

Ethics & Medicine

A Christian Perspective on Issues in Bioethics

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DEATH WITHOUT DIGNITY EUTHANASIA IN PERSPECTIVE

Edited by Nigel M. de S. Cameron
with a foreword by Bp Maurice Wood

Contributors include:
Dame Cicely Saunders,
Luke Gormally,
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COMMENT

From Mrs Rita L. Marker

Euthanasia, the Ultimate Abandonment

A perspective from the United States

In this issue we are pleased to publish the address given recently by Mrs Rita Marker of the Anti-euthanasia Task Force (USA) at a press conference in the House of Commons in London. It offers a most informative update on the development of euthanasia discussion in the United States. We must be grateful that the situation elsewhere is different. In Germany, as a recent correspondent told the Editor, the memory of euthanasia under the Nazis is still too fresh for there to be such a development. Even in Holland there are moves to develop a hospice programme, to offer a radically alternative approach to terminal care. Yet in Britain the idea of the living will is beginning to catch on, and we do well to take note of how it is being used in the United States as a gateway to euthanasia.

Although debates about euthanasia abound, there is confusion about the meaning of the word 'euthanasia' itself. It is, therefore, crucial to clarify the term. Although the word 'euthanasia' has been used to denote 'good death,' this is not the contemporary meaning. Today, 'euthanasia' means deliberately taking the life of another person. Some may ask, 'Why can't the broader meaning, that of "good death," be used?' The answer is simple. The importance of words and their ability to influence attitudes and practices can not be overestimated. We must be fully aware of the meaning ascribed to words. To be otherwise is to court misunderstanding. And such misunderstanding has deadly consequences. For the purpose of this discussion 'euthanasia' means an action or an omission which is directly intended to cause death, so that suffering may be eliminated.

I draw your attention to the fact that discussions about the suffering to be eliminated relate not only to the physical or emotional suffering of the person whose death would occur but, also, to the emotional or financial suffering that family or friends may experience in caring for a sick or dependent person. Put in its most blatant terms, euthanasia means killing a person who is sick or dependent. Euthanasia has nothing to do with what is commonly called a 'right to die.' It has everything to do with a right to kill.

When a person is terminally ill, there comes a time when it must be recognised that a cure is not possible. At such a time, curative medical treatment – those interventions intended to eliminate the illness – are stopped. This is both good medical practice and a realistic recognition of the inevitability of death. Until recently, the common practice has been to cease attempts to cure but to continue to care for the patient in such cases.

However, an ominous change is now underway – a change that, if allowed to proceed, will affect the lives of those who are the most vulnerable. Rarely are discussions limited to ending curative treatment of those who are clearly dying. Now there is strong pressure to stop even the most humane and necessary care for non-dying but severely disabled individuals. And, along with this comes a companion pressure. It is being claimed that, when one's life is not of

'sufficient quality,' it is both humane and compassionate to end that life by the quickest means possible.

To bolster this claim, proponents of euthanasia point to mercy killing cases, making such killings appear benevolent and necessary. Proposals are then advanced to lessen or remove all penalties for assisted suicide and mercy killing¹ and laws are proposed to allow health professionals – doctors and nurses – to carry out euthanasia without fear of prosecution.²

To better understand the current state of affairs, it is helpful to briefly review the origins of the euthanasia movement in Britain and the United States.

Origins of Euthanasia Movement

In Britain, the euthanasia movement originated with the 1935 founding of the Voluntary Euthanasia Society. Three years later, the Euthanasia Society of America – now called the Society for the Right to Die – was founded. Both organizations had, as their goal, the legalization of direct patient killing. An official of the U.S. group clearly acknowledged that the Society hoped 'eventually to legalize the putting to death of non-volunteers'³ since euthanasia was 'needed mainly for defectives' rather than for 'normal persons who have become miserable through incurable illness.'⁴ Neither organization progressed in the next decades, due, in large part, to horror at the word 'euthanasia' so closely linked with German atrocities in the minds of the public.

In the 1950's both organizations still openly advocated direct killing of patients deemed better off dead. In England a euthanasia bill was once again considered, and rejected, by Parliament⁵ while the Euthanasia Society of America took a public position in support of a doctor who had killed a patient, stating that 'the time has come to demand that our laws be brought into line with public opinion.'⁶ Still the euthanasia movement failed to make significant headway.

'Living Will' Clears Way for Open Discussion of Euthanasia

In 1967, however, the Euthanasia Society of America and its educational arm, the Euthanasia Education Council (known today as Concern for Dying), took a step which has had a profound impact on the advancement of euthanasia worldwide. At a Chicago meeting of the Euthanasia Society, a new document was proposed. The document was called the 'Living Will.' Publicity given it was intended 'to promote discussion of euthanasia.'⁷ Imperative to the success of the proposal was the introduction of laws, making the Living Will a legal document, which, once passed and essentially out of the light of public scrutiny, could eventually be amended and broadened.

Indeed, the Living Will's author, Luis Kutner, openly titled a 1969 law journal article, 'Due Process of Euthanasia: The Living Will, a Proposal.' In his article, Kutner presented a very guarded discussion

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of euthanasia but did acknowledge that the Living Will 'is limited in its initial creation to adult patients who are capable of exercising their will.' (Emphasis added.) His concluding remarks noted that 'as of now, a doctor cannot be directed to act affirmatively to terminate a patient's life.' (Emphasis added.)⁸

While the Living Will had not been seriously considered until recently in Britain, the push for its acceptance is now on, spurred in large part by the 1988 Age Concern Report titled 'The Living Will, Consent to treatment at the end of life.' Still, members of the health profession are wary.⁹

Perhaps a recognition of where the Living Will has led in the United States will help Britain assess more carefully whether it wishes to follow America down what appears to be a road to death on demand. At present, 40 states and the District of Columbia in the U.S. have Living Will laws which allow for the removal of 'medical treatment.' 'Medical treatment' is interpreted so broadly that it allows removal of the most basic medication and care, including a diabetic's insulin¹⁰ and the normal food and water consumed by a patient. One physician, testifying under oath in court proceedings, explained that if he 'treats a patient in a convalescent care facility, that, for that patient to even have a normal diet, it has to be prescribed and, therefore, it is always a medical treatment.'¹¹

In some states, Living Will laws have been used to remove the most basic care from patients who have not signed such documents; federal legislation which would force health facilities to promote the Living Will is now pending¹²; and proposals to amend Living Will laws to include 'aid-in-dying' – direct killing of patients by lethal injection or drug overdose – are under consideration in several states.¹³

Food and Water as 'Medical Treatment'

A decision in the first euthanasia case to reach the United States Supreme Court is expected soon. It will determine whether food and water can be removed from a severely brain-damaged young woman. The woman, Nancy Beth Cruzan, is on no life support equipment and, in fact, needs no skilled nursing care. Doctors say she could live for another twenty to thirty years. The court will decide if a guardian can order health care workers to starve and dehydrate to death those who are severely disabled.¹⁴

This progression of events is no surprise to those who have carefully followed the euthanasia movement. Such was clearly outlined at the 1984 meeting of the World Federation of Right to Die Societies when a speaker, Helga Kuhse of Australia, stated:

If we can get people to accept the removal of all treatment and care – especially the removal of food and fluids – they will see what a painful way this is to die, and then, in the patient's best interest, they will accept the lethal injection.¹⁵

Increasing acceptance of starvation and dehydration as a method of dealing with those considered burdensome has led inevitably to open discussion, now being carried out under socially impeccable auspices, of the benefits of providing a lethal dose or lethal injection.

Interestingly enough, The Netherlands led off its practice of euthanasia with the lethal injection but is now using a denial of food and

fluids for the brain damaged as a rationale for openly extending the 'need' for the lethal injection to those who definitely have not requested it.¹⁶

International Organization and Suicide Clinics

An international organization of euthanasia societies was formed in 1980. Now called the World Federation of Right to Die Societies, the Federation was founded at the end of 'An International Conference on Voluntary Euthanasia and Suicide' hosted by England's EXIT.¹⁷ The Federation now includes euthanasia societies from 21 countries with the goal of 'self-determination in dying,' explained as the right of any person of any age to decide when, where, why and how to die. Implicit in discussions at the Federation's conferences, is the right of others to choose death for those unable to do so for themselves.

In 1988, the international group held its biennial convention in San Francisco. Titled, 'A Humane and Dignified Death,' the conference was scheduled to coincide with the political campaign to legalize 'aid-in-dying.' The Federation's 1990 meeting is scheduled to take place in The Netherlands, where euthanasia, both voluntary and non-voluntary, accounts for 15% of the yearly total death rate¹⁸ and where, according to the British Medical Association's report on euthanasia, 'the development of palliative care is not as advanced' as that of Britain.¹⁹ (This point alone would seem to illustrate that if it is easy to kill a patient, it is less likely that efforts will be put into pain control and comfort measures.)

Of particular note should be the fact that, although the Dutch euthanasia's chilling implications for the elderly, the sick and the vulnerable are well documented²⁰, both British and American euthanasia proponents point to Holland as the model of 'death with dignity.' For example, Britain's Voluntary Euthanasia Society claims that if people look to Dutch practices, 'they will see adequate safeguards in operation there',²¹ and Derek Humphry, Executive Director of the Hemlock Society and current president of the World Federation of Right to Die Societies, referring to Dutch euthanasia has stated, 'It's been tested there.... It appears to be working.'²²

In 1980 also, Britain's EXIT prepared to distribute its 'Guide to Self-Deliverance,' a suicide manual. This blatant promotion of death was cut short when internal problems and criminal actions of EXIT officials were uncovered. However, in America, Derek Humphry who retained close ties with EXIT, began consideration of publishing a similar manual which appeared the following year under the title, *Let Me Die Before I Wake*. As with the EXIT draft, Humphry's book and subsequent materials provided by his organization give specific descriptions of dosages calculated to cause death.

Ironically, it is perhaps the story of Derek Humphry's rise to power in the euthanasia movement and recent damaging revelations about him and his organization that is doing much to raise grave doubts about embracing 'aid-in-dying' as a way of death.

Hemlock

The Hemlock Society was founded by Derek Humphry and his second wife, Ann Wickett Humphry, 10 years ago in Los Angeles. Hemlock now has 51 chapters throughout the United States and Humphry, who is its principal spokesperson, also serves as president of the World Federation of Right to Die Societies.

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His rise to power in the euthanasia movement began in a house in the British countryside at just ten minutes after one o'clock on March 29, 1975. It was then that Humphry, a journalist for the London *Sunday Times*, gave his wife, Jean Humphry, a lethal brew of coffee, sleeping pills and painkillers. He has described his role in Jean's death as an act of love because she had cancer and 'it was what she wanted.' There is, of course, no way to verify this with Jean Humphry. She's dead.

He later wrote *Jean's Way: A Love Story*, his romanticized account of her death. The book became a rallying point for those who espouse the belief that compassion comes in the form of a syringe or in a cup of coffee laced with lethal drugs.

Now, however, another story about Mrs Humphry is being reported. This time it is not about the British Mrs Humphry, but the American Mrs Humphry. And this time the writer is not Derek Humphry. Ann Humphry, co-founder of Hemlock and the group's deputy director until recently, is giving her version of the story – much to Derek Humphry's dismay and fury.

Mrs Humphry, diagnosed with breast cancer last September, has charged that Humphry abandoned her twenty days later, soon after she had had cancer surgery and was beginning chemotherapy.

According to Ann Humphry, her husband indicated that he 'was incapable of living with his "misery"' and had notified her of his intentions to end the marriage by leaving a recorded message for her on the telephone answering device at the couple's home.²³ She has stated that, since abandoning her, Humphry has conducted an apparent 'smear campaign' in order to justify his departure²⁴; has attempted to force her to sign a 'gag order' agreeing not to discuss virtually any of her personal or professional life without Hemlock's permission as a condition for continuing to receive sick leave and medical insurance²⁵; has alleged in a memo to a national magazine that she is mentally ill²⁶; and has threatened to accuse her of a crime in relation to her parents' suicide deaths in 1986.²⁷

When the *New York Times* asked him why he had left his wife, Humphry responded that the marriage had been unhappy for a long time but that the final blow was the 'unacceptable way' Ann Humphry handled her cancer.²⁸ He did not elaborate on what he would have considered 'acceptable.'

In a nationally televised interview, Humphry declared that 'her behavior over the cancer was absolutely intolerable to me.' He claims that this should not affect his credibility since he proved his 'staying power' in his relationship with his first wife. Further he contended that he's 'not a coward about death and dying,' since his everyday work consists of discussing death.²⁹

As a matter of fact, Humphry is very proficient in dealing with death and dying. It's living that seems to present the problem for him.

Ann Humphry has stated that she has received no support or encouragement from Hemlock members in her battle with cancer. 'It's an interesting irony that letters of support I've received have all been from people, associated with the right-to-live movement, who seem primarily concerned with the fact that I heal, that I get better and that I have a proper support system,' she explained.³⁰

According to the *AMA News*, Ann Humphry, while still committed to the stated ideals of the movement she co-founded, is now convinced that Hemlock's efforts to legalize 'aid-in-dying' are misguided. She noted that legislation allowing physicians to kill terminally ill patients who request such action, could put 'subtle but unmistakable pressure on someone to die – to simply get out of the way.'

Through her own experience, she explained, she has 'come to understand the arguments' of the anti-euthanasia movement.

Humphry's problems and those of Hemlock extend far beyond the lack of sensitivity in dealing with those experiencing life-threatening illnesses. Currently, both the United States Internal Revenue Service and the California Department of Justice are conducting investigations into Hemlock affairs.³¹ Serious allegations regarding tax violations, deception and missing funds have been made by a Henry Brod, the former southeastern regional director for Hemlock and, until his resignation in early February, the executive director of Hemlock of Oregon.³²

Implications for Medical Profession

While it is highly likely that the Hemlock scandal will damage the organization, it must be remembered that a similar scandal in Britain's EXIT did not stop, but only delayed, advancement of the British euthanasia movement. And some former EXIT officials are still heavily involved in both British and U.S. euthanasia activities.

One such person is Colin Brewer, the British psychiatrist whose instructions to suicidal persons, suggesting that they take a large dose of barbiturates and then put a plastic bag over their head, are sold throughout the U.S. by the Hemlock Society.³³ He told *Health Week* that the amount of competence one has is the key point in deciding whether someone should live or die. 'We regard some people as not worth keeping alive and others worth keeping alive,' he said.³⁴ Brewer clearly espouses the view that health professionals should be forced to perform euthanasia. Speaking at the 1985 Second National Voluntary Euthanasia Conference held in Los Angeles, California, Brewer compared attitudes on the issues of euthanasia, abortion, and contraception. 'There will never be a general consensus on these issues,' he said. But he further explained that there is no need for consensus in the medical community. He explained that, while there are still some doctors in Britain who do not approve of contraception, 'we have appealed to their baser instincts. We've bribed them. First we ask if they will provide contraception and we won't pay them unless they do. It's amazing how quickly they change their minds.'

The same strategy, he said, will work to bring physicians in line regarding euthanasia. 'The first step is for like-minded doctors to band together,' said Brewer. 'This is how we have solved the problem of contraception and abortion. We've got around any opposition by providing a service. We're going to have to found special clinics where doctors can provide the service' of euthanasia or assisted suicide.

Expressing the belief that the choice of euthanasia must be available, Brewer continued, 'A complete hospice service should indeed offer a choice between terminal care and euthanasia or assisted suicide.'³⁵

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In at least one country, the possibility of coercing the medical profession has given way to its actuality. In December, 1989, it was reported that a doctor had been formally reprimanded by the Dutch Medical Association for failing to practise euthanasia on a patient who requested it. The report cited an article in the *Herald-Tribune* stating that the 'guilty' doctor had given ordinary tranquilizers to the patient instead of a lethal dose of drugs.³⁶

The late Professor Paul Ramsey of Princeton University often pointed out: The good we do will only be complemented and completed by the harm we refuse to do. Killing, whether in the name of compassion, expediency, maintaining one's professional status, or the 'best interests of the patient,' is killing. It is the ultimate harm and the ultimate abandonment. It is harm which we must refuse to do.

In 1971, D.W. Vere, M.D., then Reader and now Professor in Therapeutics at London University and Honorary Consultant Physician wrote:

Euthanasia, practised for the individual's 'benefit,' would so deteriorate his society as to cement its harshness into permanence, and so hurt both him and others. It is therefore better, if costlier, to change the attitude of society so that it supports the individual sufferer in his illness and so that care ousts despair and a person's worth expressed becomes a worth experienced.³⁷

His words carry with them a crucial message for the problem facing us today.

Appendix: the Nancy Cruzan Case

Cruzan v. Harmon, No. 88-1503 (U.S. Supreme Court)

BACKGROUND AND FACT SHEET

32-year-old Nancy Beth Cruzan of Missouri is severely disabled as a result of brain damage sustained in a car accident on January 11, 1983. Her parents, who are her co-guardians, are seeking court approval to withdraw her food and fluids. This is the first euthanasia case to reach the U.S. Supreme Court.

Nancy Cruzan's Condition

According to her father, Nancy Cruzan is dead. On a nationally televised program, he stated, 'My daughter died six years ago and the state will not let us have a funeral.'^{*}

According to court records,^{**} Nancy Cruzan

- ...can hear (T-643)
- ...can see (T-754)
- ...smiles at amusing stories (T-599)
- ...cries at times when visitors leave (T-644)
- ...sometimes seems to try to form words (T-653)
- ...experiences pain from menstrual cramps (T-618)
- ...will die in pain if she is starved and dehydrated to death (T-690)

Nancy Cruzan's Care

According to court records,^{**} Nancy Cruzan

- ...was eating mashed potatoes, bananas, eggs and link sausages and drinking a glass of juice with meals following her accident (T-281-285)
- ...now receives food and fluids through a gastrostomy tube that was

- implanted – even though she could chew and swallow (T-283) – to make her long term care easier (T-423)
- ...requires no type of skilled nursing (T-614)
- ...could be cared for in a home setting (T-615)
- ...requires no care except food and fluids, personal hygiene and repositioning to prevent bedsores (T-316)

Court Battle Over Parents' Right to Order Starvation and Dehydration

...May 1987: After months of consultation with the Society for the Right to Die,^{***} Ms Cruzan's parents began court proceedings to force hospital employees to remove their daughter's food and water.

...July 27, 1988: Jasper County Circuit Court Judge Charles E. Teel, Jr issued a judgment directing hospital employees to carry out the request to withdraw Ms Cruzan's food and fluids.

...November 16, 1988: The Missouri Supreme Court reversed Teel's judgment, stating in its opinion, '...This is not a case in which we are asked to let someone die.... This is a case in which we are asked to allow the medical profession to make Nancy die by starvation and dehydration.'

...July 3, 1989: The U.S. Supreme Court announced that it would hear an appeal of the Missouri decision.

...December 6, 1989: Oral arguments heard by U.S. Supreme Court.

Significance of the Case

The outcome of this case will not only affect Nancy Cruzan. It will have a profound impact on society. It will:

1. Decide whether dependent or disabled persons will, as a matter of policy, be cared for – or killed.
2. Determine whether caregivers will be forced to starve and dehydrate a dependent person to death at the request of a family or guardian.

Important Note

If her family's request is granted, Nancy Cruzan will be denied all food and water but *her gastrostomy tube will be left in place** so that medication can be given to lessen the symptoms of death by starvation and dehydration.

*Lester 'Joe' Cruzan on 'CNBC Live,' 3/31/89.

**From transcript: Cruzan v. Harmon and Lamkins, Case No. CV384-9P, in the Circuit Court of Jasper County, Missouri, Probate Division at Carthage, 3/9/88–3/11/88.

***Formerly known as the Euthanasia Society of America.

¹ 'Report of the Select Committee on Murder and Life Imprisonment,' (House of Lords), Vol. 1 (July 24, 1989), pp. 30–31.

² Attempts to legalize 'aid-in-dying' by amendment to existing Living Will laws were made and failed in Hawaii (H.B. 807, 1987) and in California (Initiative campaign for the 'Humane and Dignified Death Act,' 1988). A similar proposal (HB 3005) is pending in Washington State. In Oregon State, Senator Frank Roberts has agreed to introduce such legislation in the next session. In addition, the University of Iowa College of Law has drafted a 'Model Aid-in-Dying Act' which is expected to be offered to legislatures throughout the country.

³ "Mercy" Death Law Proposed in State," *New York Times*, January 27, 1939.

⁴ "Mercy" Death Law Ready for Albany," *New York Times*, February 14, 1939.

⁵ Derek Humphry and Ann Wickett, *The Right to Die*, Harper &

Row (New York) 1986, p. 14.

⁶ 'New England Sifts "Mercy" Pros, Cons,' *New York Times*, January 9, 1950.

⁷ 'History of Euthanasia in U.S.: Concept for Our Time,' *Euthanasia News* (New York: Euthanasia Education Council), Vol. I, No. 4 (November, 1975), p. 3.

⁸ Kutner, Luis, 'Due Process of Euthanasia: The Living Will, a Proposal,' *Indiana Law Journal*, Vol. 44 (1969), p. 553.

⁹ 'The Living Will,' *Nursing Times* (London), Vol. 84, No. 49 (December 7, 1988).

¹⁰ Faith Conroy, 'Family keeps eye on U.S. right-to-die issue,' *Great Falls Tribune* (Montana), January 22, 1990, p. 3A.

¹¹ *McConnell v. Beverly Enterprises*, Superior Court of Connecticut, Judicial District of Danbury, Docket No. 0293888 S, Transcript of Proceedings, June 15, 1988, p. A-56.

¹² Senate Bill 1766, 'Patient Self-Determination Act.'

¹³ See note 2.

¹⁴ *Cruzan v. Harmon*, No. 88-1503 (U.S. Supreme Court). For additional information about the Cruzan case, see Appendix, 'Background & Fact Sheet.'

¹⁵ Fifth Biennial Conference of the World Federation of Right to Die Societies (Nice, France) September 20-23, 1984. From 'Ethics Panel: The Right to Choose Your Death - "Ethical Aspects of Euthanasia."' Remarks by panel member Helga Kuhse, Ph.D., lecturer in philosophy at Monash University and research fellow at the Center for Human BioEthics in Melbourne, Australia, September 21, 1984.

¹⁶ 'Doctors starve coma victim,' *Daily Telegraph*, January 9, 1990.

¹⁷ 'Issue of Assisting Suicide Dominates Meeting in England,' *Concern for Dying Newsletter* (New York: Concern for Dying) Vol. 6, No. 4 (Fall, 1980), p. 5.

¹⁸ *De Telegraaf*, Amsterdam, August 12, 1989.

¹⁹ British Medical Association, *Euthanasia: Report of the Working Party to Review the British Medical Association's Guidance on Euthanasia*, (London), British Medical Association, 1988, p. 49, no. 195.

²⁰ For a discussion of Dutch euthanasia, see 'A Case Against Dutch Euthanasia' by Richard Fenigsen in *E & M*, 6:1, Spring 1990

²¹ *The Voluntary Euthanasia Society Newsletter*, (London) December, 1988, No. 35, p. 1.

²² 'Face the Nation,' National Television Program, September 2, 1985.

²³ Memorandum to Members of the National Hemlock Society Board from Ann Humphry, November 2, 1989.

²⁴ Memorandum to Members of the National Hemlock Society Board from Ann Humphry, December 20, 1989.

²⁵ Letter and enclosure from Lee D. Kersten, attorney for the National Hemlock Society, to Charles Gudger, attorney for Ann Humphry, December 8, 1989.

²⁶ Memorandum and release from Derek Humphry to *People* magazine, February 13, 1990.

²⁷ Tape recording of phone message left by Derek Humphry on Ann Humphry's telephone answering machine, February 15, 1990.

²⁸ Robert Reinhold, 'Right-to-Die Group Shaken As Leader Leaves Ill Wife,' *New York Times*, February 8, 1990.

²⁹ 'Larry King Live,' CNN national television program, February 20, 1990.

³⁰ Personal communication from Ann Humphry, February 16, 1990.

³¹ Diane M. Gianelli, 'Right-to-die leaders' divorce dispute spotlights rift in national group,' *AMA News* (Newspaper of the American Medical Association), February 23, 1990, p. 18.

³² Letter from Henry Brod, former Executive Director of Hemlock of Oregon to all Hemlock chapter leaders and media, February 2, 1990.

³³ Colin Brewer, 'Self-Deliverance with Certainty,' *Hemlock Quarterly*, January, 1988.

³⁴ 'Insider Interview: Colin Brewer, Convenor, Medical Committee, Voluntary Euthanasia Society,' *Health Week* (San Francisco), June 6, 1988.

³⁵ Rita L. Marker, 'Euthanasia: The New Family Planning,' *International Review*, Vol. XI, No. 2 (Summer, 1987), pp. 122-123.

³⁶ Bernard Levin, 'Under patient's orders - to kill,' *The Times* (London), December 11, 1989.

³⁷ Duncan Vere, *Should Christians Support Voluntary Euthanasia?* C.M.F. Publications (London), 1971, p. 7.

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DEATH WITHOUT DIGNITY EUTHANASIA IN PERSPECTIVE

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The Doctor's Ethics

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The title *Ethics & Medicine* usually provokes a reflex association with contentious ethical issues in the practice of medicine such as abortion, *in vitro* fertilisation and euthanasia. Whilst these are in the forefront of public debate another line of discussion is being increasingly centred on the ethical implications of priorities and resource allocation. The purpose of this article is to concentrate on a third, and more often neglected, ethical area – namely that which deals with the ethics of the practice of medicine as a profession and the way in which it reflects the moral and religious position or presuppositions of the practitioner; in other words, the ethics of doctors.

Patient-doctor relationship

Today's social climate stresses the importance of the rights of the patient. This is part of the patient's autonomy which dictates that the patient has both the right to know and the right to decide. The contemporary stress on this aspect is an inevitable and, on the whole, overdue corrective to excessive paternalism in the past on the part of the medical profession.

The medical doctor has historically been regarded as a representative of a learned profession amongst those who in the main have been unlearned. Hence the title 'doctor' has been granted in an honorific sense, whereas only a minority have earned it on academic criteria. There is a long tradition of an implicit acceptance that the sick person consults a doctor who should know what is best and who would, regardless of any other consideration, do his best for that person. This understanding is at the heart of the debate on the recent White Paper, *Working for Patients*, where questions of cost may or may not undermine this relationship.

The practice of paternalism by the medical profession and the readiness of the population to accept this role probably reached its peak during and immediately after the Second World War. However, the dramatic changes that have taken place in society during the 1960s and 1970s have, in a fundamental sense, modified or even changed the way in which many people regard the establishment in general and figures of authority in particular. It is interesting that at a time when medical knowledge and technical capability has exploded, this has been accompanied by an increasing reluctance on the part of people to accept an authoritative role on the part of the doctor. Thus tension is created whereby the doctor has to tread a careful path between the assumption of a paternalistic role on the one hand and the abdication of his responsibility as a skilled professional on the other. This is illustrated in several aspects of medical practice. We note in passing the irony of the term 'paternalistic' becoming pejorative. The sick and weak could do worse than lean on a father figure. Scripture does not hesitate to use the human model as an illustration of the perfect divine Father (Mat. 7:9-11).

Truth v. compassion

It cannot be right that a doctor should lie to a patient. Certainly, this practice could not be justified from the Bible. The Christian doctor

will be committed to truth as a concept and obligation that applies to all aspects of his life, recognising that *the truth* is inseparable from truth as we use it in everyday life. Therefore, the patient who asks to be told the truth about his or her condition has the right to be given a 'truthful answer'. The Christian doctor will feel the additional obligation of indebtedness to the patient that a life-threatening or life-curtailling condition should be declared.

We all need to know the truth about ourselves, and Scripture denounces quackery and placebos in the spiritual realm – physicians who have 'slightly healed' the hurt. Kings and others were given warning that they had leprosy or that they would die in a certain time. Pestilences and illness were predicted and promised. The relationship between sin, suffering and death is made explicit. Individual responsibility is taught and with it the corollary of personal knowledge.

However, one of the difficulties and tragedies in this field is that doctors, whether Christian or otherwise, tend to take entrenched positions on the question. Some may tell, others may deceive. But is life or death that simple? There are several factors which every doctor needs to recognise and remember. These include the extreme variability of disease whereby its behaviour in an individual patient is exceedingly difficult to predict. The practice of giving life expectancy to individuals or their relatives is often little short of arrogance. In fact, the occasional unpredictability or even completely unexpected and perverse behaviour of disease is the very thing that makes the evaluation of claims for miraculous healing so difficult to assess. A necessary part of truth in medicine is an admission of ignorance and fallibility. Another factor is the problem of accurate communication. Doctors tend to forget or minimise the degree of ignorance or misunderstanding that patients have regarding themselves and their bodies – despite all the efforts of the media to enlighten them.

More important than any of these technical aspects is the fundamental doctor-patient relationship which has to do with the reason for anyone consulting a doctor. The patient is justified in expecting a degree of technical competence which should be an integral part of a properly trained professional, and is also right in anticipating a degree of courtesy and consideration that used to be known as a good bedside manner. The relationship presupposes an acceptance that the doctor will seek first and last the patient's best interest. This will involve not only what the patient is told but how and when. For example, to tell a patient that 'you have cancer' is, apart from anything else, a completely insufficient statement. There will always be the need for modification or qualification depending on site, extent, type, and many other factors. Therefore the doctor who is concerned for the patient, whilst at the same time wishing to act truthfully, will have to exercise judgment, which is the very essence of being a professional. The patient comes to be made 'better'. The scriptural model, apart from the examples of miraculous healing (which were exceptional), is one of providing rest and comfort, and support. Even on a spiritual level, a belief in eternal damnation is not

a warrant for a correspondingly explicit prognostication in life's human contacts. When a human father seeks to protect and to encourage his suffering child, we do not accuse him of paternalism, although that is the literal role he seeks to fulfil.

One of the basic threads of entire Scripture is that of communication – communication between God and the creature; between Jesus and his disciples and the people. But all this is primarily in respect of redemptive truth, and is it justified to apply these illustrations to the doctor-patient relationship? Whereas the Christian doctor will maintain that it is more important for the patient to be right with God than to be comfortable with his doctor, this does not remove the doctor's professional relationship with his patient which is still that of being there to support and help, even when he cannot heal.

The oath of the Hebrew University (1952) expresses this – 'You are charged night and day to be custodians at the side of the sick man at all times of his need. And you shall seek to fathom the soul of the sick, to restore his spirit, through understanding and compassion'. In other words 'speaking the truth in love' or, more literally, 'truthing in love' (Ephesians 4:15).

Doctor-employer relationships

As a professional, a doctor will have differing and sometimes conflicting relationships, e.g., to patient, employer and society. The tension between these relationships will depend to a large degree on the type of speciality or practice in which the doctor is engaged. The majority of doctors working in the National Health Service in Britain have enjoyed a considerable degree of freedom in the practice of their profession, whether as principals in general practice or as senior hospital doctors. It is, however, doubtful whether this will obtain in the future. Governmental and commercial pressures for 'value for money' dictate that all employees have to give an account of their stewardship. It is difficult to see how any Christian doctor could or should object to his job being evaluated by those who employ him. In fact, such evaluation should serve to show that any senior Christian professional worth his salt is putting in more than that for which he is contractually engaged and paid.

It must nevertheless be remembered that every contract is a two-way business and that the doctor, although engaged and paid by the NHS, is taken on in order that he might carry clinical responsibility. Once the doctor is employed in a clinical capacity it is inescapable that the patient-doctor relationship must take precedence over all others. This is the premise of any contract, and the core of the 'job description'. Whereas in the past doctors may well have invoked this relationship as a mechanism for excluding administration and management, perhaps the pendulum has swung in the other direction so that management may be too ready to invade areas of clinical decision and be authorised by the state to do so.

Lee and Etheridge* ask the question: 'Will medicine continue as an autonomous profession, or will it become increasingly influenced by large purchasers and the ethics of the market place?' In ethical terms autonomy must be preserved for doctor as well as patient.

Clinical responsibility and accountability are not simply slogans to be invoked, but are real and basic commitments taken by every doctor engaged in medical practice. The reality of this concept is given tacit recognition by the fact that doctors take on a peculiar

personal responsibility when they treat patients and, therefore, were, until this year, the one professional branch that had to be compulsorily insured as a condition of employment. The assumption of this obligation by the employing authority has ethical implications that do not appear to have been considered.

Personal v. professional

Are the ethical codes that are demanded of a professional in any way different from those expected of an individual, whether Christian or otherwise? We have already seen an example of this tension with regard to truth and compassion which may appear to justify a modification of any approach based on 'truth at all costs' policy.

Similarly, in respect of a doctor's relationship to his employer, distinction may be necessary between the qualities expected of an individual from those of a professional doctor. Thus, humility is a prerequisite Christian virtue and this alone should be sufficient to safeguard against any hint of the besetting sin of medical arrogance. But surely the doctor should not allow a mistaken sense of humility to silence his professional voice if he should see mismanagement in the NHS. If doctors are to be subjected to value-for-money studies, they in turn are justified in expecting the same criteria to be applied to the management process itself.

Even more crucially, the doctor must not allow his employer to impose standards of practice that are contrary to the doctor's ethical view. Hitherto, this has seldom been a problem in Britain, but increasingly the state or the Establishment through the General Medical Council, defence unions, or professional associations, are finding, in an open society, that they are almost forced to issue guidelines or formal instructions. Thus, a doctor could readily be in conflict with 'official' attitudes on such questions as contraceptive advice to minors without parental consent; methods of clinical practice, and communication with the media and the public. An ominous foretaste of this occurred when the General Medical Council itself notified doctors that if they refused to give contraceptive advice to under-age girls without notifying their parents they could be guilty of a disciplinary offence.

Ethics for doctors

The prominence sometimes given to the usual ethical questions such as abortion may overshadow the relative neglect of the fundamental ethical attitude of the doctor as an individual. Hitherto, at least until two or three decades ago, most students entering medical school in Britain will have had some exposure to ethical attitudes at home and in school, where these were based on vague religious or even distinctly Christian premises.

This background can no longer be taken for granted. In fact, the evidence is to the contrary. What then is to replace this? Is it sufficient to leave these questions to the moral philosophers of the day as tempered by the norms of society or the expediency of the government? This, surely, is an issue that needs to be addressed as never before. Christians in general need to make a positive contribution to the principles that should govern the relationship between the doctor and patient, and Christian doctors in particular must be more than ever alert to the danger of this world 'squeezing them into its mould' (Rom. 12:2).

*P. R. Lee and L. Etheridge, *Clinical Freedom*, *Lancet*, 1989, I.263-5.

Rapiers and the Religio Medici

Jonathan Sinclair Carey, London

Dr S. G. Potts in his article, 'Persuading Pagans' (*Ethics & Medicine*, 1988, 4.2) has employed military imagery, favoured by many a church father and later church reformer, to depict the situation confronting the modern Christian 'soldier' or *miles* (of each age) who must wage warfare against the so-called pagans in the name of Christ. According to Dr Potts, 'The conflict today is verbal and philosophical, but no less fierce, and the modern Christian *miles* needs a weapon' (p. 32). That weapon is what he calls the rapier of reason, which is 'flexible, lethal, and can seek out the chinks in the opposition's armour'. He considers this approach far more responsible and effective than engaging in polemics (a word he might be interested to learn comes from the Greek *polemos*, meaning war).

I must admit to a twofold discomfort with Dr Potts' article, much as I may personally admire my colleague. In the first place, I find his *bellicose leitmotif* fairly belaboured and, if honesty may prevail, somewhat offensive: as if the world were made up of the *we's* and the *they's*. And onward, onward Christian soldiers march the *we's* in the name of charity into battle with the rapiers of reason and the shields of faith to triumph over the pagan *they's*. All a bit much.

In more pragmatic ways, a study of the denominational membership of the World Council of Churches shows that it can be just as exclusive as inclusive, depending on confession of faith.

Yet my second discomfort with his article is far more serious and academic. It concerns his use of faith itself (and by ramification his understanding of reason, Scripture, and tradition). It seems to me that Dr Potts has altogether failed to realize that faith itself, even in service to reason in whatever admission of priorities of influence, is hardly as clear or universal as he seems to imply. For example, one can turn to the works of Troeltsch for a classic exposition of the different meanings of faith, or to William James to see the variety of religious experiences. In more pragmatic ways, a study of the denominational membership of the World Council of Churches shows that it can be just as exclusive as inclusive, depending on confession of faith.

When the thoughts and actions pertain to a so-called Christian practice of medicine, obviously the stakes become quite serious: world-views may implicitly or explicitly conflict—even among professing Christians themselves.

Obviously different expressions of faith, whether pertaining to the nature of God, the person and work of Jesus Christ, the work of the

Spirit, or the meaning and significance of revelation, will influence the perception of reality or its perspectives. After all, theology is about the framing of a world-view; it becomes an admittedly difficult task to try to articulate one's faith, let alone put it into action.

After all, Christians are hardly united in their opinions regarding the rightness or wrongness of abortion. In the name of Christian faith, or in the name of reason itself, wide divisions remain.

When the thoughts and actions pertain to a so-called Christian practice of medicine, obviously the stakes become quite serious: world-views may implicitly or explicitly conflict—even among professing Christians themselves. And this pertains to patients, physicians, chaplains, and everyone else in the given situation. Sometimes the conflicts may be relatively minor; other times, however, of rather serious difference, whether based on sacramental meanings of the body, the justification for certain therapeutic acts from theological and philosophical perspectives, or the personal and unarticulated faith of one of the people not part of the tradition advocating reasonableness, as it were, or desiring informed consent. In short, one person's informed assent about religious faith, its salvific sense and intentionality on conduct, may be diametrically opposed to another person's faith as it pertains to his or her sense of values, rights, and obligations.

Now, I agree with Dr Potts that the use of the cardinal virtues and the theological virtues may help in the development of a logically valid argument to justify some conclusions; but even that use of the rapier of reason may not altogether suffice. After all, Christians are hardly united in their opinions regarding the rightness or wrongness of abortion. In the name of Christian faith, or in the name of reason itself, wide divisions remain. Does this, therefore, suggest that Dr Potts might be forced to admit that some so-called Christians are really pagans? I would have to wonder. Or perhaps Dr Potts would want to draw up his own criteria for what constitutes valid faith. No doubt Cardinal Newman and Karl Rahner, SJ, would have been interested in his insights. (*As an aside, Rahner might want to have tried to convince Dr Potts that a better way of perceiving the *they's* would be as anonymous Christians, not as pagans.)

There is also the case to be made that numerous Protestants, for example, would argue a doctrine of original sin so that reason itself is not to be trusted in ways admitted by Roman Catholics. Unless the scriptural warrant exists in reference to some issue and is obvious in what it says, biblical exegesis of whatever sophistication establishing the rightness or wrongness of some belief or act, then we cannot hope to know or be able to reason adequately upon the matter. When you consider that there are some 1200 Protestant

The Medical Dilemma

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'If it is possible, it is permissible'. A thoughtful observer of the medical scene over the last twenty-five years might well conclude that this is the ethical basis upon which medical research has been conducted. There are signs, though, that even those involved in the forefront of such research are becoming unhappy about this slogan as the basis of medical practice.

Many of those recent dramatic medical advances have been made in the U.S.A., but evidence is mounting that even there is concern about proceeding with further research using the above slogan as the basis of medical morality. One instance of this concern is the symposium held recently, at a University Medical Centre, entitled 'Moral Choice and Medical Crisis'. The programme of this conference illustrated the growing awareness amongst many doctors and ethicists of the increasing need for serious ethical thought in the contemporary medical and moral maelstrom. It was interesting to observe that at this symposium serious attempts were made to ground medical ethics in a consistent ethical philosophy, and it was equally interesting to observe the directions of this philosophical choice.

With its long Hippocratic tradition it is, in one sense, not surprising that medicos should look for their moral and ethical basis in Greek thought, that is, in Aristotelian ethics. Several speakers, including keynote speakers, appeared to base their ethical investigation upon Aristotle. Perhaps it was indicative of the relative isolation of medical ethicists that little awareness was shown of the fact that the influence of Aristotelianism has, at most, been only peripheral in the development of the ethics and morality of Western civilization. The fundamental bases of all the ethical systems of the West have been firmly established upon Hebrew-Jewish-Christian thought, and without a realization of this fact the contemporary search for a workable and consistent medical ethic will inevitably flounder.

To illustrate, one keynote speaker, a recognized leader of American medical-ethical thought, spent an unconscionably long time in trying to give an abstract definition of 'The Good'. If he had possessed a greater understanding of the traditional basis of Western ethics he could have saved himself and his audience a lot of trouble. Western ethical tradition is much more existential, much more empirical, because it is founded upon the existentialism of Hebrew-Jewish-Christian thought. 'The Good' is not abstract but is personal and concrete.

If an adequate solution is to be found to the moral crisis and the problems of medical choice arising from that crisis, it may well be necessary to begin by returning to fundamentals. That, in this instance, would mean beginning with a re-statement of the philosophical understanding of the nature of man. After all, both medicine and morals are to do with mankind, and therefore an understanding of the nature of man is a pre-requisite for the search for an adequate solution, and is much more fundamental than an attempt to make an abstract statement about 'The Good'.

It cannot be denied that the traditional understanding of the nature of man in Western civilization is based upon the biblical statement that man is made in the image of God. It could be argued that as now much of Western society demonstrates a pluralistic culture, such an understanding can no longer be accepted as the basis for a contemporary medical ethic. But to take such a view would be to strain at the gnat and swallow the camel. In every society there have been deviant groups, and equally in every society these groups have had to accede to the ethical mores of the total society, just as they have to live by that society's laws. Furthermore, it should be remembered that not only is this biblical view the basis of both Jewish and Christian understandings of the nature of man, but of the Islamic understanding also. Even atheistic humanism is heavily indebted to the biblical understanding of human nature, and such cultures as those of the American Indian would have no difficulty in the acceptance of such a position. In other words, Western society is nothing like as philosophically pluralistic as might be supposed.

Although there have been a variety of interpretations of the meaning of the statement that man is made in the image of God, one thing, at least, is certain. It is that this belief has insisted upon the dignity of man, both in life and in death. Anything, and this must include medical treatment, which unnecessarily robs the individual of that dignity is a violation of the historic Western understanding of the nature of man. Of course, historically, the dignity of the individual has frequently been forgotten or ignored, but that is beside the point for the serious ethical investigation. Ethics are concerned with what should be, and not what has been, in the hope that what will be may conform more nearly to what should be.

Whilst the dignity of man is a fundamental part of Western civilization's understanding of the nature of man, there is another aspect of human life, equally important for a medico-moral discussion, but not dependent upon any particular view of the nature of man. It is an aspect of which the medical profession should be more aware than almost any other profession, but it is one which is frequently ignored by medical research and philosophy. It is that man is born to die. Mortality is of the nature of mankind. Furthermore, death is not, in itself, a failure, nor is it, in either Jewish-Christian or Greek understanding, an evil. Death is a fundamental part of life; it is an extremely important part of life, and any philosophy, or any moral or ethical system which attempts to ignore these facts, or seeks to diminish the importance and significance of these realities is being false and unrealistic. If there is no complete philosophical acceptance of the reality and normality of death, medical ethics will exist in a fantasy world.

Now whilst, as it has been argued above, a degree of pluralism in the understanding of the nature of man does not seriously affect that philosophical understanding of the nature of man, pluralism of attitude towards death can and does. Indeed, there is, at the present time, a sharp dichotomy of beliefs about death, and this presents a dichotomy of attitude causing dilemmas in practice. Historically,

religious denominations in the United States of America alone, obviously the range of opinions on divine revelation will vary tremendously. As we also know, especially since the time of *Humanae Vitae*, even having a Roman Catholic magisterium to safeguard the *depositum fidei* hardly guarantees professed and practised orthodoxy.

I certainly believe that Christianity must be reasonable. Scripture, to cite its influence, does note quite clearly that 'reason is the candle of the Lord'. As anyone working in the field of medical ethics knows, Roman Catholic moral theology has exerted a tremendous impact on many of the people – whom Dr Potts would consider 'pagan' and otherwise – keen to fathom the applications of faith through the use of reason.

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Yet, even the most cursory examination of the two-volume compendium of 'notes', authored by Richard A. McCormick, SJ, which chronicles the various moral literature since the Second Vatican Council (1965-1984), shows that the use of reason in Christian faith – by Protestants and Roman Catholics – is inadequately understood despite various efforts by some theologians and others to argue the distinctiveness of Christian moral reasoning. Obviously much work remains to be done.

Dr Potts deserves credit for his earnestness and efforts to be reasonable as a defender of the faith, as a philosopher and physician. Yet, in closing, I would like to call to his attention the important study by Garth L. Hallett, *Christian Moral Reasoning: An Analytical Guide* (University of Notre Dame, 1983). The book begins with a treatment of how the Crusaders used their understanding of God's will to justify the First Crusade of 1096-1099. Hallett goes to some lengths to advocate prudence in using such moral claims as 'God wills it'! History has shown much of the subsequent tragedy of such crusades and the well-intentioned thrusts of rapiers of reason.

Even more important is the concluding paragraph of the book, which should provide Dr Potts and other readers with food for thought and spiritual reflection:

'Do not be childish, my friends', St Paul advised some enthusiastic but unreflective Christians. 'Be as innocent of evil as babes, but at least be grown-up in your thinking' (I Cor. 14:20). Weigh the value of what you are doing or intend to do. Recognise the need for such balancing. But acknowledge also the limits of your powers; cherish no illusions of self-sufficiency. Thus the serpent and the dove, surprisingly paired (Mat. 10:16), form an appropriate symbol of Christian moral reasoning (p. 228).

Sir Thomas Browne, the celebrated physician-philosopher, who wrote the seventeenth-century classic, *Religio Medici* (Religion of a Physician), is also instructive for this modern age. Like Dr Potts, Browne also embraced the traditional military imagery when he wrote that:

'Tis true, there is an edge in all firme beliefe, and with an easie Metaphor wee may say the sword of faith; but in these obscurities I rather use it, in the adjunct the Apostle gives it, a Buckler (i.e., a shield); under which I perceive a wary combatant may lie vulnerable.

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Unlike Browne, whose 'reason hath beene more pliable to the will of faith', and who preferred the security of the shield of faith, Dr Potts seeks to stand firm with his symbolic rapier of reason in hand as the hallmark of this twentieth-century *religio medici*. Yet I still wonder, even after reading his article, about the precise ground of reason and faith upon which he stands and seeks to duel.

*John MacQuarrie, it must be said, rejects Rahner's doctrine of the Anonymous Christian as inadequate, failing to recognise the reality and value of the non-Christian in himself or herself with the concomitant different religious perspective.

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the attitude towards death in the Western world has, overwhelmingly, been based upon the belief that death is not the end, but that it is merely the gateway to another and better life. Perhaps a more effective way of describing this belief about death is that it is an eschaton rather than a terminus. In this century, however, there has been in the West, a growing disbelief in the reality of heaven, (a belief which has not been shared in the Islamic East,) and, instead, an increasingly widespread belief in the finality of death.

The growth of this new belief is probably concomitant with the slow erosion of the traditionally deeply held belief in God, and in his providence and power. Whether or not the medical profession as a corporate body has been universally concerned with this theological matter is, again, beside the point. Probably it may have decided that, professionally, this is not its concern, but the present dilemma, the medical and moral crisis, is indicative of the truth that such fundamental human questions cannot be dodged; at least, cannot be dodged for long.

The medical profession has fallen into its present moral morass precisely because it has, perhaps unconsciously, separated its practice from ethical, philosophical theory. In practice the medical profession as a corporate body has accepted the disbelieving point of view, and, unconsciously, adapted its moral principles accordingly. Death has been considered to be final. It has been seen as the obliteration of the human personality, and therefore, all possible means have been permissible for the avoidance of the final tragedy, and for the prolongation of life. In its fight to avoid what it has seen as the final disaster, the medical profession has accepted, far too frequently, that all means of delaying death have been permissible even when those means have, most evidently, violated the dignity of human life and death.

It has been said, very truly, that death is the great, late twentieth century taboo, perhaps the only taboo left in this country today. Until our society is prepared to abandon this taboo it may not be able, honestly, to ask the question, 'Are there limits to the cost to human dignity, and to the cost in actual financial terms, to the avoidance, or more properly, the postponement of death?' Some may consider the introduction of financial concern as an intrusion which has no real part to play in the medical-moral debate. Such an attitude, however, would reveal a sad misunderstanding of Christian morals upon which so much of the life of Western society and culture has been based.

If the medical profession is finding it necessary to embark upon an exploration of moral questions in relationship to its practices, it must realise quite clearly that, if the investigation is to be real, and not a cosmetic enterprise, or a sop to concerned individuals, it may well take the medical profession into realms it would prefer not to enter. It may indeed compel very painful and even sacrificial decisions. Once a serious medical-moral discussion has begun it cannot stop half-way. As someone so wisely said 'You can't fall half-way down the Niagara Falls'. It may come as a shock to many that a corollary of the biblical doctrine of man is that it has no limits in its application, just as, no doubt, it would have come as a shock to Thomas Jefferson, if someone had pointed out to him that his deathless statement about the universality of freedom applied equally to his slaves. The universality of the dignity of man is basic to our inherited ethical tradition.

The dignity of human life is not only applicable to those who are sufficiently fortunate to live in the affluent West. It concerns all human beings. It is here where the contradictions of medical research and practice are so evident. Mrs Thatcher, perhaps unaware of the total implications of her statement, said, in her recent speech to the United Nations Organisation, that when she was born, the population of the world was two billion. By the time her grandchild grows up it will be six billion. At the same time medical scientists are researching improved techniques for producing 'test tube babies' for infertile couples in the Western world. The philosophical confusion is compounded when colleagues of those same medical scientists are feverishly working to produce a safe abortion pill.

Discussing the contradictory messages coming from our British hospital system (e.g. anaesthetists have recently declared that both costs and waiting lists could be cut substantially if operating theatres were better organised, while other hospital staff deny this), with a pathologist, I was told that all the medical care problems could be solved if there was sufficient money. The question is, however, what is sufficient money? Such a statement is really to demand a bottomless purse, and this, too, is a moral problem. The people of the U.S.A. are probably more aware of this insatiable appetite of the medical world than we are in Britain, because most individuals over there have to be responsible for the ever-increasing cost of medical insurance. Some six years ago I knew a man whose life was prolonged in hospital for three months, at the cost of immense suffering, and with a considerable assault upon his human dignity. When he died the cost to his widow of his hospital treatment was a quarter of a million dollars exclusive of doctors' fees. This man had been both retired and in poor health for years. His wife worked as a librarian in a small country town. This was not a case of the wealthy being able to afford unlimited treatment.

At the time of the oil crisis in 1973, the Western world at last realised that the resources of the globe are not infinite. In spite of the contemporary concern with green issues this truth is largely disappearing from human minds. It is time the medical profession returned to a study of its ethical foundations, and realised that, at both national and world levels, resources are not infinite, and the use of resources is a fundamental moral question. Furthermore, it must learn that not everything that is possible is permissible. Equally, it must understand that not everything which is permissible is morally desirable. Already in so many spheres, Western society has consumed far more than its fair share of resources; not least of finite and even irreplaceable resources. The medical research scientist must come to appreciate that there is a cost to medical advances, and because mankind is one, that cost, ultimately, is borne by those in the Third World least able to carry it.

The Mother-Child Relationship: A Tradition Recalled

Soren Holm, Blegdamsvej, Denmark

It is a characteristic of modern medical ethics that people are described as totally separated moral agents. Special relations such as nationality, community ties or family relations have no role in the moral discourse.¹

Modern medical ethics paints a bleak picture of an atomistic society consisting of people whose only real interface is when their border, their armor of rights, is transgressed.

That this conception of ethics and the moral life is severely wanting has long been recognized, and it is indeed one of the main criticisms against the kind of pure utilitarianism that pervades modern thought.

W.D. Ross put it in this way in his *The Right and the Good*:

The essential defect of the 'ideal utilitarian' theory is that it ignores, or at least does not do full justice to, the highly personal character of duty. If the only duty is to produce the maximum of good, the question who is to have the good – whether it is myself, or my benefactor, or a person to whom I have made a promise to confer that good on him, or a mere fellow man to whom I stand in no such special relation – should make no difference to my having a duty to produce that good. But we are all in fact sure that it makes a vast difference.²

In recent years there have been a number of papers trying to show that special relations are morally significant³, but we are still left without an account of the contents of the obligations flowing from special relations. This paper will look at the meaning and content of the mother-child relation, and will provide a preliminary outline of the obligations flowing from this special relationship.

The Good Mother

The mother-child relationship is the primordial paradigm for any human relationship. In the old natural law tradition it would not be difficult to argue for specific obligations falling upon the mother and the child. But our society has lost the connection to the world view that could support 'idealistic' conceptions of the good, and the 'is-ought' gap of Humean scepticism has severed the strand which connected Christian and secular ethics.

There is, however, still one possible way to bridge the 'is-ought' gap, because actions directed towards a goal can be judged from the goal they aim at. The same is true for goal-directed relationships, roles or occupations. It is trivially true that 'A captain of a ship ought to do, what a captain of a ship ought to do'. But this is not merely a trivial tautology, because being a captain of a ship is (partly) a goal-directed occupation, and we can therefore deduce some *prima facie* oughts from the simple is, that the person in question is 'captain of a ship' (e.g. that he ought to take care of the ship and its passengers and crew).

If we look at the role of a mother we see that it is also partly goal-directed, and it is therefore possible to derive some actions that a

mother ought to do from these goals. Although this view has some similarities to the ideas put forward by several neo-aristotelian philosophers, its claim is more restricted. It does not claim that human life in itself has a goal which can be determined solely by philosophical discourse. But only that the natural goals of certain human endeavors makes a moral evaluation possible.

An obvious objection to this attempt to bridge the is-ought gap is to point out, that the same arguments could be applied to thieves. A good thief being one who was never caught by the police. But this objection fails because the goal of a thief, stealing, is not a morally good goal, and the means to it therefore only good in a purely instrumental sense. Whereas the goal of most captains is morally good, or at least morally innocuous; and the goal of mothering in almost all instances good. It can further be pointed out, that where it is quite sensible to wonder whether there ought to be any thieves or even captains of ships, it is quite difficult to make any sense of the question of whether there ought to be any mothers.

Another problem is, that some of the goals of mothering are imposed by society, whereas some are necessary and in a sense natural parts of the role of mother. But how do we separate these two different kinds of goals?

Our society has not only lost its philosophical foundations, it has also lost its primary understanding of different social roles. I will therefore submit that we have to go back in time to find a full conception of the role of mother. And that this conception is not to be found in works of philosophy, ethics or education but rather in literary works. The fullest understanding will be found in narratives of the mother-child relationship, and not in specific philosophical accounts. The task of the modern philosopher is then to elicit the 'protoethical' statements from these old narratives.

The Story of a Mother

Many novels and short stories from the 19th century, could have been used as the basis of such a protoethical study, but in this paper I will use 'The story of a mother' by the well known Danish writer H.C. Andersen.⁷ This story has the advantage that its main focus is 'the mother', and it portrays H.C. Anderson's conception of the mother-child relationship. It is often assumed that the writings of H.C. Andersen are just children's stories, but nothing could be more wrong. The stories are deeper than they appear, many carry a distinct Christian message, and all can be read with profit by adults.

'The story of a mother' is about a mother sitting at the bedside of her child who is ill. Death comes and takes the child, and the mother runs after him. She has to ask her way several times, and each time she has to give something in return. First she has to sing all the songs she sung to her child, and then she meets the blackthorn bush:

'Have you not seen Death go by, with my little child?' 'Yes,' replied the bush, 'but I shall not tell you which way he went unless you warm me on your bosom. I'm freezing to death here,

I'm turning to ice.' And she pressed the blackthorn bush to her bosom, quite close, that it might be well warmed. And the thorns pierced into her flesh, and her blood oozed out in great drops. But the blackthorn shot out fresh green leaves, and blossomed in the dark winter night: so warm is the heart of a sorrowing mother!

Later she weeps her eyes into a lake to be able to cross it, and gives away her beautiful black hair for information. Finally she stands in the hothouse of Death, where each living person has his or her own plant. She finds the plant of her child, and stands to protect it when Death comes:

And Death stretched out his long hands towards the little delicate flower; but she kept her hands tight about it, and held it fast; and yet she was full of anxious care lest he should touch one of the leaves. Then Death breathed upon her hands, and she felt that his breath was colder than the icy wind; and her hands sank down powerless... All at once she grasped two pretty flowers with her two hands, and called to Death, 'I'll tear off all your flowers, for I'm in despair.' 'Do not touch them,' said Death. 'You say you are so unhappy, and now you would make another mother just as unhappy!' 'Another mother?' said the poor woman; and she let the flowers go.

Then Death takes her to a well, and asks her to look down into it and see the future of two children:

And she looked down into the well, and it was a happiness to see how one of them became a blessing to the world, how much joy and gladness she diffused around her. And the woman looked at the life of the other, and it was made up of care and poverty, misery and woe. 'Which of them is the flower of misfortune, and which the blessed one?' she asked. 'That I may not tell you,' answered Death; 'but this much you shall hear, that one of those flowers is that of your child. It was the fate of your child you saw – the future of your own child.' Then the mother screamed aloud for terror. 'Which of them belongs to my child? Tell me that! Release the innocent child! Let my child free from all that misery! Rather carry it away!...' 'I do not understand you,' said Death. 'Will you have your child back, or shall I carry it to that place that you know not?' Then the mother wrung her hands, and fell on her knees, and prayed to the good God. 'Hear me not when I pray against Thy will, which is at all times the best! Hear me not! Hear me not!' And she let her head sink down on her bosom. And Death went away with her child into the unknown land.

Four elements of this rich and multi-faceted conception of the mother-child relationship are prominent in the narrative:

1. Love as the sustaining force of the relationship.
2. Suffering and sacrifice as integral parts of the relationship.
3. Concern for the good of the child as the primary goal of the relationship.
4. The realization that although I can renege my own interests, to further the interests of my child, I can not and should not violate the vital interests of others.

That love is the sustaining force of the relationship is evident. The mother does not pursue her own interests through the child, but sacrifices these interests for the sake of the child. It is not a

relationship primarily based on rational deliberations but on feelings. The encounter with the blackthorn bush shows that very clearly, 'so warm is the heart of a sorrowing mother!' This does not imply that rationality has no place in the relationship. The actual actions taken by the mother are all rationally designed to pursue the good of her child as she perceives it. She believes death to be the most horrible thing that could happen to her child, and she rationally takes the actions she believes will prevent the death of her child. These actions involve great suffering and sacrifice on her part, and although she pleads with the 'informants' to get information 'cheaper', she is quite willing to take the suffering upon herself. It is important to note, that the suffering is a direct consequence of pursuing the good of the child. She did not have to renege on her own interests. She could have avoided all suffering by saying: 'It will be difficult to rescue my child. I will have to suffer so much, so I'll let death take her.' Throughout the narrative the mother pursues the best interest of the child as she sees it. She hurries to overtake Death, and when Death arrives at the hothouse, she is already there protecting her child. But when Death shows her, that the best interest of her child may not be what she believes it is, she chooses to do what is best for the child, even though it causes her great sorrow.

Even though the best for her child is her primary objective, the mother in the narrative does not pursue this objective regardless of the vital interests of others. Her actions are limited by these interests. She grasps two other flowers, and threatens to tear them off, but as soon as she realizes that this would cause sorrow to other mothers, she no longer sees this as a valid line of action (for a real life parallel to this attitude see note 6). Some might claim, that 'The story of a mother' was only chosen to prove certain points, and that the conception of the mother-child relationship found in this story is exceptional and not typical. But if one, for instance, studies the German folk tales collected by the Brothers Grimm, one finds the same picture, although often portrayed in the 'mirror image' of the bad mother/parent, e.g. in the well-known tales 'Hans my hedgehog' and 'Hansel and Gretel'.⁸

How do we Apply this Conception of the Mother-Child Relationship

The conception of the mother-child relationship in H.C. Anderson's 'The story of a mother' contains several elements which are absent in the present bioethical conception of this relationship. Love as an important element in the relationship plays no part in the ethical discourse, and is normally relegated to appendices on virtue and supererogatory acts, if it is mentioned at all. The thought that parents ought to make sacrifices for their children is rejected, as is the idea that the interests of the child should have priority over the interests of the parent.

But all these elements are necessary to achieve the goal of parenting. Seedhouse has argued convincingly that it is *always* morally wrong to dwarf other people physically or mentally.⁹ We can therefore state the minimal goal of parenting as facilitating and aiding the development of mature and full grown (both physically and mentally) persons. It is impossible to achieve this goal if the parents are unloving and only pursue their own interests. Parents ought therefore to be loving and pursue the interests of the child.

If this preliminary framework is applied to the case of the severely

handicapped newborn as presented by Kuhse and Singer in their book *Should the Baby Live?*¹⁰, it leads to conclusions which are distinctly different from Kuhse and Singer's conclusion that parents should have a right to have the handicapped baby killed if they so wish.

Four sets of interests are at play in this case, the interests of the child, the interests of the parents, the interests of other children in the family, and the interests of society. Within the framework presented in this article the interests of the child ought to take precedence over the interests of the parents, though it is still necessary to weigh it against the interests of the other children in the family, to whom the parents have a similar obligation of care. Parents may sincerely believe, that the acceptance of the handicapped child into the family would disrupt the family and preclude proper parenting for the other children. If this is really the case they may be justified in choosing to set the interests of the other children first and 'reject' the handicapped child. But this does not mean that the parents can absolve themselves of the obligations they hold. They must try to ensure that the life of the child will be as good as possible (possibly through adoption), even if their obligations towards their other children prevents them from rearing the child themselves. The obligations towards the other children in the family can never be a justification for killing the handicapped child or letting it die. If it is in the best interest of the child to live, discounting the interests of all other parties, then the parents are obligated to help in promoting this interest. There is no other way to square the circle and resolve the fundamental problem of whether we can set aside the life of one person for the non-vital benefits of others.

There may be very rare cases where the handicap is so demonstrably awful that it precludes human fellowship and a human life. In these cases some would argue that there may be justification for letting the child die, not because further existence conflicts with the interests of others, but because its particular handicap vitiates even our most compassionate attempts of caring by turning them into further agony for the child.¹¹

The interests of society should normally not be of any importance in such decisions, since acting on the best interest of the child will normally only cause minimal violations of (non-vital) rights of others in society at large. There may however, be catastrophic circumstances where the interests of society become important, but such instances will be very rare.

It is not surprising, that a conception centered on relationship and obligations and not on moral status and rights must be at odds with the prevailing ideas in modern bioethics. Moral status and rights are important factors in the moral fabric of society, but it is a fatal mistake to take these two factors to be all there is (see note 5). Moral life is far richer and unless all aspects are taken into account we may go seriously wrong, as the debate over the last decade has so amply demonstrated.

The framework for a proper understanding of the moral content of the parent-child relationship presented in this paper is only preliminary. There is a lot of philosophical work yet to be done to fill in the 'holes'. But I think it shows some of the promises inherent in trying to formulate 'richer' and more complex moral theories, which without unwarranted reduction can grasp the complexities of life as it is.

¹ J. English 'What do grown children owe their parents?' in O. O'Neill, W. Ruddick, eds, *Having children: Philosophical and Legal Reflections on Parenthood*, New York, 1979.

² W.D. Ross, *The right and the good*, Oxford, 1930, p. 22.

³ C.H. Sommers, 'Filial morality', *Journal of Philosophy*, 83 (1986) pp. 439-56.

⁴ A. MacIntyre, *After Virtue* (2nd ed.), Notre Dame, Illinois, 1984, p. 57.

⁵ R. Hursthouse, *Beginning Lives*, Oxford, 1987.

⁶ G. Gillett, *Reasonable Care*, Bristol, 1989.

⁷ H.C. Andersen, *The Complete Illustrated Stories of Hans Christian Andersen*, London, 1987, pp. 88-93.

⁸ *The Penguin Complete Grimm's Tales for Young and Old*, New York, 1984

⁹ D. Seedhouse, *Ethics - the heart of Health Care*, Chichester, 1988.

¹⁰ H. Kuhse, P. Singer, *Should the Baby Live?*, Oxford, 1985

¹¹ P. Ramsey, *Ethics at the Edges of Life*, New Haven, 1978, pp. 212-17.

SEXUALITY AND FERTILITY

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REVIEWS

Worse than the Disease: Pitfalls of Medical Progress

Diana B. Dutton

Cambridge University Press, 1988, 528 pp.; £25.00

ISBN 0 521 34023 3

In this book Diana Dutton, who holds a doctorate in health policy analysis from the Massachusetts Institute of Technology and directs a social sciences programme for physicians, explores the problems arising from medical and scientific innovations.

Most of the book is taken up with the results of a multi-disciplinary research project which studied four areas of clinical and technological advance – the use of the synthetic oestrogen diethylstilbestrol, the development of an artificial heart, the preparation in the USA for an epidemic of potentially lethal swine 'flu which never materialised and the challenges of genetic engineering. The second part of the book addresses the serious implications and problems which may arise from the attitudes of doctors, scientists and government, well-illustrated by the case studies chosen.

These attitudes include over-optimism about the benefits of new treatments and the feasibility of introducing them, lack of clinical evaluation in appropriate groups before introducing new agents, slowness to recognise complications and the inappropriateness of the American system of compensation. The study the artificial heart introduces the problem of the development of high technology relevant to only a few at the expense of initiatives of wider general usefulness and, with the discussion on genetic engineering, looks at the increasing influence of commercial involvement in medical research. The study of the development of a vaccine for swine 'flu shows on what flimsy bases programmes are sometimes based and how valid dissent may be silenced for political or economic considerations. These illustrative cases are well-chosen, often fascinating to read, and sometimes devastating. Only the discussion on genetic engineering is less than satisfactory – probably because the retrospective dimension to assess its impact is lacking. The conclusions she draws seem of immediate relevance to the situation in which the British system of health care now finds itself, with a need for public participation in medical decision making, independence of research from commercial interests, and greater emphasis on provision of basic and preventative medical care to those whose interests are poorly represented by powerful medical or political lobbies.

I think this is an important book though it will probably not get as wide a reading in the UK as it deserves. I should like to send a highlighted copy to the authors of the White Paper on the National Health Service to suggest the direction in which its proposals might lead.

Ann Barrett

The Power of the Powerless

A brother's legacy of love

Christopher De Vinck

Hodder & Stoughton, 1989, 152pp., £2.50, Paperback, ISBN 0 340 50260 6

This book began life as an article for *Reader's Digest*. That says just about everything one needs to say about its style, content, scholarship and readability. That article was, in the event, printed in the *Wall Street Journal* and the *New York Post*, and only later in the *Reader's Digest*. It prompted reaction from numerous people including President Ronald Reagan.

In the article the author wrote about the impact on his own life of the life and death of his severely handicapped brother. Oliver lived for 32 years, was blind, mentally handicapped and permanently bedridden. He could say nothing and do nothing. Oliver's dependence and his family's full acceptance of him was movingly described. The book is an enlargement of the article. It is more of an autobiography than a biography, more about the author and his response to Oliver than about Oliver himself. Among the many correspondents who contacted Christopher De Vinck after reading the article were some with similarly dependent sons and daughters. Their stories were also told in the book. They too affirm the value to themselves of a handicapped person in the family.

The experience of relatives of handicapped people might reasonably be expected to result in bitterness. While that does occur it is not the whole story. The author tells of the positive result of bearing and living with severely dependent sons and daughters, brothers and sisters. The pressures and demands are great, often exhausting. The disappointment of oh! such slow progress is at times overwhelming. But alongside of this the immense joy at every sign of recognition and appreciation, the sense of privilege at learning so much about life which would otherwise have been missed, the greater value placed upon things which are ordinary. Mr De Vinck brings this out strongly.

His book is interesting and gripping. I found it generally disappointing. It failed to explain how it was that powerless Oliver had power over his family. It did not address the issue of his personal value and what contribution he made to his family and social circle. The reader is offered mystical, quasi-religious and subjective considerations. Nothing to hold, to look at, to understand. Throughout the book one is left with the feeling that Oliver is somewhere upstairs in his own room and we are only allowed to know him secondhand.

Handicap raises serious issues which need to be addressed. Abortion, infanticide, and euthanasia are advanced as the solutions to handicap. The strength and seeming humanity of the advocates of these solutions deserve reasoned response. Scripture can provide the framework we need in asserting the value of people with handicaps, validating their place in society (and the church). A mystical or subjective appreciation will prove inadequate.

David C. Potter
Reading.

REVIEWS

Unholy Sacrifices of the New Age

Paul de Parrie and Mary Pride

Crossway Books 1988, ISBN 0 89107 482 1.

This book associates the generally acknowledged increase in influence of the 'New Age' movement and the tendency of medical science to view human life only in terms of its relative value to society. The argument is that if the majority of people are not bound by any absolute values there is nothing to prevent all kinds of evil forces from exerting unfettered influence over the way in which medical techniques are used in the control of human life.

There are horrific descriptions of human sacrifice, both imaginary and factual. These are placed in conjunction with accounts of modern abortion practice and some people's demand that handicapped children and the infirm should be despatched. The current advocacy of euthanasia by humanists is well known but the claim that the New Age movement is wedded to the concept of eliminating the unfit and the 'ignorant' – supported by arguments from Maharishi Yogi and the pre-nazi German lawyer Karl Binding – will come as a surprise to many. The New Age movement is equated with paganism and the authors set out to show that the current trends in science and medicine are moving towards implementing pagan practices.

A very strong emotional atmosphere is created in which the validity of the arguments become hard to assess rationally. None the less the central question is put clearly – Is an unborn or deformed baby an object that can be disposed of at will or is there some value in every living individual however early in development or handicapped that we should respect? (My paraphrase.) It also sets out to expose medical scientists who use the tissues of aborted babies for research or transplantation as 'neo cannibals' and claims that there is a 'New Age' plan to eliminate all Christians.

On a more positive note, the chapter headed 'Holy sacrifices' sets out very well the challenge to Christians to care for the defenceless, sick and disabled, following Christ's example.

The book is clearly aimed at a broad non-academic readership who will not be too critical of arguments that move from quotation to speculation with little logical connection. It starts with a foreword stating that 'every day reports come in from... around the globe... of satanic sacrifice, witchcraft rituals, murder, and butchery.' There are, apparently, child and animal sacrifices in San Antonio, teenage satanic cults in Dallas, and demonic sex orgies in Florida. These and atrocities that result from them are said to be evidence of the growing kingdom of Satan and in particular there is a movement towards pagan sacrifice unopposed by police, judges and the media who, it is suggested, even encourage it. This is followed by the description of an imaginary pagan human sacrifice. Baal is back, we are told, in the form of unholy sacrifices... not just the elimination of an unwanted pregnancy but the sacrifice of the unborn baby to the devil.

The book is divided into five parts – 'Those old time religions', 'To live and die in the New Age', 'Cannibal rites and wrongs', 'Prepped for sacrifice' and 'Holy sacrifices'.

This book is difficult to assess objectively – it contains a large numbers of references ranging from established medical journals and the writings of Kubler-Ross to *Parade* magazine. These are

used in a random and incoherent manner to bolster very speculative statements and imaginative descriptions charged with emotion.

There can be no quarrel with the two initial premises. Firstly that there is an increasingly utilitarian attitude to human life in our society and in particular that fetal tissue from aborted healthy babies of 'test tube babies' can be used for treatment and experimentation. Secondly, that there is an increase in the activity of satanists, the New Age movement and occult practices in general. What is harder to accept is that there is a systematic merging of the two whereby the geneticist or specialist in reproductive biology become modern priests of Baal sacrificing the defenceless young to Moloch. Implausible as this seems one is left with the uneasy feeling that perhaps such a manipulation of modern biological science by evil forces could actually happen or is happening – so C.S. Lewis was not completely in the realm of speculation in the picture he painted in *That Hideous Strength*.

The manner of writing and presentation does nothing to make the arguments of the book plausible – and at places sinks to rank sensationalism. This is sad as the issues that are raised deserve serious and credible treatment. It will unfortunately give the opponents of Pro-Life movements grounds for accusing them of sensationalism and lack of rational argument and will be unlikely to change the minds of the uncommitted.

Dr P.K. Buxton, FRCP
Edinburgh.

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