Ethics & Medicine

A Christian Perspective on Issues in Bioethics

7:1 SPRING 1991

ISSN 0266-688X

COMMENT

From Pekka Reinikainen M.D., Helsinki, Finland

Biotechnology and Warfare

Crude use of biological organisms as weapons goes back millennia – the ancient Romans were known to foul the wells of their enemies with animal carcasses. In 1347 the Tartars captured the city of Caffa by using catapults to hurl the corpses of soldiers killed by the bubonic plague over the city walls. They did not understand the etiology of the diseases these tactics caused, but their impact was never in doubt. The only major modern use of biological weapons, however, was by Japan during World War II. In their invasion of China, the Japanese used a variety of biological warfare agents, causing thousands of casualties. The United States, the Soviet Union, Great Britain and most other major powers built sizable biological warfare research and development programs in the early 1940s.

The Geneva Protocol on chemical and biological weapons, written in 1925, was a great step forward. It is essentially a no-first-use treaty, with many nations reserving the right to retaliate in kind.

This pioneering 1972 agreement marked the first time in world history that people banned an entire class of weaponry.

The problem of biological warfare was widely thought to have been solved once and for all by 1972 Convention on biological and toxin weapons. This pioneering 1972 agreement marked the first time in world history that people banned an entire class of weaponry. The reason that military and political leaders allowed the treaty to be signed was the same reason why biological warfare had seen little action in modern warfare, namely biological weapons are inherently difficult and dangerous to store, handle and disseminate effectively. Because it is virtually impossible to control or even predict the spread of this kind of warfare, and because their effect is usually slow acting, living organisms are almost always useless as battle weapons and highly problematic as weapons of retaliation. The major powers were probably also enthusiastic about banning biological warfare, because such weapons could give small nations great destructive power quite cheaply. It is in the interest of the great powers to keep war expensive.

The advent of recombinant DNA-technique in the mid-1970s however had an important impact on perceptions of the potential of biological warfare, because in the past there were only a very limited number of biological agents that could be used as weapons. A viable biological weapon must namely be highly virulent, robust in the environment; stable during storage and amenable to dissemination. Biological weapons should allow for no easy medical countermeasures, but the attacker must have effective medical defense against it. Moreover, an ideal weapons agent should be suitable for secret dissemination and offer the attacker a degree of plausible deniability.

We have been delighted by the response to our Appeal of last year for financial support to develop the work of *Ethics and Medicine*.

One special area in which we are keen to establish new contacts is Eastern Europe. We plan to mail complimentary copies of this journal to all medical school libraries in Eastern Europe and the Soviet Union, starting with this issue. We hope also to be able to make subscriptions available to doctors and others who may not have access to convertible currency. Any subscribers to *Ethics and Medicine* who wish to support this project may care to send a gift (for example, one or more further subscription(s)), designated for this purpose. Subscribers may also be able to help us by letting us have the names and addresses of potential recipients.

The Board of *Ethics and Medicine* is actively exploring the possibility of meetings and perhaps conferences in these countries as well, though much more substantial funding would be necessary. Comments and offers of help from subscribers will be greatly welcomed.

Editorial Board

The new genetic technologies have made it possible, for the first time, to have a potentially limitless range of mutated organisms that could circumvent existing medical countermeasures, such as vaccines and drug therapies. And advanced bioprocess techniques mean that relatively safe, cheap and rapid production of pathogens and biological toxins is now within the grasp of most nations.

While these technical advances are significant, they do not solve the problem of controlling organisms that can multiply in the environment. The release of deadly organisms that can survive in the environment and mutate to bypass a protective vaccination could infect the attacker, too.

Despite these potential dangers, however, military planners may believe that they could construct a sufficiently targetable and controllable weapon and in this way the new genetic technologies have changed military perceptions of utility of biological warfare. The offensive advantages of the new technologies, combined with military perceptions that biological warfare is now a major threat, have made biology a dangerous and potentially destabilising factor in war scenarios.

The 1972 Convention was written as a good-faith argument lacking mechanisms for enforcement or verification and while it prohibits stockpiling of biological or toxin weapons, it allows research of any

kind. With the advent of recombinant DNA, military leaders suddenly had a powerful new incentive to exploit that 'loophole' in ways potentially hazardous to public health and provocative to enemies. The difference between offence and defence in this type of research is usually in the eye of the beholder.

Molecular biologist Keith R. Yamamoto of University of California has reported studies that involve making small changes in the surface structures of deadly organisms, ostensibly as a means of trying to develop vaccines to those individual agents. Such changes could evidently also lead to the production of a biological weapon that could make vaccines ineffective.

With the advent of recombinant DNA, military leaders suddenly had a powerful new incentive to exploit that 'loophole' in ways potentially hazardous to public health and provocative to enemies.

Efforts to understand the biochemical mechanisms by which toxins operate could simultaneously lead to production of super-toxins. One could couple a toxin that poisons a cell and another toxin that inactivates the cell's enzyme responsible for degrading the first toxin. Hormone and bioregulator weapons could also eventually be produced by the recombinant DNA technique.

Who would use such weapons and why? Developing nations often lack a sophisticated public health infrastructure that would minimize the impact of a biological attack. Desperate governments fighting for survival might also be tempted. Consider Iraq, which has already exercised the chemical option regardless of legal and moral constraints. The UN was powerless and international legal action was nil. Today Iraq is second only to US and Soviet Union as a chemical warfare superpower and also has an army of one million. With Iraq's modern rockets, superguns and SU 24 bombers all nations of the area are seriously threatened with massive casualties without being able to adequately defend themselves.

Defensive or offensive research?

It is usually claimed that research is defensive in nature. But to produce a vaccine against a biological warfare agent, one must use and reproduce the agent itself. For vaccines against potential new threats, those novel agents must be synthesized in order to understand their essential characteristics. In order to understand which agents could effectively be used as weapons, a well designed defensive program would study each potentially threatening agent's infectivity, stability in storage, environmental persistance, and ability to be grown in large quantities *etc*.

Biological research by itself may seem ambiguous or provocative, but becomes a real threat when linked with a strategy that has no realistic hope of success. It was difficult enough to develop vaccines against microbes in the old days, but the vaccine strategy is self-defeating in the age of recombinant DNA because it is impossible to anticipate the almost limitless variety of new microbes that could be created by genetic manipulation of existing organisms. Even if the new microbes were known, it would be impossible to develop the thousands of vaccines needed. Most experts do not consider the development of new biological warfare agents a simple matter, but they agree that producing vaccines against such agents is a vastly more complex and time-consuming task. Scientific developments in recent years seem to favour offence over defence. Paradoxically, the greater the efforts towards defence, the more likely it is that offensive applications will result.

Today widespread biological and chemical arms proliferation, particularly in countries like Iraq and Libya, is a matter of grave international concern.

If vaccines could be developed, how would they be administered? Their incubation periods mean you would have to anticipate an attack months in advance. How could mass vaccination projects be concealed from the potential attacker who would then simply choose another microbe? It is clear that effective use of vaccines would be impossible.

Today widespread biological and chemical arms proliferation, particularly in countries like Iraq and Libya, is a matter of grave international concern. The use of chemicals in modern warfare has become a reality with the horrendous attacks by Iraq and it is very alarming that no action was taken either to prevent or to condemn it. The poor man's nuclear weapon poses a formidable threat in the future and its manner of destruction of life and not property reminds one of the ominous threat from neutron bombs. Finland has developed a system for monitoring the use of chemical weapons but the task of developing an effective surveillance system for biological warfare remains as yet unsolved.

References:
Piller C., Yamamoto K.R., *Gene Wars: Military Control Over the New Genetic Technologies*, 1988.
Piller C., Lecture given in Helsinki, 2 July 1990.

Matters of Conscience

Pamela F. Sims, Consultant obstetrician and gynaecologist, Hexham, Northumberland

Section 4 of the 1967 Abortion Act states that 'no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection...'.

Background

It has long been felt by those of us working in the field of gynaecology that there was discrimination against doctors holding a pro-life position. As in the case of discrimination on grounds of race and sex, it is always difficult to prove. How has the present situation evolved since 1967?

It has long been felt by those of us working in the field of gynaecology that there was discrimination against doctors holding a pro-life position.

After the Abortion Act was passed the Chief Medical Officer wrote various letters to the Regional Medical Officers (who are responsible for employing consultants) seeking to amplify the practical outworking of the law. On 19 February 1975 the CMO wrote: 'Where it can be established after consultation with the relevant specialist advisers that there is a demand which cannot be met and where patient care would suffer if a doctor appointed to a particular vacancy did not feel able, on grounds of conscience to be involved in, or advise on, the termination of pregnancy it may be stated that the post includes duty to advise on, undertake, or participate in termination of pregnancy.... No reference to such duties should be included in the advertisement of such a post'[1] but prospective candidates should be able to refer to 'further particulars' i.e. the job description. Note, the (then) DHSS was to be informed whenever such wording was used.

The Select Committee on Abortion published its First Report from the House of Commons in 1976. At that time they felt that certain doctors were being barred from a number of posts. They recommended that the CMO's 1975 letter should be withdrawn and 'that any new guidance should emphasise that conscientious objection should not normally be a bar to appointment and that "exceptions should be made only in rare circumstances".'[2]

Thus the Chief Medical Officer wrote again on 16 July 1979. He felt that the procedures recommended in the previous letter had been working 'reasonably well' but he needed to 'clarify certain points'.

The CMO emphasised that termination duties should only be included in job descriptions if adequate services within the NHS were not already available. If they were, then termination duties should not be specified.

Guidance on interviewing procedure was given. The letter clearly states that: 'Unless the job description specifies that the duties of the consultant appointed include termination of pregnancy or advice on termination, candidates should not be asked whether they would be prepared to undertake termination of pregnancy.'

Regarding junior medical staff, that is any doctor 'junior' to consultant, the CMO is unambiguous: 'it is not necessary for training purposes...to undertake duties involving termination, and for this reason it would appear inappropriate for termination responsibilities to be included in the job description of junior staff. It follows that (juniors) should not be questioned prior to their appointment about their attitude to termination.'[3]

Recent Events

As abortion became increasingly commonplace during the 70's and 80's so it is likely that the CMO guidelines were waived on many occasions. In February 1988 the President of the Royal College of Obstetricians and Gynaecologists, Mr George Pinker, understated the situation in the College newsletter: 'there have been one or two unfortunate examples recently of Consultant Appointments in which there has been no mention of the need for termination of pregnancy duties in the job description and yet candidates have been questioned about this at interview. This is against the instructions issued by the Department of Health... I hope this recent rash of problems...will not continue.' However, his exhortations evidently went unheeded. By the end of 1989 there was clear evidence of three more instances of breaches of the CMO guidelines.

The Lancet of 8 April 1989 placed advertisements on behalf of Trent Regional Health Authority for two consultant posts in obstetrics and gynaecology. The following appeared: 'The successful applicants will each be expected to develop a special interest...for managing the District's abortion service within the terms of the existing Act. The undertaking of abortions will be shared amongst all Consultants in post.' Similar cases involved West Lambeth Health Authority, advertising for a consultant community gynaecologist and South Tees Health Authority advertising for a locum senior house officer. Both these appeared in the *British Medical Journal* on 7 October.

***The Lancet* of 8 April 1989 placed advertisements on behalf of Trent Regional Health Authority for two consultant posts in obstetrics and gynaecology.**

A member of the Christian Medical Fellowship, a consultant in a related speciality, became aware of the wording of the Trent RHA advertisement before publication. He informed CARE Campaigns who in turn reminded the RHA and Central Nottinghamshire Health District of the CMO guidelines.

'Despite this warning, the advertisements were printed, whereupon CARE Campaigns complained to Trent RHA. There was a weak apology, but recruitment continued on the basis of the discrimina-

tory advertisements printed, and interviews of short-listed candidates were due to be held on 5th June.

At this point CARE prevailed upon a sympathetic MP (Sir Bernard Braine) who contacted Mr Kenneth Clarke (Secretary of State for Health) directly. On Friday, 2nd June, on the last working day before the interviews, Mr Clarke intervened and cancelled the interviews and recruiting process, and ordered that the posts be readvertised.'[4]

In the wake of these events the Chief Medical Officer wrote another letter consolidating the advice given in his letters of 1975 and 1979. It was dated 11 October 1989 and simply reaffirms the message of the previous ones.
This 'rash of problems' to which the College President referred began to gain a higher profile in the media. The Social Services Committee of the House of Commons decided to hold an Inquiry into the application of the Conscience Clause of the 1967 Abortion Act, in particular seeking evidence as to whether recruitment into obstetrics and gynaecology is affected. Written evidence was invited from those of us who had directly experienced such discrimination, or witnessed it first-hand. But we were given very little time to respond. Individuals wrote, bodies such as the Christian Medical Fellowship and CARE – to whom we owe grateful thanks for bringing the whole matter to a head the previous summer – also submitted evidence. It was all in by the end of November 1989.

For once we were able to see an organisation such as CMF making its position clear. A range of positions on abortion is represented within its 4,000 members, nevertheless it was able to clearly state 'we believe there IS evidence for discrimination against those holding conservative views on abortion'.[5] This evidence was based upon the results of two surveys conducted by the CMF amongst its own members during 1986 and 1987.

CARE, in its submission to the Social Services Committee was able to refer to its 70,000 supporters. The CARE Report clearly outlines the recent development of 'an abortion culture', reminding the committee that as consultant gynaecologists retiré they tend to be replaced by those holding more liberal views. In the present climate not only is recruitment to the specialty affected, but also the training and professional advancement of young nurses and doctors. Both CARE and CMF expressed concern over a wider range of issues than would appear to be immediately relevant – from the recruitment of medical students to the secretary who is unwilling to type letters referring patients for abortion.

I submitted my personal testimony, recounting my experience as a registrar in a large London hospital. I was applying for senior registrar posts at the time and was actually told by my consultant that 'I would never get a job while I held those views'.

I submitted my personal testimony, recounting my experience as a registrar in a large London hospital. I was applying for senior registrar posts at the time and was actually told by my consultant that 'I would never get a job while I held those views'.

Oral Evidence

The Social Services Committee sought oral evidence from various sources. Firstly they sat with representative members of the Department of Health. That meeting took place on 10th January 1990. In the Chair was Frank Field, the rest of the Committee comprised Andrew Bennett, Jerry Hayes, Ian McCartney, Geoffrey Pattie, David Price, Roger Sims, Ann Widdecombe, and Nicholas Winterton. This Committee was altered slightly when oral evidence was taken on 21st March 1990; Jerry Hayes and Ian McCartney were replaced by Martin Smyth and Audrey Wise.

From the published Report of the Minutes of Evidence of the first session, it would seem that the Department of Health has most certainly not been fulfilling the requirements laid down in the 1975 CMO guidelines. They had not been effectively monitoring medical job descriptions and advertisements. Mr Roy Cunningham, Assistant Secretary, Department of Health, stated the following in response to the challenge from Ann Widdecombe as to whether the DoH is 'doing their job which statutorily they are obliged to do?' – '... It is possible with the passage of time the advice issued in the late 1970's had fallen into some kind of disuse in the Health Service.'[6]

The problem of nurses holding to a position of conscientious objection was also explored. Daphne Patey, Principle Nursing Officer, was of the opinion that the Conscience Clause of the Abortion Act was working out satisfactorily for nurses. Naturally Ann Widdecombe had evidence to the contrary! It is worth remembering that numerically very many more nurses than doctors could be affected by the Abortion Act simply because there are very many more nurses than doctors. However, nurses are much more likely to move jobs or take a break from their career than doctors; certainly once they have become established in a definitive post.

The second session of oral evidence before the Social Services Committee took place on 21st March 1990 and heard evidence from doctors. Some of us who had earlier submitted written evidence were given the opportunity to amplify our position.

Four gynaecologists, John McGarry, David Paintin, Timothy Rutter and Wendy Savage were the first to be examined by the members of the Social Services Committee. They were of the opinion that doctors were not being discriminated against on the grounds of conscientious objection to abortion. The three consultant gynaecologists (all except Timothy Rutter) were at pains to explain that they regularly appointed junior doctors who did not perform abortions, on the grounds that they were otherwise well qualified and had other qualities to offer. They presented glowing statistics showing that they did much of the abortion work themselves. In discussion there was a tendency to veer off the point (the implementation of the Conscience Clause) towards the pros and cons of abortion itself and current practice in the UK.

Eventually it was the turn of 'our side' to give voice to the other point of view. Representing the view that discrimination is in fact rife was family planning doctor, Naomi Bankole; recently (at long last) appointed consultant gynaecologist, Jonathan Brooks; teaching hospital consultant (Birmingham) John Kelly; general practitioner, Adrian Rogers and myself. One by one we were placed under the spotlight and quizzed – fairly mercilessly at times – about our

respective positions. Not all of us held quite the same views, and indeed the waters were even muddied by the issue of freemasonry by Jonathan Brooks!

We had met as a group shortly before going to the House of Commons but were somewhat unprepared for the questions. A view was emerging by the end of the questioning of both sides which was to prove quite worrying to onlookers (particularly friends from SPUC, Society for the Protection of the Unborn Child). The Committee was wondering whether the answer to the problem of doctors not wishing to do abortions, and for the women wishing to obtain them easily, would be to separate abortion services from the rest of gynaecology.

Both sides felt this might possibly be an answer, though speaking for 'our side' we had not been able to give this due consideration beforehand. SPUC worried that this could pave the way for even more 'abortion on demand' than we have at present. The presence of anti-abortion doctors within the system has a braking effect, which once removed could possibly result in an increase in abortion numbers. This is conjecture, however, as one could argue that there might be a new stigma for those undergoing abortion, perhaps even having an inhibitory effect.

On a broader level one could also argue that there are many controversial areas in medicine – are they going to hive off other bits of medical practice into separate units when too many of us object?

It would seem that the way ahead is to establish a clearly defined complaints procedure – as has been done in the areas of sex and racial discrimination. Young doctors, and the older ones on interviewing committees should be made aware of the existence of this and of course there should be appropriate ways of dealing with offenders. One or two cases going through a year would serve to raise everyone's sensibility.

We do not yet know the final outcome of this Committee's deliberations, nor whether there will be any material difference in the way the doctors and nurses who hold anti-abortion views are treated. Meanwhile we can but hope and pray.

Post-Script

Since writing the above the House of Commons has finally published their Report (HC 123, Social Services Committee, Tenth Report, Abortion Act 1967 'Conscience Clause', 24 October 1990).

The conclusion and recommendations are extracted as follows:-
(clause) 41. ...some form of conscience clause is necessary.
42. ...We welcome the fact that the Department of Health has instituted a monitoring system for advertisements for consultant posts and we believe that this should prevent any future breaches of the guidance.
43. ...it has to be accepted that such discrimination does take place, although... very difficult to prov.....
44. We are unable to see an easy remedy.... .
45. The Committee were very concerned about those... who did not want to do more than their fair share of abortion work,... unhappy at the appointment of staff who would want to exercise their right to object, since inevitably this would increase their abortion work.
46. Conscientious objection is not just a matter for doctors.... We ***recommend that the Department of Health considers extending the provision of section 4 of the 1967 Act to cover some ancillary staff.***
*47. ...****recommends that the Department of Health should bring forward proposals to delete the provision that the burden of proof of conscientious objection shall rest upon the person claiming it.***
48....at medical school.... ***Candidates should not be asked such questions and we recommend that guidance to this effect is issued to medical schools.***
*49. ...wide variation in provision of abortion service from one authority to the next. ...****We recommend that the Department of Health should continue to monitor the working of the abortion service from region to region.***

Footnotes

1. Letter from the Chief Medical Officer, Department of Health and Social Security, 19 February 1975.
2. Select Committee Report of 1976 referred to in Social Services Committee, Abortion Act 1967 'Conscience Clause' Minutes of Evidence, 10 January 1990, HMSO, page 1, para. 6.
3. Letter from the Chief Medical Officer, Department of Health and Social Security, 16 July 1979.
4. CMF letter to all Consultants and Senior Registrars in Obstetrics and Gynaecology, 8 June 1989.
5. CMF Memorandum to the Social Services Committee, November 1989.
6. Social Services Committee, Abortion Act 1967 'Conscience Clause' Minutes of Evidence, 10 January 1990, HMSO, page 7, para. 9.

Embryo Research and Abortion – the Arguments that Swayed Parliament

David S. Short, Emeritus Professor in Clinical Medicine, Aberdeen

Over April 23rd and 24th last year, Parliament voted on two key **issues in the** Human Fertilization and Embryology Bill.

On April 23rd, the issue was basically whether embryo experimentation should be permitted up to 14 days (subject to strict regulation) or whether it should be forbidden altogether. The voting was 364 to 193 in favour of allowing experimentation.

On April 24th, the issue was whether abortion should continue to be permitted up to 28 weeks or the limit be reduced to 24 weeks. The voting ended with a majority in favour of setting the limit at 24 weeks; with certain exceptions such as severe fetal handicap or danger to the mother, in which cases the pregnancy might be terminated at any time up to birth. This debate, although ostensibly about the deadline for abortion, threw up all the main arguments for and against abortion.

Although there was inevitably a certain amount of rhetoric, the general standard of debate was high. So the arguments on both sides are worth studying with future action in mind.

The arguments advanced in favour of embryo research

1. The most powerful argument advanced was that of beneficience; or, in Christian terms, love for our (post-natal!) neighbour. The distress of infertility was emphasized, and the fact that IVF had had many outstanding successes (37, 38, 49, 70, 77[1]). Further improvement in the treatment of infertility, the hope of reducing the number of births of handicapped children, and the promise of more effective contraception were urged as the main reasons for continuing research. Such research inevitably involves the possibility of destruction of the embryo; mere inspection is inadequate (45).

2. It was argued that the contraceptive intra-uterine coil acts by destroying the early embryo, and this is already legal.

3. It was also stated that in IVF work there are inevitably spare embryos, some normal and some defective, which would be wasted if not used for research (48, 84).

4. The proponents of embryo research considered that the embryo was not really significant until the 14th day; being undifferentiated, minute, prone to twinning and, in any case, a large proportion perish naturally (33, 34, 59, 80, 83, 226). For these reasons, the Secretary of State, who opened the debate, and is by training a lawyer, argued that legal protection was 'not appropriate' until much later than 14 days (42).

5. One speaker brushed aside ethical objections by stating that in the past many important and valuable medical advances had initially been delayed by ethical objections (77).

Comment: Although never stated, the lure of research into the unknown must be regarded as a motivating force. Research is, of course, commendable if conducted in a manner worthy of God's regent, but unworthy if undertaken primarily for reasons of selfish ambition and prestige.

Arguments advanced against embryo research

1. The main argument advanced against embryo research was a belief in the sanctity of human life from conception (fertilization) (67, 70, 72). Against those who argue that at the morula stage half the cells are destined to form the placenta rather than the fetus, one MP drew the analogy of an orange, which is not rejected even though some of it is peel (67).

2. It was urged that in view of the uncertainty with regard to its status, the embryo should be given the benefit of the doubt.

Several MPs pointed to the danger of a 'slippery slope' situation. Fourteen days is a limit made to be breached, because it has no firm rationale. Sir Bernard Braine, the Father of the House, cited the Nazi experience.

3. Several MPs pointed to the danger of a 'slippery slope' situation (41). Fourteen days is a limit made to be breached, because it has no firm rationale (84). Sir Bernard Braine, the Father of the House, cited the Nazi experience (54).

4. Against those who stated that a ban on embryo research would bring advance in IVF to a standstill, it was stated that:–
a) IVF could be further improved without destructive research (49).
b) 95% of the research needed could be done without the use of human embryos (85).
c) There are alternative techniques of IVF which avoid the creation of excess embryos – and also have the advantage of avoiding the side effects of super-ovulatory drugs (55).

5. It was pointed out that embryo research cannot cure genetic diseases (50).

6. Children conceived by IVF have a greater risk of abnormality and greater peri-natal mortality than those conceived naturally (51). (Further evidence for this was published in the *British Medical Journal* 3 weeks later).

7. One MP pointed out the vested interest of drug companies.
Comment: It has been stated that for any meaningful research, a few 'spare' embryos would be totally insufficient: thousands would be needed.
No one clearly answered the objection that to continue IVF as at present generally practised without destroying any embryo would

involve the preservation and even the use of defective embryos. Perhaps someone could have repeated the adage: 'Thou shalt not kill, but needst not strive...'.

The arguments for abortion

1. The argument which came across most strongly was that abortion was a woman's right. One MP went so far as to say that she would not put any limit to the right of a woman to an abortion (232). Another MP took the opportunity to attack Christianity for its allegedly misogynous attitude (229–230).

2. The other argument which was urged equally strongly was that to restrict abortion in any way would be to open the door to 'back street' terminations with their tragic morbidity and mortality (202).

3. Selective abortion of abnormal fetuses was urged on the ground that the life of a handicapped child is hard both for the child and the mother (238) so that such births should be prevented where possible.

4. It was claimed that the UK rate of abortion was not high by international standards (202).

5. Although not strictly relevant to the debate, it was urged that since early abortion was simple and safe, it should be available on demand up to 12 weeks.

The arguments against abortion

1. The fundamental argument was that abortion is the destruction of innocent human life for insufficient reason (210, 211, 238). Human life is sacred, and if it is not considered as meriting protection from the time of conception, it surely does do so later (232, 252).

It is undeniable that fetal life is now taken for the most trivial reasons. Indeed, in many areas, there is virtual abortion on demand. Even David Steele voiced concern over the rise in the number of abortions over the past two years.

It is undeniable that fetal life is now taken for the most trivial reasons (208–210). Indeed, in many areas, there is virtual abortion on demand (249, 255). Even David Steele voiced concern over the rise in the number of abortions over the past two years (204).

2. The admittedly tragic deaths of a score of mothers each year from 'back street' abortions prior to 1967 has been exchanged for the current annual slaughter of 200,000 unborn babies.

3. Abortion is not always the answer to the mother's problems (238, 252).

4. Abortions consume scarce resources (253).

5. It is illogical that embryos over 14 days should be protected whilst fetuses are vulnerable (223).

6. The legalizing of abortion puts doctors in an invidious position. Many pro-abortionists pointed out that each abortion was undertaken with medical approval (205, 232, 247–250). The fact is that the profession can scarcely do otherwise. The concept of medical support is, in many cases, a 'legal fiction' (252).

[1] The figures in brackets refer to the corresponding columns in Hansard.

'Too Busy for Ethics'

G. Raymond Selby, Milverton, Somerset

The title of this article appeared as headlines in several national newspapers in late 1989. Anyone reading the information appearing under that headline might have been surprised to find that it was not concerned with the worlds of commerce, industry or politics, but with medicine. A doctor, who was described as a leading kidney surgeon, appearing before the General Medical Council's professional committee, was described by a witness as being 'too busy for ethics'. One wonders if a stunned silence followed this declaration. Two questions were immediately raised in my mind on reading this report. The first was 'Is there any necessary connection between medical practice and ethics?', and secondly, 'Has any human being the right to be "too busy for ethics"?'

A doctor, who was described as a leading kidney surgeon, appearing before the General Medical Council's professional committee, was described by a witness as being 'too busy for ethics'

That the first question could even be asked must shock many medical practitioners. They could point out, rightly, that historically speaking, the medical profession has always seen itself as an ethical profession. I am fortunate in that I have several doctors amongst my immediate circle of friends, and they are amongst the most honourable, ethical, and, in fact, Christian people I know. Without a firm ethical basis the practice of medicine for them would be impossible.

Nevertheless, in the recent years of great medical, technological achievement, it is difficult to resist the conclusion that those who have been in the forefront of those remarkable developments, seem to have tried to work without the rudiments of first principles in the ethical sphere. In fact these people seem to have assumed that, in general, ethics were just not their business. This brings us to my second question, 'Has any human being the right to be "too busy for ethics"?'

In order to attempt to answer both of these questions we need to provide ourselves with a basic definition of ethics. It is difficult to suggest a more basic definition than that the ethics are concerned with what might be described as the 'oughtness' of life. It is not difficult to demonstrate that there is a near universality in the use of the 'ought' in human life. No matter how thoroughly past moral codes are rejected by radicals of every age, the word 'ought' is never totally eliminated from their vocabulary. A mundane, yet contemporary illustration of this fact may be seen in the 'agony' columns of newspapers, and even *avante garde* magazines. Individuals who have thrown over almost all traditional values still ask their chosen oracle if they, or more often their partner, friend or relative 'ought' to do a certain action; usually an action which the questioner finds repugnant.

Moral and ethical systems have developed from a consensus of 'oughts'. The great traditional ethical codes have been built upon foundations which have taken centuries to construct. This construction has been upon the basis of both conscious decisions, and subconscious awareness of the needs of individuals, and, even more so, of societies. Many sophisticated ethical beliefs are just the 'tip of the iceberg', based upon much ethical thought and experience. In our present culture many ethical beliefs have been jettisoned simple because the foundations are, as it were, out of sight. Because the bases of many deeply held and significant ethical positions have not been immediately apparent, contemporary radicals have assumed that there were no sensible or systematic bases for these beliefs, and have, therefore, claimed immunity from as many ethical inhibitions as they chose. However, whilst this freedom is not infrequently claimed, in practice it is limited by the 'oughtness' which is part and parcel of the same radicals' thought structure. This does mean, however, that little can be taken for granted, and, in so much ethical discussion, a foundation has to be laid. There is, as the author of the epistle to the Hebrews says in another context, a need to teach again the rudiments of the first principles, and to feed with milk those who should be able to digest solid food.

Ethics and morality, therefore, are to do with the 'oughtness' of life, and our major concern will be to ask what then, if any, are the 'oughts' of medicine? But first, more needs to be said about 'oughtness' itself. Moralists have long debated the basis of the 'ought' in human society. Some have sought to demonstrate that its basis is enlightened self-concern. Others have emphatically denied such a basis. An analogical illustration may help us to adjudicate on this issue.

Ethics and morality, therefore, are to do with the 'oughtness' of life, and our major concern will be to ask what then, if any, are the 'oughts' of medicine?

In the growth of a child there is much to be said for the belief that, in microcosm, the development of the human race is re-capitulated. For instance, a child has to come to an understanding of the 'ought' through enlightened self-concern. It has to learn that some things are right and that some things are wrong, often through bitter, and even painful experience. Such experiences assist, but do not create, the development of what mankind has called the 'conscience'. Indeed, small children frequently have a very developed sense of the 'ought', even if the content of their 'oughtness' does not coincide with that of their parents, or the outside world. Similarly, the human race may be said to have had to develop much of its understanding of morality by enlightened self-concern. These beginnings should not be despised, but neither should it be uncritically assumed that self-concern is the basis for the whole of morality. A little thought can easily demonstrate the falsity of such a position.

Take, for instance, a situation where a child falls from the bank into the river, and is in imminent danger of drowning. Two men, also, are standing on the river bank, neither of whom is a very good swimmer. One man jumps into the river in an attempt to save the child, even at the risk of his own life. The other remains rooted to the spot. Observers will commend the first; he did what he ought to have done. They will similarly condemn the second man; he did not do what he ought to have done, but showed complete self-regard and concern. This would seem to indicate that 'oughtness' implies a concern for others, rather than for oneself. The advocates of enlightened self-concern as the basis of morality, however, might well argue that what has been forgotten in this illustration, is the corporateness of mankind, and of human society. The impulse to save the child, they would argue, still comes from enlightened self-concern, because without the continued existence of the child the future of the tribe, clan or society would be imperilled.

Such an argument, though, falls to the ground on two counts. First, the action to save the child must be either instinctive, the result of a rational process of internal argument, or a response to conscience; that is, to the power of the 'ought'. If it is instinctive, based upon a long development of tribal consciousness, it has to be asked why did not both men obey the instinct and jump in? If it is the result of an internal, rational argument as to the importance, or desirability of rescuing the child, how did the first man have time to rehearse this internal argument, and so quickly take immediate action? It can only, logically, be concluded that the first man jumped into the river to save the child in response to the promptings of his conscience, whilst the second man rejected the promptings of his conscience.

The influence of the teaching of Jesus has been paramount in the development of the contemporary attitudes towards children which we find normal and unexceptionable.

The 'enlightened self-concern' argument is essentially utilitarian. But even from a utilitarian point of view the grown man is of much more value in any clan or community than is the child. The child might, in any case, die from other causes before reaching maturity. Furthermore, it is still a dependent upon the social economy, and will be so for many years. The grown man, on the other hand, is a contributor to the economy, and a potential defender of the clan. What is more, it is likely that he has the capacity for begetting other children. In passing it is worth remarking that it is frequently forgotten by utilitarian advocates, that past societies have not valued children, other than as potential economic assets, as does our society. The influence of the teaching of Jesus has been paramount in the development of the contemporary attitudes towards children which we find normal and unexceptionable. It is evident, therefore, from what has now been said, that the argument that ethics and morality are based upon enlightened self-concern has an internal inconsistency.

Ethical attitudes and codes of moral behaviour do contain elements of enlightened self-concern. It could not be otherwise for each self is a basic cell in the structure of human society. But developed ethical systems such as that which is based upon Christian teachings and, in the past, has been the foundation upon which Western civilisation has been built, greatly transcend, whilst still containing, the self-concern element. The higher the ethical system, the less the part played by self-concern. In other words, the 'oughtness' of all ethical systems is an essential part of the human condition. Without this 'oughtness', without an ethical element in one's life, a person ceases to be truly human. We find, therefore, an emphatic answer to our question 'Has any human being the right to be "too busy for ethics"', and this emphatic answer is 'No'.

If the answer to that question has such a universal application, our first question 'Is there a necessary connection between medical practice and ethics?' can only be answered in the affirmative. But the answer to this question must go much further. In the illustration used above, the ethical action of the first man demonstrates a desire to serve others. In fact it becomes evident that the higher an ethical system, the more concomitant it becomes with the desire to be of service to others. It must be argued, therefore, that the very basis of medicine and medical practice must be an ethical basis, because it begins with and from, and continues with a desire to serve others, especially the unfortunate who are suffering from pain and disease. If medicine departs from an ethical basis it ceases to be a humanistic discipline, and abandons its whole purpose and ethos.

For the leaders of medical technology to have assumed that ethics was not their business is utterly illogical and inconsistent. Medicine is to do with mankind, and, as has already been indicated, 'oughtness' is an essential, and indeed, inescapable element in human existence. It is even more illogical when the extreme sophistication of modern medicine is recognised. Sophistication in medical practice must, inevitably, call for sophistication in ethics, but instead, whilst using the most delicate of medical techniques, the leaders of the developments in medical technology have tried to exist with only the bluntest of ethical instruments.

To an observer of the post-war medical scene, there seem to be only two beliefs which are held to have ethical implications for the medical world; to wit, that life is good, and that suffering and death are bad. Anything, therefore, which can prolong life, reduce suffering, and postpone death must be unconditionally good. The superficiality of such a view can be illustrated by a recent experience of the present writer. A ninety-two year old woman went to see her doctor after recovering from an illness. 'You are now in fine shape, Mrs X,' said the physician. 'I plan to keep you alive to see your hundredth birthday.' 'Then I shall change my doctor,' came the brusque, wise, and emphatic reply. It surely must come as no surprise that such a simplistic ethic cannot but be inadequate for highly sophisticated and complex medical activity in a highly sophisticated and complex society. Those members of the medical profession who have appeared to hold this ethical point of view might complain that, in adopting such a primitive ethic, they were only sharing in the moral malaise of the society and culture of which they are part, and which they seek to serve. However, such a complaint only demonstrates how urgent is the need for a penetrating ethical enquiry into the implications of the ethics for and of medical technology.

Such an enquiry would have to begin from such a question as 'What are the basic presuppositions upon which a consistent medical ethic can be built?' The answer to this question can only be provided by the explicit realisation that medicine is to do with human life. It is not primarily to do with technology. Therefore, the answer to this

question must be humanistic in the fullest and truest sense of that word. It must be concerned with the age-old question 'What is man?' It is only through a consideration of this question that the 'oughtnesses' of contemporary medical practice can be ascertained.

The question 'What is man?' is, of course, one of the most fundamental questions of human existence. It is not, however, a question which has overly concerned our late twentieth century culture. It is, for instance, far too metaphysical for much of contemporary philosophy. Yet it is difficult to see how any society can have a consistent ethical basis unless it is built upon a philosophical (and even, a theological) metaphysic of life, which includes a clear appreciation of the nature of human beings. Without such a basis, as we have argued above, it cannot be truly human. To be true to its foundations medicine also needs such a metaphysic as a basis for its ethical activity. Justifiably, though, those involved in advanced medical work, could claim that the search for such a metaphysic is not its responsibility. It could, in its own defence, point out that if some of its practitioners have been 'too busy for ethics', many philosophers, theologians, and other thinkers have been 'too busy to ask fundamental questions'. Those whose business it is to develop an acceptable twentieth century answer to the question 'What is man?' need to get on with that business. It would then be more possible for the medical profession to develop a careful and sophisticated ethical system, which would help them to face the many urgent ethical questions which challenge all those involved in the medical care of their fellow human beings.

To be true to its foundations medicine also needs such a metaphysic as a basis for its ethical activity. Justifiably, though, those involved in advanced medical work, could claim that the search for such a metaphysic is not its responsibility.

In the meantime, nevertheless, there should be a sufficient residual ethic to enable the medical profession to face up to some of the primary ethical and moral questions which others outside the profession see as besetting the practice of medicine at the present time. The episode with which this article began highlighted the growing commercial tendencies of some medical practice. From small acorns great oaks grow. Until recently it was considered unethical to advertise medical services. This change, in itself, is perhaps not very important, but the sale of human kidneys is. The spending of millions of pounds on an advertising campaign to resist changes in the N.H.S., (so reminiscent of the actions of the legal profession, and of the brewers when their *status quo* was threatened) raises real ethical questions, and the commercialisation of medicine in the U.S.A., which makes sickness one of the most financially hazardous experiences of American life, provides much material for ethical consideration. These are but a few, and perhaps the most simple of the many ethical questions which face medicine today. There are many deeper and more difficult ethical questions which are in urgent need of examination.

Of course there must be a fundamental connection between ethics and medical practice. In fact, because of the nature of medicine itself, ethics are more important to the practice of medicine than technological advance. Technological advances can dehumanise medicine, and it is not difficult to point to examples where this dehumanisation has already taken place. A vital and continuing concern with ethics is the only defence against such a scandal, and is the only moral basis upon which the practice of medicine can be built.

A vital and continuing concern with ethics is the only defence against such a scandal, and is the only moral basis upon which the practice of medicine can be built.

Is IVF Good Medicine?

Pauline Connor, Honorary Research Officer, Feminists against Eugenics

A paper presented at a Liverpool University Medical School Study Day on Embryo Experiments, March 1990.

In 1969 Dr Robert Edwards, the co-pioneer of asexual human reproduction, stated 'The social issues that emerge involve health, economics and law. The physical health of the patients does not demand that their infertility be cured.' ('Social Values and Research in Human Embryology,' Edwards and Sharpe *Nature* Vol. 231 May 14 1971 p. 87). As infertility is not a simple homogenous condition which can be classified as a disease, *in vitro* fertilisation can be most accurately described as a high-tech medical procedure deployed for social reasons. Also it is important to realise that IVF does not cure infertility. It simply remedies childlessness in less than 10% of patients who undergo the treatment.'[1] Any aspect of medicine that is practised ostensibly to meet a social desire, and *not for therapeutic* reasons, is not the sole province of the medical profession.

This is particularly relevant in the field of reproductive medicine and embryo experiments because the majority of claims made by the research lobby are speculative – what would be best described as the 'high hopes' school of science. Yet such high hopes, although influential in Parliamentary debate, are not the key issues. The main issue is that the acceptance of experiments on human embryos means the acceptance of experiments on women. As stated by Wagner and St Clair in *The Lancet*,[2] 'Until full appraisal of the short-term and long-term risks and estimation of efficacy, IVF/ET must be considered experimental.'

As stated by Wagner and St Clair in *The Lancet*,[2] 'Until full appraisal of the short-term and long-term risks and estimation of efficacy, IVF / ET must be considered experimental.'

The Hippocratic tradition demands that the principle 'first do no harm' governs the doctor-patient relationship and in its modern formulation the 1975 Declaration of Helsinki states that the interests of the patient must never be secondary to the interests of science or society.

At this point in the history of medicine the decision has been made that the guiding principle of doing none harm, in the name of science or progress, is negotiable. Reproductive engineering does not exist primarily to serve the patient but the patient exists to serve the aims of reproductive research. One illustration of this is the encouragement of women to act as gamete donors. In 1984 Dr Patrick Steptoe stated 'I hope volunteers who are being sterilised...will allow us to collect eggs from them' (*Daily Telegraph* 20th July 1984). Also, concern has been expressed that some women have been pressured into donating ova in exchange for free sterilisation (*Sunday Times* 14th May 1989 'Test tube clinics exploit women.').

At this point in the history of medicine the decision has been made that the guiding principle of doing none harm, in the name of science or progress, is negotiable.

Most of you will be aware that the IVF industry has spawned not only asexually reproduced children but fierce political debate resulting in Parliamentary approval of destructive, non-therapeutic embryo experiments up to 14 days after completed fertilisation. Such approval will not guarantee that the practice is safe for women. In fact, the issue of women's health has been largely ignored.
Before considering the merits, or otherwise, of IVF I must define what I mean by good medicine. Basically, it is that which does not result in the intentional death of the patient, medicine which heals, necessary treatment which has no intention of causing harm. It might seem like an old-fashioned definition but I haven't found a utilitarian equivalent which has the appeal of Hippocrates.

Is IVF Good Medicine?

It is essential to consider whether IVF is good medicine. The first question that must be asked is what sort of illness the patient is suffering from and what is the most appropriate form of treatment? Infertile women are not incomplete human beings and neither are they necessarily diseased because they cannot conceive children. If we decide that the childless are diseased because they cannot reproduce then this inevitably means the perpetuation of negative social attitudes towards infertile men and women. In conjunction with this danger we must recognise that the infertile may experience anger, grief, a sense of loss, loss of status, self doubt, depression and anxiety. The psychological effects are not adequately acknowledged nor assuaged by high-tech treatment. It must be recognised that both diagnosis and treatment has a major impact on people's lives. As Mahlstedt recognises[3]

> 'It is a process which invades one's body, one's personality, one's job, and one's mind. Diagnoses are often vague and inconclusive, and treatment is painful, intrusive and time consuming.'

In such circumstances it is appropriate to provide positive help. It is equally important to recognise that – because of social and familial pressure to conform and prove fertility – infertile women are extremely vulnerable to exploitation.

After twenty years of unregulated research the national success or live birth rate of IVF is still less than 1 in 10. If no pregnancy results from high-tech treatment it is the woman who is left with the sense of failure. This is the account of one woman, Isabel Bainbridge, who

says

> 'When you are on the program [*sic*] you are set up to be a parent. You are very supported by the team. It is like a little world away from the real world. You are encouraged to be the person you think you want to be, that is a parent, and not what you are, which is infertile.
> IVF pressures the community into thinking that anyone can now get pregnant. There is an emphasis that if anyone wants to be happy they must go and have this baby transplanted into them. "Medicine will make me happy." Medicine does not make the majority of these women happy....
> [The final acceptance after IVF that the infertility is insoluble] was a long dark tunnel of desperate depression for me...it has taken me five years to get over [it].'[4]

This is only one account of a woman for whom the high failure rate of IVF had a disastrous effect and there are many more. I do not refer to it to prove that IVF is never an appropriate treatment but to show that it is not always appropriate, and that it may have a negative effect which is not adequately acknowledged amongst the 90% who do not have a baby.

Risks to the Women's Health?

Another crucial aspect of the IVF question is whether it presents any risks to women's health. There are various risks to women's health associated with all stages of IVF treatment. The relevant stages of treatment are superovulation, collection of ova (by laparoscopy or ultrasound), induced multiple pregnancy. Also the psychological health of patients may be at risk from high-tech procedures. Before I outline some of the risks I must point out that laparoscopy and the drug regimen used to induce superovulation is not confined to the IVF process. However, concern about these procedures must increase when they are applied for social reasons and the benefits do not outweigh the risks.

What Risks are Associated with Induced Superovulation?

In most procedures superovulation is induced by the use of drugs.[5] There are indications of risk to women's health associated with artificial superovulation which include ovarian hyperstimulation syndrome (OHSS), cysts, coagulation problems leading to thromboembolism, stroke, molar pregnancy, myocardial infarction[6] and ovarian cancer.[7] Fishel and Jackson[8] record three cases of ovarian carcinoma in women of 25, 26 and 32 years of age. Also a recent report records a case in which a woman developed a 'potentially lethal complication [*i.e.* of deep venous thrombosis] during her second stimulation.'[9]

There have also been a few recorded cases of deaths in women as a result of adverse reaction during drug treatment for infertility. Such cases and reports of hazards during superovulation must be taken seriously. In fact, although IVF can be done without superovulation and has indicated positive results comparable to superovulation IVF in terms of pregnancy,[10] it does not yield spare embryos for experimental purposes. However, the application of superovulation in IVF will continue if the medics and scientists involved are more concerned with experimental freedom than the health of women.

What are the Health Risks Associated with the Collection of Ova?

Laparoscopy under General Anaesthetic: This technique is much less frequently deployed now in IVF than ultrasound but in addition to the slight risk of death and cardiac arrest associated with general anaesthetic the dangers of this process to women include haemorrhage, bowel puncture, large vessel damage and even tubal infertility[11] as well as the post-operative complications of pain, infections, fevers and scarring.

Ultrasound: Ultrasound-guided collection of ova is the most commonly used method and is less hazardous than laparoscopy. However, transvaginal or transabdominal ovum retrieval guided by ultrasound is not without risk. Seibel[12] mentions 'the potential hazard of concealed hemorrhage [*sic*] after ultrasound-guided retrieval of oocytes' and also the death of one patient as a result of the procedure.

Statistics show that multiple pregnancies as a result of high-tech treatment are more than 30 times the normal rate and that caesarian births are high.

The final aspect of the IVF procedure that I want to mention is the deliberate induction of multiple pregnancy to increase the chance of a live birth. Approximately 2 in 5 babies born as a result of IVF are twins or triplets *etc.*[13] Statistics show that multiple pregnancies as a result of high-tech treatment are more than 30 times the normal rate[14] and that caesarian births are high. (The Australian In Vitro Collaborative Study showed a rate of 43.9% caesarian births compared to 15%–18% nationally.)

In addition to the deliberately induced higher health risks to women from multiple pregnancy concern must be expressed about the practice of 'selective reduction.' This is the process deployed to destroy one or more of the children in the womb by injecting a lethal dose of potassium chloride into the child's heart. In addition to the fact that no one can judge which of the children are most likely to survive, 'selective reduction' carries a relatively high risk of premature delivery in relation to the live child(ren) remaining and the damage to the psychological health of the mother is unknown.[15]

There is one remaining area I wish to discuss before concluding. In 1982 the Medical Research Council reiterated its 1978 statement concluding that 'in the context of female infertility due to tubal occlusion, *in vitro* fertilisation with subsequent embryo transfer should be regarded as a therapeutic procedure covered by the normal ethics of a doctor/patient relationship.'[16]

However, we have progressed since that date to IVF being used when the cause of infertility is located in the male partner, where IVF is deployed experimentally for eugenic reasons (*i.e.* to attempt to screen and destroy 'unfit' embryos) and where superovulation is used on women who are willing to donate ova for use either in IVF or for embryo experiments.

So, the original purpose of IVF and the stricture that it must be governed by the 'normal ethics of the doctor/patient relationship'

have been superseded because it is clear that IVF itself can and does cause harm to patients.

So, the original purpose of IVF and the stricture that it must be governed by the 'normal ethics of the doctor/patient relationship' have been superseded because it is clear that IVF itself can and does cause harm to patients.

The purpose of this paper is to discuss the controversial aspects of embryo experiments. I have chosen to concentrate on the issue of women's health because it has not played a large part in public discussions but for me it remains the central issue of reproductive and genetic engineering.

In conclusion I would like to draw your attention to the statement made by 17 French scientists in *Nature* in 1988 which called for a better control over science. The corresponding author of the statement was Jacques Testart – the French IVF specialist who continues to practice IVF but abandoned embryo experiments over 2 years ago – fearing the eugenic and social implications. The statement read:

> 'The direction in which research proceeds is governed by economic, social, health-related or military considerations.
> This orientation cannot be ignored by research workers and society has the right to pass judgment on it. With its reductionist viewpoint and disregard for all other forms of truth and knowledge, science puts itself in conflict with nature, culture and individuals.
> Thus, unless science can be brought under control, it represents a serious risk to the environment, to [humanity] and to individuals.'

1. Third Report, Voluntary Licensing Authority, 1988. 8.6% live birth rate *re* all stimulation cycles.
2. Wagner and St Clair *The Lancet* October 28th 1989, 'Are In-Vitro Fertilisation and Embryo Transfer of Benefit to All?'
3. Mahlstedt *Fertility and Sterility* Vol. 43 No. 3 March 1985 'Psychological Component of Infertility.'
4. Murdoch A (1985) Melbourne *AGE* 10th April 1985 'When IVF is a lost labour.'
5. Fisher *IVF The Critical Issues* p. 24 Collins Dove, Australia 1989. Also note: *The Lancet* 16th Sep 1989 letter indicates that there has been diminishing use of clomiphene and increasing use of gonadoptropin releasing hormone analogue, leuprolide acetate – made with a pituitary down regulation scheme.
6. Congress of the United States, Office of Technology Assessment *Infertility: Medical and Social Choices*. Washington DC US Govt Printing Office, 1988.
7. Atlas and Merczer J. (1982) *Acta Obstetrica et Gynaecologica Scandinavica* 61: 261–3. Bamford P.M. and Steele S.J. (1982) *Br J Obs and Gyn* 89: 962–4. Carter M. and Joyce D.N. (1987) *JIVF* 4:126–8. Cramer and Welch (1983) *J. National Cancer Institute*. 71:717–21.
8. Fishel and Jackson (1989) *BMJ* Vol. 299 29th July.
9. Kaaja *et al* (1989) *The Lancet* 28th Oct.
10. Foulot, Ranoux *et al. Fertility and Sterility* Vol. 52 No. 4 October 1989 'In Vitro Fertilisation without Ovarian Hyperstimulation: a simplified protocol applied in 80 cycles.' 18 pregnancies/14 sustained from 80 cycles. (22.5% success rate).
11. Kovacs GT (1984) 'Patient Management and Preparation for IVF' in Wood and Trounson's 'Clinical IVF' Berlin, Springer-Verlag. Also: Philips and Keith (1974) Gynaecological Laparoscopy: Principles and Techniques. Proceedings of 1st International Congress of American Association of Gynaecological Laparoscopists, New Orleans, La. Royal College (1978) Report of Confidential Enquiry Into Gynaecological Laparoscopy. Also: Ashkenazi *et al.* (1987) *JIVF* 4:316–8.
12. Seibel M.M. (1988) *New Eng Jr of Med.* 318:828–34.
13. Fisher as at ref. (5) p. 50.
14. NSPU, 1987 (Aus & NZ) Of the 1,851 livebirths in Australia and New Zealand up to Sept 1987 as a result of GIFT and IVF, 750 were multiple pregnancies.
15. Goldberg (1988) *Ob. Gyn News* 23 (19):3.
16. MRC Statement 'Research Related to Human Fertilisation and Embryology' *BMJ* (1982) Vol. 285 p.1480.

REVIEWS

AIDSFACTS: Educational material on AIDS for teachers and students.
Cambridge Science Books

This is a pack of 31 facts sheets on AIDS which has been produced as a teaching aid for school children in the age range 13–19 years. The first two sheets are introductory and are followed by suggestions for consultation with parents and governors. The fourth sheet is a questionnaire designed to find out the students' basic knowledge of AIDS. Sexually transmitted diseases other than AIDS are discussed in sheets 5–7, and the remaining sheets deal with the biology of HIV, statistics and spread, modes of spread. Sheet 17 deals with safer sex and the use of condoms. The twenty-second sheet gives 19 opinions for stimulating discussions.

Sheet 23 deals with moral aspects from a Christian perspective. This consists of four quotations from different sources: Dr Roy Clements, Dr John Habgood, The Terrence Higgins Trust, Martin Evans. These cover a range of views and are to be used to stimulate response to the 8 questions which include 'Is homosexuality wrong?', 'Does God punish people through suffering and disease?' The second sheet on moral aspects deals with the costs involved in dealing with AIDS. The final sections present some 'real' situations for discussion and lists of resources and glossary.

This pack can certainly be recommended for use in schools and probably also in Bible classes and with youth groups. It presents the facts clearly and gives excellent material for discussion. It is not a specifically Christian publication but could certainly be used in a Christian context.

The publishers waived copyright and thus unlimited photocopying is allowed within a single educational establishment.

Ian Brown
Glasgow

We Speak for Ourselves
Jack Babuscio
SPCK 1988, 170pp., £6.95, ISBN 0 281 0043499 3

This book has been written with a two-fold purpose in mind. Firstly it allows 'gay men and women to explore the personal and social implications of their own situations in their own words,' each speaking as an individual and not as a stereotype. Secondly it is intended as a guide for all professional and other counsellors to further enable them to help the homosexual who suffers the pain of loneliness, social isolation, discrimination and rejection.

The author, Jack Babuscio, certainly does a good job in allowing homosexuals to speak frankly and honestly of their situations. To quote: 'What I long for is a loving mutually pleasurable relationship. This isn't easy for me since my sexual preference is for children under the age of twelve - both sexes.'
'This is the way I am', Alex married and father of four children, with a male lover; 'perhaps having two loves seems selfish to you....'
Transvestite: 'I enjoy being this way ... and I'm not hurting anyone.'

Self-acceptance, Babuscio argues, can be realised only when gays are enabled to evolve a means of proudly embracing their sexual identity. This one assumes is what the professional counsellor will therefore help the homosexual to accomplish. The problems of the homosexual, he writes, spring from negative societal reaction to homosexuality, rather than from anything inherent in the homosexual orientation itself.

There is much information in this book which is helpful. The chapters dealing with 'weapons of oppression' highlights the problems the homosexual can be faced with in employment, housing and in law. The section on family and friends underlines the tremendous areas of need for pastoral love and care, especially where parents find themselves confronted by homosexual children. The final chapters deal with AIDS, deal with the issue of whether or not one should test for HIV, and chart the reactions of AIDS sufferers. They underline the responsiveness of AIDS sufferers to genuine caring love and surely this is the role the Church above all others is called upon to play.

So much for the information. The morality and theology which undergird the author's case present me with real problems. The refrain of a modern pop-song chants ' If it makes you feel good... do it, do it, do it' and that basically sums up much of what is described here. In a very lop-sided chapter 'GAY SEX / STRAIGHT RELIGION' Babuscio, using carefully selected texts dismisses all the Pauline teaching on love and marriage and the family and claims 'Paul's aversion was for sexuality generally, not just homosexuality. The moral teachings of Christ regarding sexual expression are just as adaptable to homosexuals as they are to heterosexuals.' Where the teaching of the Bible militates against full acceptance of practising homosexuals then it must be modified and re-interpreted to suit our society. There is no clear acceptance of any moral law. There is no concept of sinfulness. 'Nothing is to be gained by preaching abstinence and instilling guilt'. No-one is to feel guilty about anything, whether it be 'open marriage' cottaging, satisfying 'surplus sexual needs'. Promiscuity, he writes, is no more than a direct by-product of those very prohibitions imposed by society against gay relationships. It would appear to me that a very thorough rewriting of Scripture would be needed to accommodate these standards. Anything goes because God loves everybody. Surely a deeply flawed concept of what love really is.

This is a well written, well documented account. It contains excellent notes, a full bibliography and a guide to organisations for Gays. However in my opinion Christian readers would need to assess whether it would be worth paying £6.95 for its 170 pages, in the knowledge that they would need to interpret what is written in the light of their knowledge of a Holy God, who loves sinners and who said to the adulteress, 'Neither do I condemn you. Go, and sin no more'.

Martin A.W. Allen
Chryston

Principles of Biomedical Ethics, third edition
Tom L. Beauchamp and James F. Childress
OUP, New York and Oxford, 1989, 470pp, ISBN 0 19505902 6

This is the third edition of a major bioethics textbook, and it will be found of much value in university and college courses touching on this complex of questions. The approach is philosophical and comprehensive. Eight major chapters are followed by fifty pages of case study material, to root the philosophical discussion in practical clinical dilemmas.
The opening chapters set the scene for the discussion to follow, setting out types of ethical theory under the familiar utilitarian and deontological headings. Chapter 3 focusses (significantly, ahead of other questions) on the principle of 'respect for autonomy'. Chapters 4 and 5 move on to nonmaleficence and beneficence, with such chestnuts as 'killing and letting die' and the 'principle of double effect' covered *en route*, and a particularly helpful discussion of 'paternalism'. Chapter 6 is on 'justice', chapter 7 'professional-patient relationships', and the final chapter picks up the threads of 'ideals, virtues, and conscientiousness'.

The book's emphasis on procedures rather than substantive ethical issues will frustrate many readers, though it is the style of the new medical ethics. Particular questions (euthanasia, abortion and so on) are discussed, at times well, but this is not a book of set-piece discussions on these *foci* of controversy. In a revealing comment the authors write that 'rules against killing, like all moral rules, are *prima facie*, not absolute', but their inclination in the matter of euthanasia is very cautious: 'we have argued that the prohibition of killing expresses important moral principles and attitudes whose loss, or serious alteration, could have major negative consequences' (p. 146). The treatment of abortion is less satisfactory.

But this is a stimulating book which seeks to offer a balanced assessment of each question before coming down on one side of the fence. It would have been helped by the return of footnotes to the foot of the page, which aids the reader altogether more than it can possibly save the publisher in the age of computer typesetting. The index is very full.

Nigel M. de S. Cameron
Rutherford House, Edinburgh

Ethics in Paediatric Nursing
Gosia M. Brykczynska (ed.)
Chapman and Hall, London, 1989, 157pp.

Recent book-length discussions of nursing ethics have tended largely to be overall surveys of the subject which consider ethical problems arising in various fields of nursing without giving detailed attention to any one field. For this reason the present volume deserves to be welcomed. Paediatric nursing is an extensive field, and the contributors make no claim to have covered it exhaustively; but they do focus on six areas of central importance. The editor, Gosia Brykczynska, contributes two chapters, the first (a discussion of ethics in general and its application to problems arising in paediatric nursing) and the last (on paediatric nursing research). Other chapters are devoted to neonatal nursing (Dorothy A. Whyte), intensive care nursing (Belinda Atkinson), community care (Mark Whiting), psychiatric nursing (Wallace B. Hamilton) and care of the profoundly multiply-handicapped child (Philip Darbyshire).

Miss Brykczynska's opening chapter, 'Ethics and paediatric nursing practice' is largely taken up with ethics as a rational inquiry into the nature of good and bad, right and wrong human action. It has to be said that this chapter displays many of the defects of such accounts when composed by medical or nursing specialists, or social scientists, whose familiarity with philosophical viewpoints and arguments is slight. There is a good deal of confusion about the import of various philosophical and ethical theories, and even about their titles: so existentialism is consistently rendered as 'existentionalism' and in one place (p.2, 1. 12) deontological ethics is contrasted, not (as it should be) with teleological ethics, but with 'theological ethics'. As for deontological ethics, it is said to be

> ...a type of ethical reasoning...which argues that one should be solely governed by the laws and principles enshrined in a dictum from an outside authority. For those who subscribe to such reasoning no explanation of their choices is relevant since they argue that they must be doing the 'right thing' if they follow the guidelines imposed upon them (p.11).

This seriously misrepresents what deontological ethics is about: it is, in fact, the view that our knowledge of what is *right*, of what we ought to do in given circumstances, is in no way based upon our understanding of what range of benefits, what realisations of human goods, we may bring about in acting. More briefly, a deontological ethic involves accepting that 'the right' is prior to and independent of 'the good'; it has nothing essentially to do with the question of whether certain moral truths can be disclosed to us by an outside authority.

This first chapter contains interesting reflections on moral problems seen from the nurse's point of view, but confusions of the sort just mentioned are far too common. Here we have a clear case of someone trying to write authoritatively on a subject without possessing the requisite background knowledge. By contrast, when, in the chapter dealing with paediatric nursing research, Miss Brykczynska reflects on nursing issues of which she has first-hand experience, the result is definitely more satisfactory. Here questions concerning the patient's consent to participating in research are thoroughly examined, with the author arguing, on the basis of recent research studies, that adults have tended to underestimate the extent to which young children are able to give informed consent to participation in research programmes. In general, she claims, 'A child's word is as good as that of an adult; anything short of this touches upon that bugbear of modern health-care ethics – paternalism' (p.131).

Some summary comments on a couple of other contributions to the volume will have to suffice here. Dorothy A. Whyte's 'Ethics in neonatal nursing' deals at length with problems concerning care of the handicapped newborn. She rejects any idea that doctors or nurses may deliberately aim at the death of a severely handicapped child, either by direct intervention or by omission. Likewise, she says, the nurse's everyday experience tells decisively against any suggestion that neonates are not to be regarded as human persons; for

> A detailed consideration of the organized behaviour of the newborn infant...makes it very hard to accept that such a complex organism, 'programmed' for human interaction, should be denied the title of person. Nurses working with pre-term infants have an intuitive appreciation of their individual personalities (p.33).

Miss Whyte sees the widespread acceptance of abortion in our society as largely responsible for a similar acceptance of death-dealing practices in paediatric care. Her resolute opposition to the idea that it may sometimes be right for a health professional to aim directly at a child's death makes her contribution particularly welcome. It is good also to see Philip Darbyshire ('Ethical issues in the care of the profoundly multiply-handicapped child') rejecting any attempt, along the lines of Michael Tooley in his *Abortion and Infanticide* (1983), to define human personhood in terms of the actual possession of certain fully-exercisable mental abilities, thereby denying the status of person to large numbers of human beings.

Chapter One is the only part of this book which I would judge unsatisfactory, for reasons set out above; if there is ever a second edition this chapter should be rewritten with the assistance of a specialist in philosophy. On the whole, *Ethics in Paediatric Nursing* is valuable and timely, and deserves to be read widely.

F.J. Fitzpatrick
The Linacre Centre for Health Care Ethics, London.

The Status of the Human Embryo. Perspectives from moral tradition
G. R. Dunstan and Mary J. Sellar
King Edward's Hospital Fund for London, London, 1988, ISBN 0 19 724644 3, 119pp, cased, distributed by OUP

Experiments on Embryos
Anthony Dyson and John Harris
Routledge, London and New York, 1990, ISBN 0 415 00749 6, viii+152pp, cased, £25

These two important volumes of essays bring together perspectives on the embryo debate which is not soon going to end. They offer a variety of perspectives. Professor Keith Ward concludes: 'embryos as a developmental stage prior to the formation of a brain, a necessary condition of conscious life, are not human persons. It is thus morally permissible to conduct experiments which promise a great and otherwise unobtainable good for persons, since there is no possibility of causing pain or distress to the organism. Further, I would regard this as part of the proper exercise of human responsibility for eliminating suffering and gross malfunction from the natural world as far as possible' (*Experiments*, p. 118). In the same volume, Professor John Marshall argues eloquently (but unequally) 'The Case against Experimentation' on the lines of his Warnock dissent, Margaret Brazier offers a (now somewhat dated) critique of the Government's White Paper, and Professor Anthony Dyson offers a critique of the

(generally anti-research) position of the churches from his own, well-known perspective.

The *Status* volume offers greater interest. Peter Byrne's fascinating essay on 'The Animation Tradition in the Light of Contemporary Philosophy' argues that 'there is reason to make humanity a sufficient condition for the attainment of personhood', yet still to recognise a developmental account of that attainment. Brendan Soane writes on 'Roman Catholic Casuistry and the Moral Standing of the Human Embryo' and argues on similar lines to John Marshall in the other volume – that 'even though the status of the embryo is uncertain' it 'shares our common humanity and is well on its way to becoming an individual if permitted to do so'. The central essay of the volume is that of Professor Gordon Dunstan, one of its editors whose presence is almost inevitable in such a gathering, especially in one (like this one, like most of them) where the centre of gravity is such as to favour embryo research. He offers a scholarly apologia for his view of the status of the embryo from the perspective of his interpretation of the 'western moral tradition'.

There is an element of balance in both these collections, but their centre of gravity is plainly to the 'left' of the moral spectrum. It is a shame that they are not more carefully balanced, and a shame also that more care has not been taken to structure discussion within them (with opportunities for writers to answer one another, and to engage in dialogue). But the greatest shame is that we cannot compare them with volumes of essays from the 'other side' – at least, £25 hardback volumes. There is an increasing need for scholarly engagement in this discussion from the perspective associated with this journal. Perhaps these volumes will themselves provoke a response.

Nigel M. de S. Cameron
Rutherford House, Edinburgh

The Foundations of Bioethics
H. Tristram Engelhardt
Oxford University Press, New York and Oxford, 1986, casebound, £30, xvi+398pp., ISBN 0 19 503608 5

'A philosophical analysis of the character of bioethical debates reveals deep divisions of opinion', writes Engelhardt in his preface. 'Numerous ideological and religious viewpoints bring special answers to the moral questions raised by bioethical disputes. Insofar as these special answers cannot be justified in terms of general rational analysis and argument, a gulf yawns between the bioethics of general secular philosophy and the bioethical analyses undertaken within the embrace of particular religious and ideological viewpoints. Secular pluralism has become a watchword for moral crisis.'

This substantial book is offered as 'an acknowledgement' of the 'inevitability' of secular pluralist ethics, out of which its author believes it is possible to fashion 'by reason a particular view of the good life' and to secure it 'by general rational arguments' (p. viii). So the reader knows from the start what he is going to get.

The discussions which follow are interesting if frustrating, since many readers will feel that questions are being begged in order for the argument to proceed. So, 'it is not plausible that fetuses are persons in the strict sense. In fact, there is not even evidence to hold that infants are persons in the strict sense. Whatever sort of mental life might exist for fetuses and infants, it is minimal...' (p. 216).

Engelhardt is welcome to try and construct a bioethics for the new, pluralist society, but he will forgive those of us who stand by the remnants of the old consensus and who protest that it can't be done; the idea of a post-consensus consensus is pure illusion and depends upon assumptions as 'particular' as the 'religious' and 'ideological' viewpoints which Engelhardt dismisses and which he considers himself to be above in this new bioethical Enlightenment.

Nigel M. de S. Cameron
Rutherford House, Edinburgh

Ethics in Nursing Practice: Basic Principles and their Application
F. J. Fitzpatrick
The Linacre Centre, 1988, 290 pp., £9.95. ISBN 0 906561 05 1

This book goes a considerable way towards filling a gap which Christian nurses may become aware of when studying ethics, *i.e.* a clear exposition of a Christian perspective on ethical issues affecting nursing. Concentrated effort is required to follow the philosophical discussion in the early chapters, but a discursive approach, liberal use of examples and concise chapter summaries are helpful. The use of footnotes is also helpful but I would have liked to have the references listed at the end.

In the first chapter the complexity of the role of the nurse is discussed, a rather narrow definition of health offered and the importance of advocacy by nurses briefly explored. Nursing is affirmed as a profession, leading in to a discussion of professional codes, the focus of the second chapter. While acknowledging the usefulness of codes of professional conduct as expressing concisely the basic attitudes and standards to which the nursing profession is committed, Dr Fitzpatrick emphasises the need for nurses to be able to 'get behind' the codes, and to think critically and independently about moral issues.

The next five chapters are intended to enable nurses to engage in such an analysis with a greater understanding of philosophical issues and arguments. The case for objective truth is defended and the notion that morality is largely centred on human flourishing or well-being is explained. Utilitarianism is examined and found wanting, and in Chapter Six there is an attempt to identify the fundamental approach which should be taken to moral issues. This follows the natural-law tradition and requires respect at all times for 'basic human goods'.

Chapter Seven contains a rather tortuous discourse on the importance of intention as determining the very nature of peoples' acts. This concept, and the subsequent discussion of the principle of double effect is used in this and in later chapters to analyse a nursing response to difficult moral choices, including the question of co-operating in evil acts. The second half of the book makes easier reading as specific issues are considered. These range from respect for individuals and difficulties surrounding informed consent, through to problems of life and death such as euthanasia, abortion, embryo research and treatment of the handicapped newborn. I found the discussion of confidentiality in Chapter Nine particularly useful. In contrast, the penultimate chapter on sexual ethics highlights a fundamental difficulty for non-Catholics using this book, *i.e.* the reliance on papal and other Catholic writings as the major points of reference. The insistence that 'freely chosen sexual intercourse which is deliberately rendered sterile is an instrinsically wrong act' while natural family planning is seen as acceptable, seems inconsistent with earlier discussions of the importance of intention.

There are a number of such inconsistencies in the arguments presented which make it difficult to accept some of Dr Fitzpatrick's definitive statements as to when nurses would be acting wrongly. When such statements clearly reflect Christian thinking they are refreshing and affirmative; when they follow a tortuous argument supporting Catholic dogma they are troubling. Overall this is a book well worth reading for anyone who wants to explore the natural law position; those out of sympathy with this perspective are likely to find it irritating.

Dorothy A. Whyte
Dept. of Nursing Studies,
University of Edinburgh