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From Dr Bernard Nathanson, MD

OF PRE-EMBRYOS AND BOURBON KINGS

In 1979 the Ethics Advisory Board of the Department of Health, Education and Welfare designated an interval of 14 days after fertilization as having a 'special moral status'. In 1986 the American Fertility Society Ethics Committee devised the term 'pre-embryo' to encompass the biologic and moral status of the living human being from the end of the process of fertilization ('syngamy', or the complete fusion of the sperm and egg into a genetically complete and actively organizing person) until the 14th day of life. Concurrently (and not surprisingly) in 1986, the Voluntary Licensing Authority of Great Britain, a creature of the Royal College of Obstetricians and Gynecologists and of the Medical Research Council, also proposed the term 'pre-embryo' to define the unborn in the first 14 days of life: the term itself had been coined by Dr Anne McLaren, a member of the British government's Warnock commission which had proposed a 14-day 'free-fire zone' for wide-ranging experimentation on unborn human beings.

Why the rush to segregate the unborn human into a scientific ghetto in the first 14 days of its life? And why 14 days? With the advent of *in vitro* fertilization in 1976, increasing attention was being paid by scientists to the earliest phases of human life and there followed a cascade of articles in the medical literature describing the minutiae of the process of fertilization, division and implantation of the fertilized egg, organization of the various basic layers and structures of the early embryo; but like consuming potato chips, scientific experimenters seemed unable to satiate themselves: more sophisticated, more expensive, more intricate experiments had to be devised, funded and carried out if for no other reason than to be busy and publishing. Consider this: a recent report from the Medical Research Council's National Institute for Medical Research in London which appeared in the British journal *Nature* describes injecting the sry male gene into three female mouse embryos and creating three male embryos; in a chilling aside, Dr. Lovell-Badge said he did not foresee this technology applied to human reproduction (wanna bet?). Put me down as an unregenerate old grouch but that kind of idle genetic tinkering is only a step or two removed from sadistic little boys pulling the wings off flies or sawing the hind legs off frogs—pointless, dangerous and unimaginably offensive.

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In order to carry on experimentation of this sort it is necessary to strip the subject of such experiments of full enfranchisement in the human community; thus the establishment of the 14-day ghetto. If one can cast sufficient doubt on the qualifications of the unborn in the first 14 days to enter the community of full-fledged humans, one has then succeeded in dehumanizing them and all varieties of experiments can go forward unapologetically.

In speaking of experimentation of human beings, the great French physiologist Claude Bernard wrote in 1865:

> 'Experiments then may be performed on man but with what limits? It is our duty and our right to perform an experiment on man whenever it can save his life, cure him or gain him some personal benefit. The principle of medical and surgical morality therefore which might be harmful to him to any extent even though the result might be highly advantageous to science, i.e. to the health of others.'

What is there, please, in changing an embryo from one sex to the other, which can save that person's life, cure that person or gain that person some personal benefit?

The theoretical basis for setting the 14-day limit was (and is) that it is not until the 14th day following the end of fertilization that biologic individuation is certain, i.e. that it has been determined that a single biologic individual will result from that fertilization and, as Dr. Howard Jones put it in his defense of the concept of the pre-embryo:

> 'In the absence of such a single individual, the assignment of full rights of an adult human individual is inconsistent with biologic reality . . . If this biologic basis for moral status (the emergence of a developmentally unitary individual) has any validity, it follows that it is most unreasonable to assign full moral status—the status of a newborn child or adult—to the pre-embryo.'

It is true that, in the present state of our knowledge of early human development, we do not know with precision whether any given fertilized egg will:

(a) split at any time up to the 8th day to form twins, ie., *two* separate individuals,

(b) fail to implant in the womb and be lost in the next menstrual flow; or once implanted fail to flourish and die, to be cast out as an occult miscarriage,

(c) form a grape-like cluster of structures called a hydatidiform mole containing no fetus, or even go on to end as a malignant tumor called a choriocarcinoma (again, with no fetus),

(d) fusion of two 'pre-embryos' of different sexes can result in the development of a single adult individual,

(e) go on (in the *overwhelming* majority of cases) to become an adult human being.

The advocates of the pre-embryo ghetto hold firmly to the notion that it is not until the appearance of the primitive streak in the early embryo (at the 14th day) that one can be *assured* that a single separate individual has been successfully launched, and that absolute certainty of individuation enfranchises one in the human community.

In short, there are two biologic principles advanced here to support the basis for a litmus test to define humanity: the principle of biologic certainty, and the principle of one fertilization leading to one and only one human being—to remain one human being for the rest of the natural span (however long that may be). A pretty dubious pair of qualifications for entry into the humanity club—as Groucho Marx once said, I wouldn't want to join a club that would have *me* as a member, given those entrance exams.

Let's look at those qualifications a little more carefully: to believe that biologic certainty exists in an increasingly uncertain scientific world is to believe they are going to put a dining car in the subway next week. You can count the absolute biologic certainties on the index finger of your right hand: we are all going to die (I pass over the certainty of taxes as an extra-biologic phenomenon). Within my medical lifetime I can recall the assured and certain air of my instructors at McGill University when informing me that each human had 48 chromosomes (not 46 as we now know). Back in my father's day pneumonia and tuberculosis were certain killers; transfusion of blood from one person to another was unthinkable, and abortion was the destruction of a living human being and unallowable under the precepts of the classic Hippocratic oath—now, alas, no longer whinnying with us. The supposition of the existence of biologic certainty is an exercise in the purest kind of fantasy: will you be here tomorrow? Are you willing to bet the family farm on it?

Look now at the other and more demanding qualification: that each conception must result in *one* individual (and *remain* one individual); until that certainty is established at 14 days after the fertilization process is completed there is no reliably definable human being according to the pre-embryologists.

But so many of us now no longer remain one individual in the course of our lives: the schizophrenic literally splits into two or more human beings mentally and emotionally. The recipient of a bone marrow transplant now has the blood of another human being circulating in his body: he is indeed almost the mythic chimera, part goat head, lion body and dragon tail. And those same lofty intellects who have proposed this set of qualifications are precisely those who are pushing hardest for the transplant of fetal brain tissue from aborted babies into the brains of adults suffering from Parkinson's disease or Alzheimer's disease. Do they realize that in proposing such a procedure they are advocating putting the body of one individual into another human being to create a somatic multiple person (this concept is common to *all* tissue and organ transplant), but also in placing *brain* tissue into someone else's brain they are creating a second *personality* as well? Think of it: two human beings of separate tissues and separate personalities within the shell of one being. Certainly no individuation there. A neat irony: the patient is rescued from the torment of Parkinson's disease only to be consigned to the non human ghetto because he/she is no longer a *single* human being.

And what are we to make of those who acquire manufactured parts along the way? Is someone who wears a pacemaker or has an insulin pump implanted to regulate the diabetic state marginally more than one human being but decidely less than two? Poor old Robocop: a hero (heroes?) but quite unclassifiable as to his humanity. It is then permissible to experiment on him, perhaps pull off one leg and see how far *he* can jump? Cyborgs, beware!

Enough. The linking of biologic certainty and immutable individuation as an entrance requirement into the human community is not simply medically and morally absurd, it is ludicrous. But in the history of medical experimentations there are equally dark chapters, which have as a common theme the stripping of humanity as a pre-condition for the most appallingly unethical medical experimentation. Recall please that odious forty-year Tuskegee project planned, financed and carried out by the U.S. Public Health Service in Macon County Alabama between the years 1932 and 1972. Four hundred poor black male farmers afflicted with syphilis were designated as subjects to be studied with an eye to the natural evolution of untreated syphilis. Despite the draft call-up in 1941 when America entered the war (these 'experimental subjects' were excused from military duty as vital to a scientific study; it was also feared that the Armed Forces would treat them for their disease and thus ruin the 'experiment') and despite the advent of penicillin in the late 40's (that drug would have cured them all), the study went on until it broke with a resounding clatter in the *Washington Post*. Dr. Taliaferro Clark, Chief of the U.S. Public Health Venereal Disease Division and one of the architects of the project stated at the outset of the study:

> 'This state of affairs (the prevalence of venereal disease in Macon County, Alabama) is due to the paucity of doctors, the rather low intelligence of the Negro population in this section . . . and the very common promiscuous sex relations of this population group which not only contribute to the spread of syphilis but also contributes to the prevailing indifference with regard to treatment.'

Dr. J. E. Moore, a prominent epidemiologist who served as consultant to that infamous Tuskegee project wrote:

> 'It will be necessary of course in the consideration of the results to evaluate the special factors introduced by a selection of the material from Negro males. Syphilis in the Negro is in many respects almost a different disease from syphilis in the white' (an unconscionable racist absurdity).

Understand also that periodically over that 40-year

span from 1932 to 1972 numerous articles appeared in reputable medical journals discussing the results of the study to date—yet no one moved to denounce it as inhuman and unimaginably ethically squalid until the popular press could no longer ignore it.

From the mid-50's to the early 70's a team of researchers from New York University Medical Center, under the direction of Dr. Saul Krugman, inoculated mentally retarded children at the Willowbrook Institute in New York with the live virus of hepatitis (an exceedingly dangerous infection of the liver): they were studying the natural history of the disease. To make matters worse, the consent form pressed upon the parents of these unfortunate children to allow them to be injected with the

From the mid-50's to the early 70's a team of researchers from New York University Medical Center, under the direction of Dr. Saul Krugman, inoculated mentally retarded children at the Willowbrook Institute in New York with the live virus of hepatitis.

live virus was so ambiguously phrased that it could be interpreted by the unwary as promising that the children were to be given a vaccine against the virus, and not the infecting virus itself.

Quite obviously, what these squalid 'experiments' had in common was the necessary preliminary dehumanization of the subjects. Once the subjects were effectively exiled from the human community (blacks as subhuman, mentally retarded children as little more than animals, the Jews of the infamous Block 10 experiments at Auschwitz as non-humans) *anything* was permissible—and done. Now it is the turn of the unborn: first dehumanize, then debase.

We are grateful for permission to reproduce this Comment *in* Ethics and Medicine.

Walter H. Schuman, Associate Professor of Religion, Ashland University, Ashland, Ohio

HOSPICE CARE FOR THE 'LIVING DEAD'?

For the last fifteen years I have been teaching courses on Death and Dying at Ashland University and as a professor and pastor visited hundreds of people who were in their last stages of life. I have listened to stories from the dying to see if there are common themes that all humanity shares at the end. What I found is everyone has a personal story, an identity story, to share with those who are there at the last moments. If there is a common theme that runs through the testimony, it has something to do with community—the need to be a part of something larger than oneself. I wanted to explore this theme further so I applied for a summer study leave to work in a state mental hospital intending to visit patients who were terminally ill. When the grant proposal to study at Napa State Hospital in California came through, I suddenly felt overwhelmed. I wasn't professionally prepared to visit the terminal mentally ill. I knew very little about mental illnesses and even less about institutions that care for them. Three months of clinical training thirty years ago was certainly not going to overcome my anxiety. But I wanted to hear from people who were at critical points in their life, if not dying, certainly experiencing a death. So I took the leap, with great trepidation, and set off to visit the terminally ill at Napa State Hospital.

The first thing I was told at Napa—there were no 'terminal' patients at the institution. There were some very sick patients but none were diagnosed as terminal. It reminded me of Kubler-Ross's experience twenty years ago when she asked to visit patients who were dying at a hospital in Chicago and was told, 'There are none!' We still live in a death-denying culture. I was free, however, to visit all the wards and talk to any patients who were willing to listen. I was given the master key to the hospital which opened every door, except the chapel!, and set free to roam at my own pace.

Instead of finding patients who were diagnosed as terminally ill, I found another kind of death, a death closer to home that was ever more frightening to me—living death—patients who said they were never alive. Let me introduce you to Alice (all names have been changed to safeguard confidentiality): blind and schizophrenic but bright and articulate, she said to me, 'I can not remember a time when I felt human. I always felt trapped, like an animal in a cage, not knowing how I got in there and how I can ever get out. I am dead. This isn't living!' What is it like now to be in Napa State Hospital? 'It is a prison, a death house, where each day you get up and have to climb up a hill but never get to the top. Nothing makes sense, like rolling a stone up an impossible hill.' Alice reminded me of Ivan in Tolstoy's short story of Ivan Illych, except for the fact she never had the option of choosing life as Ivan did in his early childhood. But like Ivan, she is living death. She has her hell here on earth but not by her own choosing or actions.

Randy had another kind of living death. He is waiting momentarily to be murdered. His voices have told him that someone is after him. These voices never turn off. He is locked into headphones that never stop sending signals. So he lives not his own life, but the life of his alien voices.

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I was asked to visit Randy because he was obsessed with death. His outward appearance placed him on the beach, robust, muscular, a surfer type. After a few minutes of pleasant conversation, he abruptly accused me of trying to assassinate him. He was sure I was there as part of a massive plot. I was told to leave before somebody got hurt. That was the end of any sense of reality for Randy. Other visits with him were confrontations laced with accusations, fear, and paranoia. He is a captive to the voices.

Denise could not look at me; she held her face in her hands, crying the whole time. When she learned forward, I knew why. Her face was raw scar tissue from burns she inflicted on herself in the many attempts at suicide. She was sure God was going to punish her with even more pain by condemning her to Hell. 'But that was all right,' she said, 'she deserved it.' Through the tears and seared flesh, I could see someone who had never been loved, never given affection, never experienced the joy of living. Unlike Randy, Denise did not hear voices, she lived in the silence of her own self-hatred.

I could tell you about Lu Chew, a beautiful Asian, who claims she is a black Israelite and has changed her

appearance so people will stop punching her. Or Rachel, a native American Indian, whose slow, slurred speech reflects the brain damage from sexual assaults, or Jack Grove, whose body is worn out from literally walking in circles. Yes, I could go with hundreds more 'cases' as they are called at Napa, people who are dead, but living in normal bodies. They are real people, loved by God if not by us. They hurt, they feel pain, they wonder why life has dealt them such an unfair hand of cards. Like Job, they cry for an answer or an umpire to judge their case impartially.

Is there an answer to such inequities in life? What is the Christian response to such inordinate suffering? Compassion! No answers. As was true with Jesus with Jerusalem, all we can do is weep. If we feel the pain and understand the suffering, we join in a long chorus of God's suffering servants.

Either we bring community to the state hospitals or we provide a healing community on the outside, a hospice, to integrate the mentally ill with the mentally well.

Well, if there are no satisfactory answers to the why of living death, is there anything we can do? Maybe some other questions need to be asked. Is a state hospital a microcosm of the world? Is it a slice of life under a microscope? My guess, it reflects all the sickness of our society. It is ugly and hard to look at so we marginalize the mentally ill to help us feel they are not a part of us. But they are; we created them, we tolerated the evil forces that spawned them, and now we don't like what we see, so we warehouse them and call them 'cases'. We are all cases and that is what is contributing to this alienation. I am not for one minute suggesting that we empty out the state hospitals on to the streets as we did in the 70s and let the insane fend for themselves. No, I think we need to create communities which will support and nurture the helpless and embrace them as one of us. There are certain people who are very sick and need special attention in a hospital. We need to provide intensive caring units for them, not only with high-tech medicine but with soft touch human contact. The large majority of the patients at Napa, however, could be cared for by the family and community in a hospice setting where doctors and nurses would teach the family how to care for their loved ones. What seems to be counter-productive to healing and wellness in a state hospital is the overall experience of alienation separation of the patient from family and community. Either we bring community to the state hospitals or we provide a healing community on the outside, a hospice, to integrate the mentally ill with the mentally well.

Every small town in the U.S.A. has a 'character' that some would call mentally ill. He or she roams the streets, talks like someone at Napa, and adds a wonderful dimension to the sterile homogeneous lifestyle of that community. It is children who usually befriend this person because they enjoy celebrating refreshing differences or maybe have not developed the sharp eye of judgmentalism yet. Or, is it they see a little of the oddness of this person in themselves and know we really aren't different. Whatever, maybe all of us need to become as Jesus said, like little children, to enter into his kingdom and allow those who are experiencing living death to participate in living life.

If little children can build community with our town 'characters', and are able to integrate the mentally ill with the mentally well, it should not be out of reach for wise adults to develop hospice programs for all types of dying.

If little children can build community with our town 'characters', and are able to integrate the mentally ill with the mentally well, it should not be out of reach for wise adults to develop hospice programs for all types of dying. What is abundantly clear in the death stories of Alice, Randy, and Denise is the experience of alienation and the longing for reunion. The hospice organization in America has been successful in addressing this issue for physical death. What about those who are experiencing psychological death? Do we need to think about hospice care for the 'living dead'?

Pamela F. Sims, Consultant Obstetrician and Gynaecologist, Hexham, Northumberland

TEENAGE PREGNANCY AND ABORTION: A REVIEW

A National Symposium on Teenage Sexuality, sponsored by Agapé, took place May 20–23 1991, at Swanwick, Derbyshire. The author was invited to present this paper on an important and growing problem.

The Law Report page of the *Independent* of 22 May 1991 announced 'Abortion for 12-year-old less risky than pregnancy'. But is that necessarily so? A review published by the Family Policy Studies Centre in December of last year showed that 50% of girls have had sexual intercourse before they are 16. It is not surprising therefore that the pregnancy rate is on the increase, as is abortion, in this age group.

Why are children embarking upon their sexual careers earlier these days? Firstly there are medical factors to consider. The age of the menarche, that is the first period, has been declining. One hundred years ago it was around 17 to 18 years, since the turn of the century it has decreased 3 months every decade until levelling off at around 12 to 13 years. It is thought that factors such as better nutrition have contributed to this change. It is clear from these facts that it was physiologically unlikely for young teenagers to have become pregnant decades ago, even if they had tried!

Male maturation is also occurring at an earlier age. The FPSC Report comments that one in three boys were sexually experienced in 1988, whereas the proportion was only one in 17 in the sixties. Most authors writing on the subject of adolescent behaviour note that emotional and psychological development is not commensurate with the physical. Although the bodies of teenagers have become adult they are still children at heart.

In addition to physiological changes it is obvious that social factors have been at work too. Young people are constantly exposed to a media which persuades them of the normality of sexual encounters.

In addition to physiological changes it is obvious that social factors have been at work too. Young people are constantly exposed to a media which persuades them of the normality of sexual encounters. Those who are still immature emotionally are also particularly vulnerable to peer pressure. It is interesting to note, however, that the pendulum seems to be swinging back from what started in the sixties. There is some early evidence at grassroots level that teenaged girls of the nineties may be reacting against the lifestyle that their parents adopted as teenagers.

A third factor contributing to the overall trend in increasing sexual activity amongst teenagers has been the decline in religion. Undoubtedly even a nominal faith served to curb the behaviour of our forebears. Cynics would argue that the advent of the pill, which removed the fear of pregnancy, had more to do with our activities behind closed doors than any notion that sex before marriage was actually wrong.

Sexual activity amongst young people generally results in pregnancy sooner or later. One American study showed that 36% of sexually active teens become pregnant within two years of first intercourse.[1] Pregnancy will end in one of three ways. It may go to term the mother keeping the baby, the baby might be adopted, or the pregnancy may result in abortion—spontaneous or induced.

In my review of the recent medical literature on the subject I have been amazed to read statements such as the following in a reputable, totally secular, medical journal. 'Adolescents who are sexually inactive and wish to remain so should be encouraged in their abstinence . . . The most effective means of avoiding adolescent pregnancy is to abstain from sexual activity'.[2] Oh, that this message were more widely disseminated in our schools and youth groups!

Before we go on to examine the problems arising out of any of these options it is interesting to look at the true incidence of teenage pregnancy. It is not enough to simply look at numbers of births to teenagers, or abortion statistics because the overall proportion of teenagers in our population may be changing. For instance in England and Wales the number of females ages 15 to 19 rose from 1,645,000 in 1969 to 2,000,000 in 1983 (OPCS statistics).

Births are registered and induced abortions are notified, but there is no way of gathering information concerning the numbers of spontaneous miscarriage. However, attempts are made to express the rate of conception as the number of pregnancies occurring per 1,000 girls. Different countries may be compared, as may different age groups. The graphs escalate from an overall pregnancy rate of 10 per thousand (under 15's) to around 150 (at 19 years) in the United States, whereas in the Netherlands it is about

25 at age 19. The other European countries are scattered in between these extremes. In most countries the abortion rate is between one third and a half of the total conceptions.

The illegitimacy rate has been another frequently quoted parameter of teenage sexual mores. For it must be remembered that some, older teenagers are married and happily becoming parents for the first time. The overall illegitimacy rate has soared from 6 per hundred births in 1961 to around 25% at the present time. This does not take into consideration the numbers of babies deliberately planned by co-habiting couples.

Coming closer to (my) home some very important work was done in the 60's and 70's by the now retired Professor of Obstetrics and Gynaecology at Newcastle University, J. K. Russell. He took a particular interest in the subject and followed up in depth his cases of teenage pregnancy occuring in one part of Newcastle. Not only did he closely supervise the obstetric management but he involved himself in the educational and wider family aspects. He was also able to follow up his cases into maturer adulthood. Anyone with a particular interest in the subject of teenage pregnancy would be well advised to try and get hold of a copy of his excellent monograph[3] (unfortunately now out of print).

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In essence Professor Russell divided his teenagers going on with their pregnancies into two groups, the 16's and under and 17 to 19 year olds. Various obstetric factors were considered with a view to determining whether in fact the younger teenagers did less well than their older sisters.

Certain time-honoured teachings were overthrown by his results. For instance pregnancy-induced-hypertension was *not* commoner in the younger group (note that the condition is commoner in a first pregnancy at any age). Anaemia had more to do with socio-economic group than age. The incidence of a small-for-dates baby, breech, small pelvis requiring caesarean section was *not* greater amongst the younger girls. (In fact the caesarean rate was actually lower, perhaps due to a softer pelvis?)

The only highly significant difference in the two groups was the incidence of preterm labour. The younger girls more often had tiny premature babies, some of which did not survive. Thus the perinatal mortality rate for this group was significantly higher. However, from the point of view of *maternal* health there was essentially no difference between the two groups.

It might reasonably be argued that Professor Russell's figures were comparatively small, maybe his writings somewhat anecdotal and now dated. However, more recent studies confirm his figures. Brown and others[4] looked at 286 girls, 16 and under, having their first baby and compared them with 267 women aged between 21 and 25, also having their first child. They also found similar results.

Educationalists and psychologists have studied the wider implications of teenage pregnancy.[5,6] Many of these youngsters do not complete their education and go on to become reliant upon social services. The marriage of the girl's parents may break down. The baby itself is likely to do less well developmentally and be more like to suffer 'cot death'. In the US it seems that more is being done for these teenagers than in Britain. Programmes have been established to provide ongoing educational support for the girl and, for instance, to involve the teenaged father (as usually he is) in sharing the responsibility for bringing up the baby.

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Moving on to teenage abortion it must be made clear that we are talking about induced, not spontaneous. Very interestingly some figures for teenagers seem to suggest an incidence of about one in ten pregnancies ending in miscarriage, which is significantly better than the usually quoted figure of one in five for women of all ages. Does this mean that teenagers are actually less likely to miscarry? This is pure speculation.

Statistics have been gathered nationally by the OPCS for the numbers of abortions being done, by what method and on whom, since the Abortion Act was passed in 1967. These figures make fascinating, if depressing, reading. For instance in 1969 852 fifteen year olds had an abortion; twenty years on it had risen to 3,383.

There has been much recent publicity surrounding the RU 486 abortion pill, and plenty evidence over the years to show that the earlier the abortion, the safer. But this does not help the teenager. Many studies have shown that they present late. The Royal College of Obstetricians

and Gynaecologists commissioned a study which was published in 1984[7] to look into the 'problem' of late abortion. It found, for instance, that just over 50% of abortions done between 20 and 24 weeks were done on youngsters of 19 years and under.

Teenagers may not realise they are pregnant at first. They may not wish to tell anyone. Their periods may be somewhat erratic during their first few months or even years of reproductive life. There are instances where the girl never had her first period, she was already pregant.

The standard abortion techniques are applied. In the private sector, for the 'late' abortion, that is beyond 13 weeks gestation, this means a so-called 'dilation and evacuation'. The cervix or neck of the womb in stretched open and the baby extracted, often piecemeal. The risk to the mother's immediate health and her future childbearing capacity is significantly greater for such operations than the earlier, suction methods.

Within the NHS the commonly used late abortion method employs the drug prostaglandin. This powerful, hormone-like drug is usually pumped slowly through the cervix to initiate labour. This is probably more painful, if anything, than normal labour (though alleviated by drugs) which takes place when the body is prepared for it. It may take a day or two to complete, and the girl may yet require a visit to the operating theatre to remove the afterbirth.

Professor Russell looks very carefully at the immediate and long-term results of abortion in his two groups of teenagers. He comes to the conclusion that the younger the girl, the greater are the risks of abortion, both immediate (bleeding, infection) and long-term (subfertility, miscarriage, premature birth).

Clearly pregnancy is not a good thing for most young teenagers, physically, emotionally, socially. And pregnancy is but one result of sexual activity, amongst a list of other more sinister effects, such as sexually transmitted diseases, including AIDS, and possibly an increased risk of cervical cancer.

Studies show that once youngsters have become sexually active, albeit on an irregular basis, they will remain so. It takes very powerful motivation, such as religious conversion, to change. A survey[8] was sponsored by Agapé in advance of the National Symposium of Teenage Sexuality. It was a survey of church going youngsters and interestingly confirmed that numbers of teenagers had once been sexually active, but were no longer so, having become Christians.

In addition to praying for our young people, that they may become committed to Christ, is there anything else we should be doing in this real world? First and foremost every effort should be maintained to delay the start of sexual activity. The secular medical writers are saying this. How much more should we as Christians? Educationalists need to accept the proper role that sex education has. The writers in this area agree that there needs to be a realistic exploration and acceptance of normal physical development. Positive teaching on the family and its responsibilities should be balanced against the stark biological facts. Amongst Christians, positive reinforcement of the Biblical teaching on sexual matters, and the rewards of waiting for marriage, can be made without relying on a string of 'thou shalt not's for guidance.

What about the problem of those teenagers who are already sexually active and very likely to remain so? I have to stick my neck out here and say that personally I would recommend contraception. However, it is widely recognised that teenagers are notoriously bad at using contraception.

Firstly, any method requires forethought. It requires an acceptance of the possibility of pregnancy. Adolescents are usually emotionally immature and may be embarrassed over their new found sexuality. Barrier methods may be even more unacceptable amongst teenagers than older age groups. Intra-uterine devices are particularly not recommended (by most gynaecologists) in women who have not had their family yet, because of the risk of infection blocking the fallopian tubes. We are therefore left with the oral contraceptive pill. Again, however, compliance may be poor. Injectable, three montly, contraceptive hormones are sometimes the answer for the mentally subnormal.

Sadly, there will always be those teenagers who find themselves inadvertently pregnant. The initial response on the part of the girl and her parents may well be to panic and consider abortion to be the only way out. From what I have said above, pregnancy may be less damaging to the girl than an abortion, quite apart from the moral aspects. Pro-life organisations such as LIFE, CARE etc. provide counselling and very practical help for the girl who decides to go on with her pregnancy.

She needs expert obstetric care, and hopefully will not delay too long before presenting to the general practitioner. There will be social needs, in particular relating to support from the girl's family and also her ongoing educational requirements. Local authorities seem to vary considerably as to the provision of schooling in these circumstances.

These girls and their families, and also quite possibly the baby's father, will need plenty of loving support in the years to come. If the girl has had an abortion after all, the spectre of post-abortion depression arises, with the need for further counselling.

The Agapé Report[9] contains some frightening statistics for our church leaders and indeed all Christian parents these days. For instance, *14% of church going 16 years old in the survey had had sexual intercourse*. This is considerably better than the 50% quoted at the beginning of this article, but should give us no cause for complacency whatsoever. An average church with a youth group numbering twenty or so, half of whom are girls, may find that there is a pregnancy every other year or more, at this rate.

I find it truly inspiring to read the following in a secular, medical work: '. . . I am critical of the present strong contempt for standards and valus which have long bound families together and have contributed to the stability of our society—discipline, truth, service to the community, gentleness and consideration for others, a sense of responsibility and chastity before and fidelity after marriage.' J. K. Russell.

1. Pregnancy in Adolescents, Sally Davis, Pediatric Clinics of North America, Vol 36, No 3, June 1989.
2. The Prevention of Adolescent Pregnancy, Elizabeth R. McAnarney and William R. Hendee, Journal of the American Medical Association, Vol 262, No 1, July 7 1989.
3. Early Teenage Pregnancy, Current Reviews in Obstetrics and Gynaecology 3, J. K. Russell, Churchill Livingstone, 1982.

4. Obstetric Complications in Young Teenagers, Haywood L. Brown and Whitney J. Gonsoulin, Southern Medical Journal, Vol 84, No 1, Jan 1991.
5. The Problem of Teenage Pregnancy, Martha Cole McGrew and William B. Shore, The Journal of Family Practice, Vol 32, No 1, 1991.
6. Adolescent Pregnancy and its Consequences, Elizabeth R. McAnarney and William B. Hendee, Journal of the American Medical Association, Vol 262, No 1, July 7 1989.
7. Late Abortions in England and Wales, Royal College of Obstetricians and Gynaecologists Report, 1984.
8. Young People's Relationships, Lifestyle and Sexual Attitudes, Boyd Myers, 1991 available from Agapé, Birmingham B2 5HG at £20 inc P&P. Youngsters from a variety of denominational backgrounds were surveyed at the beginning of 1991. 1729 questionnaires were returned and processed by computer, by MARC Europe.
9. As above.

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ABORTION AND SHELTER—BEYOND THOMSON'S VIOLINIST

The abortion debate often concentrates on the status of the unborn. Yet this cannot be our sole concern, as many writers have shown. If the life of the foetus and embryo demands our serious respect, it remains to ask what kind of behaviour such respect would allow. An unborn child is sheltered and fed by the body of the pregnant woman. May the woman withdraw this shelter at will, involving, as it does, her body?

Respect for the lives of adults, or for that matter those of children, is not normally thought to require of us all the protection we can give. If I build a road, sell a new drug or pause from saving lives, innocent people will die whose deaths I could certainly have prevented. Sometimes my act or failure to act will be callous or unjust. I will then be accountable even for those deaths I at no stage intend. Other times, though lives are lost, I will have done nothing wrong. If I fail to donate my organs, on the grounds that I need them to live, I neither attack, nor fail in regard for, the lives and bodies of others.

How should we look at abortion, with thoughts such as these in mind? To focus on abortion as a withdrawal of physical shelter, we should look at those abortions which do this and only this: which do not target the body or the life of the unborn. The foetus is removed intact from the woman's body, with the aim of ending her pregnancy, not the existence of her child.[1] This is not direct killing, a deliberate attack, as in, say, abortion by D. and C. Here the foetus is killed as a side-effect of the operation. Need this be callous or unjust?

At this point, those familiar with the literature will call to mind the case of Thomson's violinist. Judith Jarvis Thomson,[2] in her well-known article, gives the following analogy for pregnancy due to rape or contraceptive failure. I wake one morning to find I have been kidnapped, and linked to a famous kidney patient with the aim of saving his life. If I disconnect myself, I will indirectly kill the patient,[3] if not, I face weeks, months, or years beside him in a hospital bed. A question Thomson asks, which we can ask about abortion, is whether I am obliged to stay connected, and if so, for how long.

I am, Thomson argues, justified in disconnecting myself both from the violinist and, by extension, from the foetus. Taking a similar line, other philosophers have argued that abortion is a severance procedure. Thus Mary Anne Warren holds that abortion can be justified in the interests of disconnecting oneself from the foetus. If this can be achieved without causing the death of the foetus, then, she says, one should not cause its death.[4] Considerations such as these are growing in importance as the age of viability falls with advances in technology. Even today, a foetus killed by mid-trimester abortion could, in some cases, be saved by hospital care. In the future we may find we are able to save the newborn child at whatever age it leaves the mother's body. Abortion patients and doctors may increasingly be invited to choose, in so many words, to end or not to end its life.

If an abortion is justified as a severance procedure, there will be, once it is over, no farther 'right to choose'. For the newborn child is no longer dependant on its mother, and the mother may not, even if she wants to, end its life. It is usually possible to pass the child at once to someone else's care. What, however, if there were to be some significant delay? Let us turn to another example.

I am (we'll imagine) a scientist who, after years of negotiation, has secured a place on an arctic depot for nine months solo research. Entering the building one day, I am shocked to find an Eskimo baby, and the body of her mother, who has died on reaching shelter. Due to a radio breakdown, I cannot contact anyone else. I have no experience with children and my work demands all my time. Must I let the baby stay—which may affect my whole career—or may I put her out in the snow and continue with what I was doing?[5]

Most of us will agree that I must let the baby stay. I cannot fairly deprive her of shelter she needs to live. The

fact she is physically helpless and has no plans of her own seems only to reinforce her claim on my kindness and forbearance. May I, perhaps, refuse to take active steps to save her life? Again, it seems that I may not. To watch her starve to death or fall from my lap would be utterly unjustified, whether direct killing or not.

As I hold and feed the baby I will, of course, be using my body. How does this compare with, say, supporting the violinist? My feelings in each case may or may not be very different; however, there is one crucial difference. The violinist's need is both burdensome and bizarre: almost a paradigm case of a need for 'extraordinary' support. Nothing about the violinist or his relationship to me makes this a normal connection between his body and mine. Once connected, it may well be that I should do something to help; however, nine months of this kind of help seems more than can be required. In contrast, the needs of the baby, however extraordinary her arrival, are as ordinary as they can be. They are those of all humans, sick and well, at a certain stage of life. She needs my body to hold her, feed her, refrain from throwing her out. She does not need it as a source of organs, or as a shield for bullets. Circumstances have made me responsible for her care; her future hangs on the way I choose to respond.

What, then, are we to say about the needs of the unborn child? Are they needs for extraordinary support? The question itself is extraordinary, when we consider that these needs were once the needs of every human being. The foetus in the womb is where every child must be—in shelter such as the parents had for at least six months of their lives. To live so sheltered, as all of us lived, is itself an ordinary claim. Nor does this mean that the pregnant woman is some kind of incubator: a comparison which again suggests that the power of women to shelter is something abnormal. Women can indeed be viewed as mere life-support systems. Such views are bizarre and demeaning, yet pregnancy is neither. A woman is not an incubator if her body shelters a child[6]—any more than a man is a cradle if a child rests in his arms.

Are there circumstances in which shelter may be withdrawn? In attempting to answer this question we will look at a final example—more bizarre than pregnancy, if less than Thompson's kidnap. I am in a damaged aeroplane, where there is no air left to breathe. I find myself with a child on my lap, who is wearing the oxygen mask above my seat. The cord of the mask is tangled, and the child cannot reach it without my continued support. I have no mask, but there is one across the aisle; I have just a few seconds to reach it. May I leave my seat for the one across the aisle, as the child slips off mylap and the mask falls off his face? Perhaps, as (to turn to a more familiar case) a woman might receive radiotherapy for cancer, despite the fact she is pregnant and this may kill her child. To prevent a fatal side-effect at the cost of one's own life is sometimes, at any rate, beyond the call of duty. The action in either case is not one of intentional deprivation. The aim is not to withdraw support, let alone to end the child's life.

What if the means of living are deliberately withdrawn, to increase our own chances? On the aeroplane, may I push the child off me and take the mask for myself? That a child has the means of living, while I do not, seems as lucky for the child as it is disastrous for me. I should not be harshly judged if I succumb to such a temptation: nonetheless what I do to the child may be less than fair.[7] What if he has been injured and will die soon whatever I do? Now it seems I may take the mask to increase my chance of survival. We may now recall the case of surgery on a tubal pregnancy: the withdrawal of shelter, 'extraordinary' and dangerous to the mother, which could not long sustain life.

Cases such as this are mercifully uncommon. Far more common are predicaments more like that of our arctic scientist, where provision of shelter poses no such threat to life. Whatever the sincere beliefs of the pregnant woman and her doctor, their intended action is on a par with exposing a newborn child.

Proponents of the right to choose may be left unmoved by such arguments, if they do not see abortion as justified merely as a severance procedure. Thus they may claim that parents have a right to choose abortion, simply because they do not want a child of theirs to live.[8] Such a view may easily be extended to infanticide, so that neither born nor unborn need be left in any shelter. Those with (for example) self-concepts need not protect those without.

To attempt to answer such claims is not the task of this paper. However, this can be offered as one very brief response: that we owe our lives to protection of our interests in childhood, as much as to respect for these in later life. Throughout human development one candidate continues for active potential, interests, and rights. A society excluding childhood from the unit 'human being' would neither be just nor, probably, of great duration. It is difficult to imagine a world quite without protective choices, although it may be useful every now and then to try. For we benefit all our lives from the willingness to shelter: valuable, if anything is, to humankind.

1. Often, in fact, whatever the method of abortion, the intention is that the foetus not survive.
2. Judith Jarvis Thomson, 'A Defense of Abortion', *Philosophy and Public Affairs*, 1. (1971) pp. 47–66.
3. Thomson refers to the act of the disconnecting oneself as one of direct killing. It is not, however, direct in the sense that I aim at any stage to damage or destroy the victim's body.
4. Mary Anne Warren, 'Postscript on Infanticide' in *Todays Moral Problems*, 2nd edition, ed. Richard A. Wasserstrom, Macmillan Publishing Co., 1979, pp. 49–51.
5. Like Thomson, I am looking here at situations in which we find ourselves unexpectedly 'supportive'. Unlike Thomson, I leave to one side altogether certain factors which may multiply our duties. Examples are: the parent-child relationship, the voluntary acceptance of the risk of creating it, and, perhaps, certain prior agreements (for example, with the father of the child).
6. Here the attitudes of others do not cancel our obligations (though they may affect our perception of these, excusing our failure to meet them). The man who cares for an infant for whom he is responsible may be shown no respect whatsoever. Nonetheless he may be meeting a straightforward obligation to supply ordinary support.
7. I do not wish to suggest that civil law should not permit at least indirect abortion in such cases.
8. Gerald Paske argues frankly for this position in his article 'Sperm-napping and the Right Not to Have a Child', *Australasian Journal of Philosophy*, Vol 65, No. 1 March 1987 pp. 98–103.

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AIDS: THE MORAL, MEDICAL, AND SPIRITUAL CHALLENGES

INTRODUCTION

When I was invited to take part in this conference, I proposed to address myself to the future relationship between AIDS and the ongoing euthanasia movement, often denominated the 'death with dignity' or 'natural death' movement. Death as a consequence of AIDS—almost invariably from so-called 'opportunistic infection'—is very seldom dignified, as both medical personnel and clergy who have had contact with AIDS patients know all too well. In order to obtain a more decent *exitus lethalis*, euthanasia in various forms is sought and practiced: however, this is not 'natural death'.

In the area of AIDS therapy and research, events are succeeding one another with bewildering rapidity. In proposing to deal with the phenomenon of AIDS and euthanasia, I assumed that two factors would be very significant: first, the incredibly heavy burden that a relatively small number of AIDS patients would place on the health care and insurance systems of our countries,[1] second, I assumed that the fact that AIDS has been very largely transmitted by means of activities that may be illegal (drug use, in some cases, prostitution) and/or considered immoral and unnatural by large segments of the population would lead to increasing moral and emotional pressure on public authorities to 'do something' to contain the problem and to limit the damage that it was causing.[2]

Instead, I discovered that there is—in the United States at least—considerable pressure on insurers and health maintenance organizations (HMOs) virtually to ignore the fact that AIDS is a specific disease with a highly distinctive etiology and a very high intensity of care requirements and of costs, in other words, not merely to treat it as any other disease, but almost to act as though it did not exist. For example, although evidence of prior health problems is universally considered by insurers and in many cases leads to 'rating'—i.e. to increasing the charges for coverage and/or to reducing the benefits to the insured—in several U.S. jurisdictions where AIDS is heavily represented, such consideration is prohibited by law:

California: Results of a blood test for antibodies to HTLV-III virus shall not be used for the determination of insurability. Reference: Cal. Health & Safety Code, §199.21(f) as amended by A.B. 488, effective April 4, 1985.

Florida: Results of TTLV-III antibody tests, conducted at state established blood testing sites, cannot be used to determine insurability. Reference: Fla. Stat. Ann. §381.606 (1986).

District of Columbia: D.C. Law 6-132, effective August 7, 1986, in part: Sec. 4. Prohibited Actions.

(a) An insurer may not deny, cancel, or refuse to renew insurance coverage . . . because an individual has tested positive on any test to screen for the presence of any probable causative agent of AIDS, ARC (AIDS-related complex), or the HLTV-III infection, . . . or because an individual has declined to take such test.

(b) (1) In determining whether to issue, cancel, or renew insurance coverage, an insurer may not use age, marital status, geographic area or residence occupation, sex, sexual orientation . . . for the purpose of seeking to predict whether any individual may in the future develop AIDS or ARC.

(d) No life insurance policy or contract shall contain any exclusion, reduction, or other limitation of benefits related to AIDS, ARC, HTLV-III infection, or any disease arising from these medical conditions, as a cause of death.[3]

Additional sections of the D.C. Law prohibit insurers from requesting any individual to take the HTLV-III antibody test and prohibit asking whether an individual

has taken such a test. Further, for five years from the law's effective date, insurers may not consider AIDS in setting premium rates.[4]

If one bears in mind the fact that insurers regularly inquire about dangerous sports, such as parachute jumping, auto racing, and scuba diving, and frequently write exclusionary clauses into their contracts with respect to incidents that may occur in consequence of such activities, legislation of the District of Columbia type must certainly appear extraordinary.

With respect to my second assumption, to the effect that moral and emotional pressure would be put on public authorities with regard to 'high risk activities' and those who engage in them, I had anticipated that Christians and their churches would be challenged to rise to the defense of HIV-infected persons and of those engaging in or suspected of engaging in high risk activities. Instead, we discover that AIDS is characterized as 'a challenge to rethinking' by theologians such as Prof. Volker Eid of the Roman Catholic Theological Faculty of Bamberg (Germany). Prof. Eid writes: 'In our case, rethinking means to come to terms with the fact of the deadly threat of AIDS, to come to terms with the plight of the affected, caused by AIDS. And it also means to come out from among our traditional customs of attributing guilt and of prejudice.'[5]

Eid writes, 'Guilt is an undeniable fact in the life of every man,' but he is very concerned that in connection with AIDS, even the merest suggestion of guilt, sin, and repentance is to be avoided: 'As to the mention of Jesus' liberating association with guilty persons in our ecclesiastical and theological talk about the theme of AIDS, one must make it very clear that even when we exercise the greatest restraint, we might create the following impression: "It is true that by your sexual behavior you have laid guilt upon yourselves in some way or other; nevertheless, we are going to help you." '[6]

Other theologians are even more emphatic in taking the phenomenon of AIDS as a reason—or pretext—to write in justification of male homosexuality, or of homosexuality of both varieties. Thus Pastor Hans-George Wiedemann, who holds a law degree as well as a degree in theology, writes with what I would describe as aggressive candor:

'If the Mene, tekel of AIDS should once again bring homophobia to the point that homosexual and bisexual lovers are stigmatized as lepers, then the credibility of the church will be at stake if it remains silent about it. The church gains credibility only then, when it not only involves itself on behalf of AIDS patients, but also makes it plain: homosexual lovers are as close to God—or as far from him—as everyman, as every man and every woman. Practically, the church will have to prove this not only be accepting Christians who practice homosexual love as members, but also as full-time workers, without reservation. The church could also raise up a standard by not withholding its blessing from loving homosexual couples who wish their partnership to be blessed in a service of worship.'[7]

The title of Wiedemann's essay, 'The Church and Homosexual Love in the Age of AIDS,' makes it plain that the author considers AIDS an incentive to justify homosexuality and make it acceptable, far from raising a warning finger.

Even former United States Surgeon General C. Everett Koop, M.D., who as a confessing Christian in the Reformed tradition accepts the biblical strictures regarding homosexual conduct as the inspired Word of God and therefore considers homosexual relations sinful, is extremely cautious about saying anything that directly stigmatizes homosexuality as such in his many warnings about AIDS:

'The Surgeon General's report describes high risk sexual practices between men and between men and women. I want to emphasize two points: First, the risk of infection increases with increased numbers of sexual partners—male or female. Couples who engage in free-wheeling casual sex these days are playing a dangerous game. What it boils down to is—unless you know with *absolute certainty* that your sex partner is not infected with the AIDS virus—through sex or through drug use—you're taking a chance on becoming infected. Conversely, unless you are *absolutely certain* that you are not carrying the AIDS virus, you must consider the possibility that you can infect others.

'Second, the best protection against infection right now—barring abstinence—is the use of a condom. A condom should be used during sexual relations, from start to finish, with anyone you know or suspect is infected.'[8]

From a logical perspective, one could fault former Surgeon General Koop for his use of the terms *absolute certainty* and *absolutely certain*. Even in the case of a long-standing, faithful marriage relationship, no woman whose husband has been out of her sight even briefly can be sure that he has not had a relationship in which he contracted the AIDS virus; indeed, the same thing can be said about a man, for although he may be completely faithful to his wife, he cannot know with absolute certainly that she has totally refrained from the kind of extra-marital contact that might make her an HIV-carrier. If we think of a couple that is contemplating marriage, a test for HIV antibodies taken before marriage could prove that a prospective spouse was uninfected three months prior to the test, but would not reveal an infection closer to the test date. For a period, the State of Illinois where I reside required HIV antibody tests prior to issuing a marriage license. One result was that many couples fled to neighbouring states, where such a test was not required, to marry. Dr. Koop obviously presupposes—and has explicitly written and said this elsewhere—that many people, from their teen years onward, will move rather quickly into an intimate sexual relationship with a person whom they do not know well and/or have not known for a long time.

To turn from Dr. Koop's medical advice to the 'pastoral' counseling of nominal Christians with whom he would not be likely to be much in sympathy—but with whose practical counsel he does not seem to differ significantly—we read in a set of 'guidelines' prepared for confirmation candidates (average age 15–16) in Düsseldorf, Germany.

'8. In the future (!?) the following principles are to be observed:

a) It is important to talk openly with future sexual partners about sexuality—also about what one has already experienced in this area.

b) 'Going to bed together' should be preceded by a

longer period of getting acquainted. "Disco behavior" is frivolous and generally frustrating.'[9]

The German clergy seem to assume a fairly high level of sexual contacts and a multiplicity of partners. If one makes this assumption, then the 'protection' that both recommend—the prophylactic or condom—is hardly a sure defense. As one military doctor in the United States commented on the use of condoms: 'If the "partner" is uninfected, the condom is pointless; if the "partner" is infected, it is an unacceptable risk.'

If one were to apply Immanuel Kant's principle of universifiability ('Act only upon the maxim that you can wish to be universally accepted') to the Düsseldorfer suggestion, it is evident that a consequence would be the rather rapid disappearance of the human race. Pastor Wiedemann polemicizes against 'the reduction of sexuality to procreation,'[10] but what we are confronting here is the absolute separation of sexuality from procreation.

Even more vigorous in his denunciation of putative ecclesiastical reactions to AIDS than Wiedemann is psychologist Dr. Siegfried Rudolf Dunde, who also has a theological degree. Dr. Dunde fulminates against 'hate' as a reaction to AIDS, and charges that AIDS turns hatred for the disease into hatred for the diseased. He also designates nonconformity, disgust, and freedom of pleasure (*Lustfreiheit*) as 'mechanisms of hatred' (*Haßauslöser*) which stimulate in Christians—at least in the kind he dislikes—'joy over the fate of those who are "different".'[11] Dunde thus overlooks all the efforts of more moderate theological voices such as Eid to show concern, sympathy, and love for AIDS victims, despite the fact that attitudes such as Eid's seem to this observer to be far more typical of the Christian response to AIDS than the kind of malicious 'joy' that Dunde claims to see. Indeed, AIDS has functioned as a *Haßauslöser*, but as a mechanism to inspire hatred of the church and Christian moralists (as well as morals). The church could plausibly be saying to most AIDS sufferers, if not 'Serves you right!', then at least 'You brought it on yourself.' Instead, Dunde as well as many AIDS activists and other critics of traditional Christianity seem to be enraged at the church as though the church were responsible for the fact that AIDS has appeared on the scene as a kind of fulfillment of Paul's warning in Romans 1:27. Most Christian observers, conservative as well as liberal, are quick to state that they do *not* regard AIDS as the 'penalty' for homosexual conduct to which Paul refers. Nevertheless, because it is in Romans, and the church preaches and teaches from Romans, it seems almost as though the church is held responsible for AIDS, and for this reason is made the target of condemnation and even of hatred. Before AIDS, the traditional tendency of the church to condemn homosexual conduct was more or less ignored by homosexual activists, whereas now they are calling on the church to repent and to disavow its previous 'homophobia.' With regard to the hidden implication that the church in some way wished AIDS upon those who disregarded its moral teachings, one can only quote the familiar French proverb, cited by Professor Jerôme Lejeune of Paris thus:

'Seul Dieu peut vraiement pardonner; l'homme pardonne parfois; la nature ne pardonne jamais.'

I. THE MORAL CHALLENGE

The moral challenge of AIDS to the Christian community as well as to medicine and health care providers is directly tied to the undeniable and yet vehemently disputed intimate tie between AIDS and male homosexuality, and especially with the frequency, promiscuity, and exotic nature of much male homosexual activity. This tie is denied over and over again, in various ways, by reference to the increasing ratio of intravenous drug users to male homosexuals among the HIV-infected, by reference to the rising number of HIV-infected women and babies, by reference to the situation in Africa, where homosexuality is relatively rare but AIDS is sadly widespread among heterosexuals. Over dinner in Basel, Switzerland, a young medical graduate, a Christian, informed the writer that male homosexuals no longer constitute the largest percentage of new AIDS patients in Switzerland. That melancholy distinction now belongs to 'Fixer,' i.e. to intravenous drug abusers.[12]

The fact that the AIDS virus can be contracted by a variety of means, and that it has spread widely in Africa where there is little homosexuality, does not alter the fact that in almost every case in the West, new infections can uniformly be traced back to original infection through male homosexual conduct.

Although homosexual behavior and individuals with a primarily or exclusively homosexual orientation have always existed, both Christianity and Judaism have strongly condemned homosexual acts. Inasmuch as the original carriers and disseminaters of the HIV in the West were unaware that they were carrying and spreading such a disease, they should not be subject to criticism for doing so. However, inasmuch as the conduct in which they engaged had been subject to moral reproach *before* it became known how much such conduct contributed to the epidemic, it is bizarre that it is precisely AIDS that has led to increased tolerance of male homosexuality and to increasing sympathy for those who engage in it. Before any compelling connection between homosexuality and the spread of disease could be shown, homosexuality was disapproved; once the connection became inescapably evident, it was accepted. It is as though cigarette smoking, which was subject to some moralistic criticism before its connection with lung disease was established, had suddenly become respectable once its role in causing lung cancer and other disorders was definitely demonstrated. This is, of course, precisely *not* what happened. Cigarette smoking has become the subject not only of medical admonitions and warnings—sometimes couched in rather grisly terms—but also of general moral disapproval and social intolerance. It is evident that something strange is going on here. 'The [AIDS] epidemic has created strong allies for gay people in the parents, friends, and loved ones of those who have died and are dying of this disease . . . it is not possible to observe the courage of people with AIDS and their friends and lovers who are caring for them without developing a great respect.'

There is apparently a confusion of categories here. Observers such as S. R. Dunde claim that Christians and others are motivated to hate those who are sick rather than the sickness. Instead, in the above citation Jim Foster observes that the misery, suffering, and courage of

the sick has moved outsiders not only to love and accept them, but also to accept their conduct.[13] Lung cancer continues to claim more victims than AIDS, and a high percentage of lung cancer patients are or were cigarette smokers. Do we hear cries for legislation to protect the rights of cigarette smokers? Quite the contrary, at least in the United States. Do we even hear expressions of sympathy for victims of lung cancer, emphysema, and other smoking-related disorders? Certainly not. Do we hear expressions of satisfaction that lung cancer is found among those who have never smoked? Indeed not. In this connection it is also relevant to note that lung cancer is not contagious, and that the lung cancer patient cannot infect others, neither via sexual intimacy nor in any other way.

Traditionally Christianity has called upon its adherents to hate the sin while loving the sinner. Most Christians, dealing with the HIV-infected and with AIDS patients, make an effort to do this. Sensitive observers such as Professor Eid of Bamberg warn them that they must do all that they can to avoid any suggestion of moral disapproval, not to mention condemnation.[14] Militant advocates of the homosexual cause, such as Dr. Dunde, demand that all barriers, scruples, and reservation be not merely dropped but repeated and actively repudiated, and San Francisco Health Commissioner Jim Foster rejoices that a disease which is primarily carried and spread by homosexual activity, that is to say, by active homosexuals, is creating not merely sympathy for these who suffer in consequence of their 'life-style,' but even for the 'life-style' which lies at the root of their suffering, and for their right and the right of others to pursue it and to advocate it as they see fit. There is certainly a difference between saying to the AIDS victim, 'You should have known better: you brought this on yourself,' true though that may be, and saying to others, to those who have not yet embraced the 'life-style' or contracted the virus, 'Take heed, lest ye likewise perish.'

Defenders of homosexual activity and of homosexual rights, such as Pastor Hans-Georg Wiedemann, previously cited, often speak in terms of homosexual love, although it is frequently hard to interpret brief, casual relationship as love. To interpret particular homosexual acts as expressions of love does not set aside biblical injunctions that apply to them, nor, to the extent that such acts are prohibited by civil law, does love produce immunity to legal action and penalties. Nevertheless, to evoke the idea of love certainly can produce a measure of understanding and sympathy among non-homosexuals, as Pastor Wiedemann demonstrates.

The earliest data gathered on AIDS, even before it was at all well understood, brought out its connection with male homosexuality: it was originally called Gay-Related-Immune-Disorder (GRID).[15] It was originally suggested that the new element responsible for the appearance of a hitherto-unknown malady 'was an unprecedented level of sexual promiscuity that had developed among a subgroup of homosexual men in New York, San Francisco, Los Angeles, and some other large urban centers since the late 1960s.'[16] In other words, it became evident early on that GRID, later AIDS, was associated not merely with male homosexuality, but with a high degree of promiscuity as well as with certain specific practices. Homosexuality as an expression of a deep same-sex emotional relationship was not the cause, although the phenomenon of deep same-sex emotional relationships was and is often evoked to secure sympathy and approval for homosexual conduct. Homosexual activists, even in the morbid atmosphere of the AIDS epidemic, claimed not the right to sex within relationships, but the right to sex as such. Thus Dennis Altman writes in *AIDS in the Mind of America:* 'The growth of gay assertion and a commercial gay world meant an affirmation of sex outside of relationships as a positive good, a means of expressing both sensuality and community . . . I do not think it is too fanciful to see in our preoccupation with public sex both an affirmation of sexuality and a yearning for community, which may be one of the ways we can devise for coming to terms with a violent and severely disturbed society.'[17] No moral code, past or present, with which this writer is familiar, has ever extolled sexual activity as such, without respect for relationships, responsibilities, self-control, or discipline. This means that the advocacy of homosexual freedom and rights, which has so paradoxically *intensified* in the course of the AIDS epidemic, implies a categorical repudiation of all aspects of every human moral code that deal with sexual conduct, and indeed, by implication, of the very existence of such moral codes. The vehement language of writers such as Altman ('a violent and severely disturbed society') and Dunde ('Haßauslöser') indicates a massive, categorical repudiation of the existing social order and of all the edifying concepts and traditions that have gone into its creation. The demand for the legitimization of homosexual love and its associated activities clearly involves a repudiation of the tie between sexuality and reproduction and implies a rejection of the idea of natural law (as does that other modern social pestilence, abortion on demand). However, as we have seen, Altman—and others with him—go beyond demanding acceptance of homosexual *relationships* and demand the affirmation of generalized and even public sex as such. Altman's book was published in 1986, three years after Professor Luc Montagnier's identification of the AIDS virus, and two years after the American researcher Robert Gallo made the same discovery.

The moral challenge connected with AIDS is this: to hate the sin while showing compassion and concern for the sinner. As St. John writes in his First epistle, 'If anyone should sin, we have an advocate with the Father, Jesus Christ the righteous, and he is the propitiation for our sin . . .'. These 'comfortable words,' as the Prayer Book communion liturgy calls them, follow the admonition, 'If we confess our sins, he is faithful and just to forgive us our sins, and to make us clean from all iniquity' (I John 2:1–2, 1:9). To fail to acknowledge sin as sin, or, even worse, to insist that it is not sin at all, but a higher good and a natural right, is to forfeit the possibility of forgiveness, and with it the offer of salvation and eternal life.

II. THE MEDICAL CHALLENGE

AIDS has confronted the medical community, health care providers and insurers with a series of challenges. Among the most immediate is this: how to pay the costs of AIDS. According to a study prepared for the Centers for Disease Control, by 1991 AIDS cases would number

68.63 per 100,000, and would account for approximately 12 per cent of all costs, direct and indirect, or illness in the United States. Estimates of the number of future AIDS cases vary widely: it is assumed that virtually 100 percent of HIV-infected persons will ultimately proceed to full-blown AIDS, barring other fatal developments, unless a means of treating the cause is found soon. Estimates of the number of HIV-carriers are simply guesses based on the number of diagnosed AIDS patients. If we take the frequently-mentioned figure of 1,500,000 HIV-carriers among the U.S. population, and take the medium cost estimate for 1991 from the C.D.C. data, $10,900 per AIDS patient, we arrive at the figure in 1991 dollars of 164,400,000,000 for current HIV-carriers. Needless to say, such a figure cannot be exact. Nevertheless, it is evident that the cost of providing medical care for those individuals already carrying the human immunodeficiency virus will be immense.

The euthanasia movement in many countries, for the moment, is concentrating on persons in a 'vegetative' state, with an emphasis on 'cost containment' as well as on 'mercy' for the patients. It may be left to physicians or others to determine when a person's 'quality of life' no longer justifies the expenditures involved in keeping him alive. Thus David Thomasma, director of the Medical Humanities Program at Loyola University Stritch School of Medicine in the Chicago, Illinois suburb of Maywood, writes: 'Medicine should aim at reconstructing life sufficiently to sustain other values . . . . When these human values can no longer be sustained because of the physical condition of the patient, then a decision should be made for euthanasia on the basis of the patient's or surrogate's request.'[18] Few modern writers are suggesting that the cost of terminal care should be the decisive factor, but when 'inducing or bring about death' is described by Thomasma as 'a virtuous and moral act, especially if it is done in conjunction with the wishes of the patient,' it is apparent that the physical and emotional misery of late-stage AIDS patients, which will increase together with both individual and total health care cost as the number of terminal AIDS cases rises, will push more and more people to begin implementing this 'virtuous and moral' act.[19] A recent survey in the *Maryland Journal of Contemporary Legal Issues* cites extensive similarities between the presentations of euthanasia advocates in the United States today and those of the physicians who endorsed and implemented Nazi Germany's euthanasia program in the 1930s.[20] According to information in that survey, currently one in six deaths in the Netherlands is caused by active euthanasia, although the death certificates almost always specify death by 'natural causes'.[21]

The combination of physical and emotional misery and sometimes mental debility, burgeoning terminal care costs, the ever-present if often unreasonable fear of infection to care givers, and the certainty of ultimate if often delayed death will surely push more and more of those who think like Thomasma, Daniel Callahan, and others cited in the just-referenced survey by Rita Marker *et al.* to encourage and perhaps ultimately to insist upon 'virtuous and moral' acts to induce death.

Medical researchers, encouraged by substantial government funding in the United States, are energetically pursuing the task of finding ways to treat or cure AIDS in the HIV-infected and to prevent future infections, even among those who insist on continuing high-risk behavior. Most authorities seem to think that it will be quite some time before such efforts bear significant fruit. Surely we have to reckon with AIDS as a very significant source of increasing pressure on the health care systems of the world. The pressure may be accentuated by the perception that most AIDS victims have contracted the disease through conduct widely held to be reprehensible or even degenerate, which could conceivably lead much of the population to begrudge huge expenditures on their behalf. Although—as indicated earlier—almost all authorities, medical, moral, theological, legal, and otherwise, vigorously repudiate the suggestion that AIDS victims should be held responsible for their condition, and especially not in a way that would permit society to reduce its care and concern for them, the danger that this may happen cannot be excluded. (Lest there be any doubt, this writer vigorously *opposes* any such reduction.)

In the previous section, it was suggested that AIDS may have the effect of causing society, government, and the churches to accept patterns of conduct previously condemned, in spite of the fact that they facilitate the spread of the dread disease. Not it appears that the consequences of AIDS could push society towards the acceptance of euthanasia, voluntary and involuntary, which naturally would be extended to situations in which AIDS is not involved.

In addition to the very clear challenge posed by euthanasia, there are two other significant issues directly related to the medical response to AIDS: the question of whether it is related to homosexuality in a specific way, and the question of whether medical advice in the area of AIDS prevention can reasonably be expected to be effective as long as it continues to avoid the type of moral admonitions that used to be implied in terminology such as 'deviance' and 'degeneracy.'

In the early days of the AIDS phenomenon, it was called, as noted above, Gay-Related-Immune-Deficiency. Before the discovery of the HIV by Luc Montagnier and Robert Gallo, various theories proposed that the immune deficiency was caused by an overloading of the body's immune defense mechanisms in consequence of intrusive exposure through frequent, highly promiscuous sexual encounters, to vast number of bacterial, viral, and parasitic organisms as well as to semen. For various reasons, there has been a marked tendency to distinguish AIDS from 'infections of homosexual men,' as is done, for example, in the text, *AIDS* **and** *Infections of Homosexual Men*, to which reference has already been made. Parts I, II, and III of this textbook discuss 'sexually transmitted diseases,' but precisely *not* AIDS, which is considered separately in the balance of the book.[22]

Reseacher Joseph A. Sonnabend writes, 'It was assumed that HIV was directly responsible because of its tropism for CD4 lymphocytes coupled with the acceptance that the loss of this lymphocyte subset is the hallmark of AIDS . . . [but it] has also yet to be explained how infection of a small number of CD4 lymphocytes can account for the widespread abnormalities observed in AIDS.'[23] The burden of Sonnabend's study is to raise the question: Has the discovery of the HIV too rapidly diverted attention from a very real possibility that it is the homosexual lifestyle that *released* the HIV—now known as the direct agent causing AIDS—from harmless latency to pursue its

virulently destructive course? In other words, should male homosexuality, especially in its more extreme forms, be stigmatized as life-threatening even more vigorously than is now being done, by all but universal consent, for cigarette smoking?

The final 'medical' question is this: Is it medically and morally responsible, in the light of what we know and are learning about AIDS, to continue to treat AIDS-related conduct, especially in the sexual realm, as though it were on the one hand natural and totally uncontrollable, and on the other could easily be rendered safe by the use of a thin latex barrier, the much lauded condom? Those wishing to avoid syphilis, gonorrhea, and other venereal diseases were not told, 'Use a prophylactic,' but rather, 'Shun prostitutes.' This writer in adolescence and young manhood never once encountered a physician, Christian, Jewish, or other, who would suggest that patronizing prostitutes was more or less all right provided one provided oneself with a proper condom. At that time, syphilis and gonorrhea were already treatable and curable. AIDS is not, and probably will not be for some time to come. What makes it possible for genuinely spiritual physicians at the top of their profession, such as Dr. Koop, to talk the way he does about AIDS, not approving homosexuality, but, as it were, praising by faint damns?

III. THE SPIRITUAL CHALLENGE

> 'And the rest of mankind, who were not killed by these plagues, did not repent . . . and they did not repent of their murders nor of their sorceries nor of their immorality nor of their thefts.'
>
> Revelation 9:20–21, N.A.S.B.

In the ninth chapter of the Apocalypse, St. John speaks of three plagues which kill off one-third of mankind. Dr. Jonathan Mann of the World Health Organization has uttered a series of such dire predictions concerning AIDS that one could well envisage it as one of the apocalyptic plagues. While Dr. Mann and other public health officials are preoccupied with the genocidal potential of AIDS, this writer has attempted to draw attention to the perverse and paradoxical potential of this disease to change morals, categorically separating sex from procreation and even from relationships, definitively overturning Hippocratic standards and replacing them with a utilitarian ethic of euthanasia, and otherwise subverting the society of those whom the plagues do not carry off. Until the present time, the reaction of much of the society and of part of the church has been that described in Rev. 9:21, namely, 'They did not repent.'

The covenant relationship between one man and one woman, known as marriage, is a very fundamental aspect of divine creation, of our human condition as created made in God's own image. Sexuality should not be limited to reproduction, but it ought to be self-evident that reproduction and family are two of the most essential ends of created sexuality. Much of the moral code of Scripture has practical relevance for health and well-being. Nothing reveals the danger of ignoring God's laws—and the laws of nature—more dramatically than AIDS. Can it be, in the declining years of our century, and perhaps of our civilization, and perhaps even of world history, that the very thing that ought to be a warning will become the pretext for ignoring both nature and reason as well as God, and for plunging full steam into the very maelstrom that destroys? Is AIDS the stimulus that will cause our society, like that of ancient Rome, to merit Paul's judgment: 'Thinking themselves wise, they became fools' (Romans 1:22)?

1. See William Carroll, 'AIDS-Related Claims Survey: Claims Paid in 1986,' in James Vculek, ed., *AIDS One. Legal, Social & Ethical Issues Facing the Insurance Industry* (Chatsworth, CA: NILS Publishing Company, 1988), pp. 395–406.
2. See Robert Fulton and Greg Owen, 'AIDS: Seventh-Rank Absolute,' in Inge B. Corless and Mary Pittman-Lindeman, eds., *AIDS. Principles, Practices, & Politics. Reference Edition* (New York: Hemisphere, 1989; pp. 314–317.
3. Richard J. Pascal, 'Statutory Restrictions on Life Insurance Underwriting of AIDS Risk With Emphasis on Restrictions in the District of Columbia,' in Vculek, *op. cit.*, pp. 72–73.
4. *Ibid.*, p. 73.
5. Volker Eid, 'Aids—eine Herausforderung zum Umdenken,' in Christel Becker-Kolle, ed., *Schwarze Angst. Leben mit AIDS* (Stuttgart: Quell, 1989), p. 57.
6. *Ibid.*, p. 74.
7. Hans-Georg Wiedemann, 'Die Kirche und die homosexuelle Liebe im Zeitalter von Aids,' in Becker-Kolle, *op. cit.*, p. 111.
8. Statement by C. Everett Koop, M.D., Wednesday, October 22, 1986, in Corless and Pittman-Lindeman, *op. cit.*, p. 196.
9. Becker-Kolle, *op. cit.*, p. 221.
10. Wiedemann, *loc. cit.*, p. 109.
11. Siegfried Rudolf Dunde, 'Der Haß gegen die Infizierten,' in Becker-Kolle, *op. cit.*, pp. 113–128.
12. Conversation with Marcel Kraft, M.D., July 31, 1991. Statistical data to confirm this were not available to the writer. American commentators have frequently confused the percentage increase among IV drug users as a high-risk group with the absolute number of new cases. In the United States the greatest rate of increase is among drug abusers, but the largest number of new victims is still drawn from among practitioners of male homosexuality. Interpretation of the statistics is made more difficult by the fact that many who practice male homosexuality are also IV drug users, and by the fact that although the group classed as 'bisexual' is often separated from 'homosexuals' for statistical purposes, it is plausible to think that the vast majority of infected *bisexuals* contracted the virus through their male homosexual contacts.
13. Jim Foster, 'Impact of the AIDS Epidemic on the Gay Political Agenda,' in Corless and Pittman-Lindeman, *op. cit.*, p. 531.
14. Cf. f.n. 5 above.
15. Julien S. Murphy, 'Women with AIDS: Sexual Ethics in an Epidemic,' in Corless and Pittman-Lindeman, *op. cit.*, p. 337.
16. Joseph A. Sonnabend, 'AIDS: An Explanation for Its Occurrence among Homosexual Men,' in Pearl Ma and Donald Armstrong, eds., *AIDS and Infections of Homosexual Men*, 2nd ed. (Boston: Butterworth, 1989), p. 452.
17. Dennis Altman, *AIDS in the Mind of America* (New York; Anchor/Doubleday, 1986), cited by Jim Foster in Corless and Pittman-Lindemann, *op. cit.*, p. 527.
18. David Thomasma, 'The Range of Euthanasia,' in *American College of Surgeons Bulletin*, Aug. 1988, pp. 4–5.
19. *Ibid.*, p. 10.
20. Rita L. Marker, Joseph R. Stanton, Mark E. Recznik, and Keith A. Fournier, 'Euthanasia: A Historical Overview,' in *Maryland Journal of Contemporary Legal Issues*, Vol. 2, Issue 2, Summer, 1991, pp. 257–298.
21. *Ibid.*, pp. 295–296.
22. Cf. f.n. 16 above.
23. *Ibid.*, p. 450.

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Pluralism, Public Policy and the Hippocratic Tradition

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