridiculous to mention', from the dangers of using a communal bucket for sports injuries, via blood transfusions, to toilet seats and shared toothbrushes.
Like Dr Collier, he raises the issue of separation. 'This is a recipe for concentration camps. Also it will not work', is his conclusion.
He goes on to discuss many moral dilemmas, including euthanasia, withholding treatment, suicide, testing without consent (which he believes will become routime before operations) and the problem of whether or not to disclose the truth to relatives.
His chapter entitled 'Wrath or Reaping' merits slow, careful reading. Reasoning from Jesus treatment of the woman taken in adultery, he argues passionately against a judgmental approach. We have all sinned, in thought if not deed. This is a long chapter, and not an easy one.

In summary, this book does not hesitate to discuss difficult and distasteful issues. It is often compelling and redical. Despite its flaws it ought to be read. If his scenario of a future Britian is right, we ought to be ready. If he is wrong, he will be the first to rejoice.

Janice Brown
Glasgow

AIDS and the Positive Alternatives

Dr Margaret White
Marshall Pickering, 1987, 118pp, paperback

Stylistically, this book could not be more different. Frequently anecdotal ('I once had a patient who . . .') it is generally interesting and informative. The title indicates her concern that AIDS be seen in the context of general morality and especially in relation to the family unit. Thus, sexually transmitted diseases do not figure largely for three chapters. AIDS itself is not discussed in detail before chapter 5. She majors on the revolution in sexual mores since the introduction of modern contraception, the breakdown of marriage, the problems of child abuse. Medical terms are helpfully explained, and illustrations given from her own wide experience. Her facts on AIDS are clear and accessible. This book will help pastors and counsellors, provided they can bear with the anecdotal style. Someone wanting a book purely on AIDS might be distracted by the many related concerns she touches on. The final chapter, for example, contains advice on how to live a good life, how to inculcate moral values in our children, and how to preserve our marriages, all advice to be found in other volumes unrelated to the topic of AIDS.

Janice Brown
Glasgow

Proceedings of the Splintered Image Pro-life Conference

Human Life Council, Scotland, 1988,
163pp.,paperback; ISBN 09513123 0 8

For the well-motivated reader this book provides a sometimes in-depth, sometimes superficial treatment of many issues relevant to a pro-life position. embryo experimentation, abortion, infertility treatment, contraception, sexual ethics, population control and euthanasia are among the topics covered.
As a record of the proceedings of a conference it is no doubt accurate, but this layout does tend to be confusing for the reader. Each chapter is an independent address and no attempt has been made to them, or even group related topics together.
I found the very heavy Roman Catholic emphasis somewhat oppressive and often longed that the Word of God rather than the word of the Pope might be presented as the basis for our actions. Bi*oethics, Christian Code and Medical Practice,* by John Kelly, and *Artificial Assistance in the Achievement of Pregnancy,* by Ken Platt, are both informative and horrific. Once again, however, I felt that Roman Catholic teaching regarding contraception and *intention* in coitus was clouding the real issues.
Contraceptives for under-16-year-olds is dealt with clearly and well by Victoria Gillick.
Understanding Population Control, by Robert Sassone, is thought provoking and informative.
Population Control in China, by Stephen Mosher, makes fascinating but deeply alarming reading, particularly in the light of recent events in that part of the world.

> In 1983, the Chinese Communist Party had passed a directive saying that all women who had one child must have ICUD's inserted, and that all women who had two children must be sterilised, and all women who were pregnant with over-quota children (that is illegal children whom they do not have permission to bear) are subjected to remedial measures – which means, of course, an abortion.
> This directive was still in force. . . . In 1987.

God's Invitation to Become Ourselves, by Jim Gallacher, is refreshingly spiritual and challenging but, for me, the highlight of the book was 'Euthanasia; an Unnecessary Evil', by Monica Pearce. the main subject of this chapter is Hospice Care, which Miss Pearce believes removes the desire for euthanasia (which she quite reasonably defines as 'Doctors killing patients'!

> What is NOT euthanasia, nor passive euthanasia (for that expression is not in my vocabulary) is knowing when the time has come to stop treatment. When the process of dying has virtually set in, when the treatment is only prolonging the process of dying, prolonging the pain and the agony, that is the time to stop. When treatment is no longer curative there comes a time – as Dame Cicely Saunders (that great pioneer of hospice care) said: 'when you take down the tubes and give the patient a cup of tea'.

I did not find this book easy to read, I did, however, feel that my perseverance had been rewarded as I discovered totally new and relevant information and insights into many issues which must go hand in hand with the knowledge that we are all created in God's Image and for his pleasure.

Dorothy J. Urquhart