Medicine and Society

- human ability at the frontiers of choice and responsibility

MEDICINE AND CHANGE

Scientific changes

The advances in modern medical science and technology have changed the face of medicine:

- Surgery has become both safe and predictable; it has pushed forward the frontiers of remedial medicine with micro-surgery, brain surgery, in-utero surgery, in vitro fertilisation, organ transplants, and reconstructions to victims of explosions etc.

- Life support systems such as transfusions, intravenous feed, respirators, dialysis etc are able to sustain a patient when previously they would have died.

- Pharmacology has given us many new drugs from tranquillisers to anabolic steroids; these may control pain, emotions, chemical imbalance or fertility. They cure or prevent diseases previously fatal or disabling and enable organ transplants.

- Micro-electronics have developed remarkable aids for the disabled to increase their mobility, communication and quality of life.

- Future developments look set to include testing to show which drug regime will be most effective for individual patients, based on what genes they have, or, for cancer, which specific genes have gone wrong. We may also see further attempts to control behaviour using drugs.[1]

Social changes

- **Doctor-patient relationships** have frequently become less personal than they once were, with the development of 'teams' and 'panels'. Balancing this, there has been a move from paternalism to partnership between physician and patient, while the latest medical training focuses on the patient as a whole person, not just an ailment. However, there is still often a tension for the doctor between being a skilled scientist and being sensitive to meet human need.

- **Health care costs** have escalated with the use of expensive technology and drugs against a backcloth of rising living costs for medical staff deserving a fair reward for their skill and responsibility. There are simply insufficient resources for everyone to receive all that medical science could do to help them. We find a close link between current ethical thinking and economics.

- **Public attitudes** towards disease have changed; public health, education, immunisation and scanning have removed both the fear and experience of disease from

[1] New Scientist 20/4/02 pp. 42-45 and 21/9/02 p. 25

many. Public expectations of medicine have heightened; they are more knowledgeable about what can be done, often wish to participate in decisions on treatment rather than be passive agents, and are more aware and demanding of their rights.

- **Legal requirements** which control medical practice have grown and with them a doctor's accountability to the patient and the authorities; this brings added pressure and complexity to their work.

Moral challenges and changes

- **New situations and choices** face medical staff, and society at large, “When is it right or appropriate to prolong life on life support machines?” “How far should one go to by-pass the obstacles to infertility?” and “Should one manipulate the genetic identity of a person yet unborn?” Economic constraints enforce a certain 'rationing' of resources, but who is to decide who may be treated and who may not? Medical personnel talk of QALYs (Quality Adjusted Life Years) - indices of the quality and length of life - but their application is problematic.[2]

- **New questions**, which were previously philosophical but now require immediate pragmatic answers; 'What is life?', 'What is death?', 'When does personhood begin?', 'What right have we to manipulate human nature?'. These new questions alone would be difficult enough but they have to be answered in the light of greater changes in society as a whole.

- **New values** are replacing those which society has accepted for generations. They are 'sociological' and 'situational' in character, dependent upon public opinion (including the so-called ‘yuk factor’), mood and given circumstance, and increasingly motivated by economics. They have no sense of 'root' or 'absolute', and have instead been described as '51% morality'. The concept of 'right' and 'wrong' has become 'relative' and 'subjective'. Traditional approaches are being rejected as outmoded or inadequate to cope with the multitude of new medical situations produced.

- **New priorities** have arisen alongside the traditional ones of healing, prolonging life, easing pain, caring for pregnancy and birth. Medical personnel have to consider the needs of the community as a whole (contagious diseases, immunisation and other public health issues) and balance the needs of the many against that of individual patients. They have to deal with the pressures of budgetary constraints and limited time. What could be done is not necessarily what can be done for every patient. The best use of resources and the requirements of the Law, as well as the needs of the individual and what might be best for society, need balancing.

[2] pp. 191-2 in Messer, N., 2002 ***Theological issues in Bioethics*** (London: Darton, Longman and Todd). Also pp. 272-4 in Kuhse, H., & Singer, P. 2002 ***'Allocating health care resources and the problem of the value of life',*** in H. Kuhse (ed.) ***Unsanctifying Human Life*** (Oxford: Blackwell) pp. 265-80.

MEDICINE AND ETHICS

Uncertain paths

'Every important scientific advance
that has come in looking like an answer has turned,
sooner or later, into a question.
And the game is just beginning' [3]

'Each new power won by man is a power over man as well.' [4]

'Freedom from the tyranny of nature
generally means coming under the tyranny of men.' [5]

The scientific, social and moral changes in medicine make it one of the most challenging areas of Christian ethics. The issues are complex and the scene is changing all the time putting great pressure upon everyone. The greater the concern to do what is right the greater the pressure. Christians involved in medicine, whether as professionals or carers at home or in the community, have the advantage of a biblical base to work from, but the difficulty of applying broad principles to particular and changing situations.

The Church must understand the particular difficulties Christians in the medical profession face, and do everything that they can to actively support them. The Church must also make a positive contribution to the public debate on medical ethical issues. People will always agree to listen to a Christian perspective, but we pray that we may clearly influence public opinion in a Christian direction through a clear presentation of ideas and the honest outworking of their implications.

One key issue that needs tackling from a Christian perspective is the whole concept of health itself. Moltmann cites the WHO definition:

> 'Health is a state of complete physical, mental and social well-being, not merely the absence of sickness and handicaps.' [6]

He comments that it would cripple any health system to try to achieve this and discusses the drawbacks of such an image of health:

> 'Being human is equated with being healthy. This leads to the suppression of illness in the individual life, and means that the sick are pushed out of the life of society and kept out of the public eye..... The modern cult of health produces precisely what it wants to overcome: fear of illness. Instead of overcoming illness and infirmity, it projects a state of well-being which excludes the sick, the handicapped, and the old who are close to death.'[7]

---

[3] Lewis Thomas '***Late `Night Thoughts in Listening to Mahler's Ninth Symphony'*** New York 1983 p. 155
[4] CS Lewis ***'The Abolition of Man'*** MacMillan 1965 p. 70
[5] Words of a Norwegian Marxist theologian (unnamed) quoted by D Gareth ***Jones 'Genetic Engineering'*** Grove Books 1978 p. 8
[6] Moltmann, J. 1985 ***God in Creation. An Ecological Doctrine of Creation*** London: SCM p. 271.
[7] Ibid. pp. 273-4

Marsha Fowler responds to this:

> 'Any adequate conception of health for the Christian community must include the physical and more than the physical - the individual as well as the communal - and must bring these aspects together cotemporaneously (sic). A more adequate, realistic, and useful conception of health can be found in the ancient concept of shalom....In this conception of health, totality or completeness can exist even in the presence of disease or infirmity....[it] must be judged both in terms of the individual and of the community....Health, then, resides in the nexus of person and community.'[8]

Biblical principles - life and death

What other principles can we find within the Christian scriptures? Biblical moral judgments demand a unified and integrated biblical theology where the parts are viewed in the context of the whole rather than trying to apply [or not] particular scriptures to particular cases. We must ask what is required of us in our actions:

- To bring glory to God's name (may God's character be displayed)
- To establish God's kingdom (may God'swill be done on earth)

Some key pointers in this direction must be:

- **Life is a gift of God**; it is a blessing, positive and good. Life is to be enjoyed. It is to be lived out in relationship with God (Gn 3; Jn 1). We must respect this gift in each person.
- **Life is God's initiative**; he brought human life into being. God is the 'life-giver' and the 'life-taker' (Jb 1:11). God breathed breath into the human person (Gn 2:7]) God forbids murder (Ex 20:13). We are unable to give life and so have no right to take it or waste it; rather we should nurture and sustain it. We cannot not take life without being held responsible. It is not a choice open to us because life belongs to God
- **We are made in the image of God**. It has been pointed out that whoever touches a person has to do with God personally[9] We were dust before creation, but we have been invested with God's image and that gives us a unique place within creation, a unique relationship with God and makes our relationships with one another unique. The 'mark of Cain' and the 'covenant with Noah' were each established to protect human life. Jesus' death and resurrection displays its worth.
- **Jesus is our role-model**. Jesus restores life from every form of death (1Jn 4:11-12), we are bought with a price (1Cr 6:19-20). Christians responsible for medical care of all kinds become Christ to the patient they are nursing. They bring Christ's ministry of healing: ministering medical care and being unafraid to use the power of prayer. They need Christ's heart of compassion towards someone made in the image and likeness of God, shouldering whatever cost may be involved to find the highest answer to their needs.

---

[8] pp. 249 of Fowler, Marsha D. M. 1997 ***'The Church as a Welcoming Community'*** in John F. Kilner, Rebecca D. Pentz & Frank E. Young (eds) ***Genetic Ethics: Do the Ends Justify the Genes?*** Carlisle: Paternoster Press pp. 246-255

[9] Cf H Theilicke '***Theological Ethics: Foundations'*** Eerdmans 1966 p147-ff

- **Physical death is not the end**; it is not the anteroom to oblivion but a threshold to a new dimension of experience when the time comes. In scripture, death's sting stands in contrast to the great joy and blessing of life. The Bible has an outraged repugnance of death. Eternal life is lost as the result of the curse for man's rebellion against God (Gn 2:17; 3:19, 22; Rm 5:12; 6:23) but Jesus has come to bring life in its fullness (Jn 10:10). Death reduces the human lifespan to make earthly existence tragically short (Ps 90:10-11; 103:15-16); it is the great enemy and within the realm of Satan (Ps 18:4-5; Hb 2:14). However, death's defeat at the hands of Jesus has broken its power. The victory of the resurrection is a real victory over a real foe (Rv 20:14). It need no longer hold fear. It is a release from itself and pain to a state where death is no more. The key is faith in Jesus' act. The weight of scripture is towards life and against death.

- **Justice is a key biblical concept**; this does not necessarily mean meeting the greatest need of the greatest number (as in a utilitarian approach), but ensuring that the needs of the poor, the oppressed, the weak and the vulnerable are met.

Christian medical ethics must work in the light of these principles. As we do, and as we endeavour to make godly ethical decisions in both specific situations and in general principle we need to both 'be aware' and 'beware':

- Beware of the very real 'domino effect' of ethical decisions; one decision changes whole attitudes and public opinion, soon making other actions permissible which at the time of the initial decision may even have been unthinkable. Where logic alone rules ethics, given time, anything is possible
- Beware that our reactions to new possibilities and important questions are not simply 'gut reactions' (i.e. the 'yuk factor'), as a result of emotional challenge
- Beware that we do not hamper scientific enquiry that can lead to good medical advances
- Beware of the use of the word 'rights'. We should look at 'interests' rather than 'rights', or balance rights with responsibilities. This may involve considering the sometimes conflicting interests of the embryo, mother, other family members, doctor, donor, and society at large,
- Beware the human factor is not overlooked; the couple without children, the poor family, the person with a disability, the unborn child.

MEDICINE IN SOCIETY

Huge issues are raised when we consider interactions between the field of medicine and society as a whole. These include:

Care by the Community?

How do we pay for medical care - through the NHS or by private insurance? Can we use the justice principles of mutual care and support laid down for ancient Hebrew communities as a model for a state-wide provision into which everyone pays and from which everyone is entitled to basic health care? If so, are there limits to the kind of treatments, which we should expect society to fund? This leads into questions such as whether or not infertility should be considered an illness.

Prioritising

As science advances, the possibilities outstrip available finances so criteria are needed to determine what gets funded and what doesn't (IVF OR heart transplant OR kidney dialysis machines etc). Are there any biblical resources, which would help us in this decision-making? Or is it better to ration medical treatment on a first come/first served basis, or even by lottery, rather than attempt to evaluate the worth of different patients to decide who gets prioritised.[10]

Responsibility

- **Personal:** Should society allocate less resources to 'lifestyle' disorders where the patient can be said to be responsible for their own illness, and instead expect such individuals to have extra insurance to cover their increased risk? This could include conditions such as lung cancer in a heavy smoker, liver disease in an alcohol abuser, or even a skier's broken leg! In this connection, how much of a 'nanny State' is desirable for the good of public health?

- **Genetic:** In the light of increasing genetic knowledge, some healthy individuals in the USA are finding it difficult to take out life insurance because they carry a gene increasing their chance of contracting a particular disease, such as breast cancer. The completion of the human genome project has made it possible to identify numerous other genes giving people greater risk of certain illnesses. If you get tested to see if you have the gene which increases your chances of a disease, should you have to tell your employer and/or insurance firm?[11]

Some are suggesting that parents carrying genetic defects should employ reproductive and genetic technologies (see below) to ensure that any child they have is not suffering from the disorder. If they do not, they should waive their right to support by society or even face criminal prosecution. Robert Edwards, one of the IVF pioneers, is recorded as having said that 'soon it will be a sin of parents to have a child that carries the heavy burden of genetic disease. We are entering a world where we have to consider the quality of children'. [12]

Inclusion

There is an expectation in society that it should be possible to eliminate all illness and risk. Some would even prefer to eliminate the sufferer rather than tolerate the presence of suffering. Many sick people are isolated from society and need to be reminded that they're part of the wider community. In response, some Christian medical practitioners suggest that medicine needs to recover its primary motivation to treat the body, and to be

---

[10] p144-7 of Campbell, Courtney S. 'On James Childress: Answering That of God in Every Person' in Verhey, Allen & Lammers, Stephen E. (eds) 1993 ***Theological Voices in Medical Ethics*** Grand Rapids: Eerdmans pp. 127-156. Also. Paul Ramsey 'A Human Lottery?' in N. Messer, 2002 ***Theological issues in Bioethics*** (London: Darton, Longman and Todd) pp. 195-201.

[11] Collins, Francis S. 'The Human Genome Project' in John F. Kilner, Rebecca D. Pentz & Frank E. Young (eds) ***Genetic Ethics: Do the Ends Justify the Genes?*** Carlisle: Paternoster Press pp. 95-103.

[12] For sources see Peterson, James C. 1997 ***Genetic Turning Points. The Ethics of Human Genetic Intervention*** Grand Rapids, MI/Cambridge: William B. Eerdmans p.22

present to those who are suffering. However, that requires a society which can accept sickness and people with less than optimal living conditions, that can accept and integrate the mentally and physically ill or handicapped. In a society that is highly individualistic, which views less-than-perfect health as an evil, and sees freedom and independence from the need of others as a good, the Christian challenge to society should be in the way in which they demonstrate inclusivity. We need to welcome the other.[13]

PERSONHOOD

Valuing People

Many people would support the contention that all human beings are of equal value. However, as Christian doctor Gareth Jones points out, in practice, we are sometimes constrained to choose between people and each have, consciously or subconsciously, a set of criteria by which we value people's lives.

Take a few minutes to consider, if you could only rescue one person from a burning building or a sinking ship, who would you help and why? [14]

- Healthy, middle-aged man, who employs 90 in a successful company
- Alzheimer sufferer, man, 85, totally dependent on aging wife, whose health is under strain
- Healthy, pregnant woman, 30, married, lecturer
- Healthy pregnant woman, 36, suspected of links with terrorism
- Highly gifted schoolgirl, 15
- Severely mentally disabled boy of two, in the care of a girl of fifteen

There was a belief in Mediaeval times that the soul entered the body of a developing child in the womb; feeling the baby move ('quickening') was an indication that this had happened and a new life was present. A woman's womb was viewed as a field in which the man's 'seed' was planted - she contributed nothing substantial toward the nature of the child.

However, consideration of biblical teaching on human beings being in the image of God leads us to consider a person holistically, rather than as an embodied soul[15,] and a modern knowledge of human reproduction includes an appreciation of the contributions by both parents and the flow of life from one generation to another: from sperm and egg, through fertilised egg and developing embryo, to a fully developed human being. Medicine today seeks to support life but when does this life begin and end and how do we value persons along the continuum of existence?

---

[13] Lammers, Stephen E. 'On Stanley Hauerwas: Theology, Medical Ethics, and the Church' in Verhey, Allen & Lammers, Stephen E. (eds) 1993 ***Theological Voices in Medical Ethics*** Grand Rapids: Eerdmans pp. 57-77.

[14] This exercise is taken from Jones, D. Gareth 1999 ***Valuing People. Human Value in a World of Medical Technology*** Carlisle: Paternoster Press, pp. 3-5.

[15] See notes on the session on 'The Image' in '**Credible or Incredible'** module.

Human development [16]

In our consideration of human persons and their value we'll start by outlining the stages in human development, beginning at fertilisation:

1. **Fertilisation: sperm penetrates egg**
2. Genetic material of sperm and egg come together after about 30 hrs
3. Fertilised egg divides into 2 cells after about 36 hours
4. Division of cells continues to give ball of identical cells
5. **Implantation: after about 1 week, ball of cells embeds itself in the lining of the womb**
6. At this stage some cells go on to develop into embryo and others form the placenta and support tissues for pregnancy. Up to 14 days it's possible for the ball to split to give identical twins
7. **During 3rd week beginning of primitive nervous system appears**
8. **Heart beat by day 24**
9. Weeks 5-8 sense of touch and movement
10. After 9 weeks we refer to the foetus, rather than embryo. Weeks 9-12 more development of nervous system; although embryo is only about 60 mm long all organs and limb buds are fully formed by 12 weeks.
11. **Movements may be detected by mother, ('quickening'), time variable - mid-pregnancy**
12. **Foetus able to survive outside womb, with modern technology, at around 23-24 weeks.**
13. **Child grows and, over months and years, develops self-awareness, relationships with others, mobility when can we speak of 'a person'?**

While no-one disputes the biology, and that the fertilised egg is a human being, several different times have been suggested as the point at which a distinct human *person* can be said to be present. These points are in bold above. So, at what point should we start talking of a person?

- **Fertilisation** is the point adopted by many Christians.[17] They refer to the creation of a new, unique genetic identity when a sperm fertilises an egg and the then unbroken continuity between that cell and a fully developed human being. This position is supported by reference to several passages in the Hebrew scriptures (including Jb 10:8-12; Ps 139:13-16; Is 49:1,5) in which God is spoken of as planning for, choosing, or knowing someone as they developed in the womb. Also, God appears to place value on the unborn child by stipulating penalties for causing a woman to miscarry or come into labour prematurely (Ex 21:22-25). The New Testament is seen as backing this up with its reference to John the Baptist responding to the presence of Mary and the unborn Jesus by himself leaping in the womb (Lk 1:41). From these verses it is clear that there is a continuity between life in the womb and after birth and that God's care extends to the womb. Certainly, the early church was as opposed to abortion as it was to another common practice in the first century, infanticide.

[16] See Campbell, Stuart 2004 ***Watch me Grow!*** Carroll & Brown
[17] Thomas, Rick 2000 ***Grave New World*** Oxford: Salt and Light Ministries pp 12-13.

However, many Christians do not view fertilisation as necessarily marking the creation of 'a person'. Regarding the teaching on humanity being made in the image of God, while agreeing that a fertilised egg is a human being, some would argue that God is a person but is not a human being in his essence (although he took on humanity in the incarnation); thus every fertilised egg need not be viewed as the image of God.[18] John Habgood has suggested that 'the image of God' resides in those qualities unique to human beings such as language, but that a person's identity is inherent in their relationship with God. 'Amid all the flux of changing relationships, different periods of life, developing and diminishing capacities, gains and losses, tragedies and triumphs, there is that which remains secure, held in the mind of God.'[19] Another suggestion is that the image of God is specifically the reflection of the inter-relationships between the members of the Godhead, Father, Son, Spirit, which we see expressed in the existence of human relationships and communities.[20] Others have seen 'image' as referring to our moral freedom and responsibility, our rationality, our capacity to love, our ability to have a relationship with God, or our status as children of God; so saying that we are made in God's image does not inevitably confer full personhood upon a fertilised human egg.[21]

We must also be careful not to read biblical verses as necessarily specifically addressing the status of the embryo, particularly the very early embryo; Jeremiah is told that God knew him before he was formed in the womb (Jr 1:5) and the writer of Hebrews (7:9) speaks of Levi being 'in the loins of' his ancestor Abraham. We are surely not to deduce from this that fragments of genetic information which will form part of people in generations to come must be treated with the respect due to full human persons?[22] Gareth Jones concludes that the biblical writers 'do not address the question of whether a very early embryo is a person with the rights of a person'.[23]

If fertilisation is viewed as the beginning of a distinct person then several common forms of contraception should be reconsidered since they may, on occasion, act by preventing implantation of the fertilised egg rather than stopping fertilisation itself.[24] However, the use of the word 'contraception' (literally contra, or against, conception) highlights the real question here. What is conception? According to the dictionary[25] it is fertilisation followed by implantation, while 'pregnancy' refers to the foetus being carried in the womb. Without trying to play with words, it is clear that conception may be viewed as being complete when the developing embryo implants in the womb, triggering the release of hormones that are then detected by pregnancy testing kits.

- **Implantation** is thus viewed by other Christians as a sensible time to see life as starting.[26] Technically and biologically, a woman is not pregnant until an egg implants itself in the wall of her womb at which point the body reacts hormonally and physically

[18] Jones, p.85 citing Robert Wennberg, 1985 *Life in the balance.*
[19] Habgood, John 1998 *Being a Person* London: Hodder & Stoughton especially pp. 37, 89, 155, 205-28.
[20] Green, Joel 1999 'Restoring the Human Person: New Testament Voices for a Wholistic and Social Anthropology' in R.J. Russell, N. Murphy, T.C. Meyering & M.A. Arbib (eds) *Neuroscience and the Person. Scientific Perspectives in Divine Action* Vatican City State: Vatican Observatory Publications pp. 3-22.
[21] For further discussion see pp 35-41 in Berry, R.J. 1999 'This Cursed Earth: Is 'the Fall' Credible?' *Science and Christian Belief* Vol. 11: 29-49.
[22] Jones, pp 59-80.
[23] *Ibid*. p.67
[24] *Ibid.* pp 19-25. Also http://guide.fateback.com/12.html and /13.html
[25] Collins English Dictionary
[26] See discussion in Bryant & Searle pp. 45-59. (on reading list)

by preparing itself to support a pregnancy. A womb is necessary for further development to occur and many fertilised eggs are lost before this stage in nature without the woman realising anything has occurred.

- Others point out that we cannot in reality speak of 'a person' *until there is no more chance of identical twins forming by the developing embryo splitting in two*. On occasions the reverse can occur; two genetically distinct early embryos can fuse and give rise to a chimerical individual, comprising cells with different genetic identities. Past this stage, the body cells are committed to specific developmental pathways and can only produce one body.

- The emergence of the idea of 'brain death' to establish the end of human life[27] has led others to propose that personhood requires a means to communicate and interact with God and with others; thus one cannot speak of a person *until the emergence of a nervous system* but, given the process of development, it would be difficult to give a reliable time for this.[28]

- Our current knowledge of development means that most modern Christians would no longer subscribe to the idea of 'ensoulment' i.e. *it is only a person when the baby is felt moving* ('quickening').

Few, if any, Christian arguments can be found for restricting personhood to later stages in development, but some secular philosophers suggest such positions based on their assumptions that certain criteria, such as ability to exist independently or a degree of self-awareness, are essential features of personhood:

- Birth is seen as the time at which the new human being is independent of its mother and some philosophers maintain that only then can it claim the rights and value of a person.

- Self-awareness, and other criteria, which appear during growth and development into a young child, are seen as key to personhood by philosophers such as Peter Singer; this renders dubious the personhood of some mentally and/or physically handicapped individuals. 'Normal adults and children, but not fetuses (sic) and infants, are persons; that is they are self-aware and purposeful beings with a sense of the past and the future.'[29]

Life is precious and fragile and medicine is dedicated to doing all it can to prolong life and maintain its quality. It is evident from scripture that God's care extends to pregnant women and those they carry but there is silence over the status of very early stages of human life, which is understandable considering the biological knowledge of the biblical writers. We must take steps to safeguard the respect with which we treat human life but there is insufficient biblical teaching with which to construct an unambiguous Christian statement on the status of the early embryo.

[27] Thomas, p.47.
[28] Jones, pp. 113, 171-2.
[29] pp. 269 in Kuhse, H., & Singer, P. *op. cit.*

However, application of the precautionary principle, where we try to err on the right side in cases where boundaries are unclear, would appear to leave us attempting to maintain the need for respect to be shown toward early human embryos and would suggest that, as development progresses, the potential of the embryo to grow into a full person demands ever greater safeguards of its integrity. Whether this latter extends to prevention of embryonic stem cell research and genetic manipulation is considered in the section on reproductive technologies.

When is death?

Death may seem a much less ambiguous area to discuss. Can we be clear about when life ends?

- The cerebral cortex, or higher brain is the seat of conscious thought, analysis etc while the brain stem controls breathing, heart rate, reflexes, i.e. all the functions necessary for the continuation of life, which our body carries out without us being aware of it.

- Nowadays, people commonly talk of brain death, to distinguish it from a state in which the heart/respiration have stopped but may be re-started. It is a point at which the brain is so badly damaged, either by direct injury or lack of oxygen, that it cannot recover its functioning.

- However, there are some cases in which only one part of the brain is damaged and the other continues to be able to function:

    - If the brain stem is damaged the patient can only be kept alive on a life-support machine which undertakes the control of circulation and respiration.

    - If the cerebral cortex shows no brain activity but the brain stem continues to keep bodily functions going, then the patient is said to be in a persistent vegetative state (PVS).[30] Such patients need to be fed but otherwise require no life support. Diagnosis of PVS is not always clear but in the well-known case of Tony Bland, who was injured during the Hillsborough football stadium disaster, the cellular structure of his higher brain had completely disintegrated and there was not even a remote possibility of natural recovery.[31]

These extreme cases raise the question of whether a body from which all possibility of personality has been lost should be viewed as a person. For medical practitioners in a world of limited resources the question is sharply focussed, because money spent supporting such patients is not available for others. But it is also important because any conclusions reached on this topic also impinge on consideration of illnesses where mental impairment is more gradual and not quite so total, such as Huntington's and Alzheimer's.

It may be that, having considered the possibility that personhood can be said to develop over time during embryonic development we must admit the possibility that it can similarly fade over time. Once again, the precautionary principle suggests that we continue to treat

[30] Jones, pp. 21-4.
[31] Discussed by Habgood, pp. 14-17.

such patients as full human beings due every respect and treatment that will keep them comfortable and retain their dignity. However, we must admit the existence of grey areas where lines cannot be drawn as clearly as we would like and some situations, which may have to be judged on a case-by-case basis.[32]

CASE STUDIES:

REPRODUCTIVE AND GENETIC TECHNOLOGIES

In the 1960s the advent of the contraceptive pill effectively separated sex from procreation. The technique of IVF (in vitro fertilisation) makes it possible, with a high degree of technological intervention, to separate procreation from sex; it has been said that there are now thirteen ways to have a baby other than by sexual intercourse.[33] Around 68 000 babies have been born, world-wide, since the first 'test-tube baby', Louise Brown, in 1975 and, in 2000, such births constituted 0.76% live births in the UK.

IVF involves the fertilisation of a human egg with a sperm, and the growing of the fertilised egg into an early embryo consisting of a few cells, outside the human body. The embryo is then placed inside the woman's womb where, it is hoped, it will implant and grow into a full-term baby. The fact that individual cells can be removed from the very early embryo without any deleterious consequences allows the testing of the embryo for identification of sex and tissue type and to check that it doesn't carry defective genes which cause a variety of inheritable diseases (pre-implantation genetic diagnosis - see below).[34]

It must be stressed that, with infertility problems on the rise (1 in 7 couples), IVF may be increasingly common but it is not straightforward and the latest data available shows there is still only a 22% success rate.35 Therefore, it is not generally undertaken lightly, for frivolous reasons. The technique requires hormone treatment to promote egg release from a woman and further hormone treatment to prepare the womb to carry the developing embryo. It used to be standard practice to put three embryos into the womb to increase the chances of one implanting but techniques are improving and it is now common to only put one, or at most two, embryos in to reduce the chance of pregnancies resulting in multiple births.

These new reproductive technologies, taken together with recent advances in genetics have led to the emergence of new possibilities in medicine which ethical debate and legislation are running to keep up with.[36]

Many Christians value the family as an institution set up by God but the use of IVF allows the separation of parental identities in a previously unimaginable way. Children have often been adopted, and artificial insemination has long meant that sperm may be donated, but now three different women could all lay claim to be a child's mother: the egg donor

---

[32] Jones, pp. 81-91.
[33] Aldridge, Susan 1998 'Ethical Dilemmas' *New Scientist 'Inside Science no. 114'* 17th October 1998 p.3.
[34] See Antenatal Results and Choices website: http://www.arc-uk.org/
[35] It is around 25% in women under 38. Figures from the web site of the Human Fertilisation and Embryology Authority, accessed Jan 2005: http://www.hfea.gov.uk
[36] See web sites for the Economic and Social Research Council Centres for Genomics in Society such as *egenis*: http://www.ex.ac.uk/egenis. Also, http://www.nuffieldbioethics.org

(genetic mother), bearer (nurturing mother) and 'rearer' (social mother). Also, the long term frozen storage of eggs and embryos in an age of sometimes short term relationships raises a number of questions:

- Which mother is the legal one? This question has already arisen in some situations where people have acted as surrogate mothers.
- Does the use of donated sperm or eggs constitute adultery?
- Should 'spare' embryos be put forward for adoption?
- If a relationship subsequently ends, leaving 'spare' embryos in storage, to whom do they belong? This has been the subject of court cases in recent years. (Storage is sometimes used for medical reasons. Women who may become sterile through chemotherapy sometimes store embryos because embryos 'keep' better than unfertilised eggs.)

Christian answers to these questions must be informed by a biblical understanding of covenant together with respect for human life but there is a need to avoid a 'knee-jerk' reaction of aversion to the use of IVF at all. Medical personnel are sensitive to the issues involved and it is possible, for instance, to only fertilise the same number of eggs, which will be implanted, avoiding the creation of 'spares'. (This does reduce the chances of getting a successful embryo to implant.) It is important for communities of believers to support those couples who experience difficulty in conceiving, to walk with them through the pain, and to avoid implications that childlessness is an 'unnatural' state, or less-than-God's-best.[37] (The same sensitivity, of course, needs to be applied to single people, especially women who feel pressure from both nature and society to fulfil their 'natural' function).

- **Pre-implantation genetic diagnosis (PGD) allows embryo selection** that is the deliberate choice to only implant embryos, which meet certain criteria. This may be used:

  I. To avoid implanting an embryo which isn't viable (e.g. some genetic defects mean that the embryo will not develop to full term or, if it does, will die very soon after birth. No medical intervention will avail. Examples include anencephaly and most embryos with one extra chromosome - those with an extra chromosome no. 23 have Down's syndrome but all other so-called trisomies cause more serious developmental faults and are fatal before or very soon after birth.)
  II. To avoid producing a child with a serious life-shortening disease (e.g. cystic fibrosis, thalassaemia), or a disease which is perceived to adversely affect the quality of life or results in an disagreeable decline in health and early death (e.g. Huntington's). In the case of sex-linked disease, e.g. haemophilia, this could involve sex selection.
  III. To produce a child who can help treat a pre-existing but sick child (e.g. has the right tissue type to be a bone marrow donor).
  IV. To choose a particular sex for purely social reasons, not medical

  The use of PGD is regulated by law and is only available in the UK where it has been licensed by the Human Fertilisation and Embryology Authority (HFEA).[38] While few

[37] Anson, Hugo & Sharon 1997 ***Some mothers do have 'em... others don't*** Eagle
[38] As of 2002, at 6 centres. ***Preimplantation Genetic Diagnosis (PGD) - Guiding Principles for Commissioners of NHS services.*** Department of Health, September 2002.

would disagree with (i), the use of PGD has been seen by pressure groups for the disabled as a means of eliminating them from the population and further devaluing their lives. 39 Some parents may find themselves under pressure to have their embryos screened if there is a risk the child may have a genetically determined but non-life threatening condition such as achondroplasia (dwarfism), or some kinds of deafness.

Both (iii) and (iv) have been viewed as reducing the child to an instrument for the purposes of others, or a consumer item. In practice, few witnessing the anguish of a couple with a child suffering from a severe inheritable disease can doubt either their desire to have a healthy child or their determination to do all they can for their first child. However, the historical evidence that some cultures value one sex above another for social reasons (e.g. female infanticide under China's one-child policy, which has already resulted in distorted sex ratios in some parts of the country) supports the idea that determination of sex for social reasons should remain illegal as it is at present in the UK.

- Concern has been expressed over the possibility of genetically modifying humans, given the information released by the human genome project. There are three main areas in which this may be carried out:

I. **Somatic gene therapy** - This doesn't involve use of reproductive technologies but attempts to insert missing, correct copies of genes into the relevant body parts of sufferers e.g. change cells in bone marrow to restore the immune response in bubble babies; cystic fibrosis sufferers inhale a virus containing the gene to get it to the cells lining the lung. These treatments have had mixed success so far. Treated sufferers still have the faulty copy of the gene and may pass it on to their children.

II. **Germ line gene therapy** - This would involve inserting a correct copy of a missing/faulty gene into an egg or embryo. This technique is currently illegal because it may have unforeseen consequences on other genes and because the genetic manipulation would be passed on to the next generation.

III. **'Designer babies'** - To 'enhance' the human race for intelligence, height etc - is not legal in the UK and is unlikely to be feasible with many important traits; one gene may affect many different body characters and many characters are determined by several different genes interacting with one another in a complex fashion. For instance, tinkering by adding just one gene could have disastrous effects on developmental processes.

Most people see (i) as an extension of current medical practice in alleviating suffering. In practice, (ii) isn't likely to happen because it is easier to make several embryos and eliminate the ones carrying faulty genes when choosing which to implant. Thus, PGD allows a sophisticated form of eugenics. Whether or not you find de-selection of embryos carrying genes for severe disease any more acceptable than abortion of affected foetuses will depend on your view of personhood. (iii) is still in the realm of science fiction and, even if legalised, is unlikely to become widespread since making babies the conventional way is so much easier! However,

[39] Kerr, Anne & Shakespeare, Tom 2002 *Genetic Politics. From Eugenics to Genome* Cheltenham: New Clarion Press.

if it did occur, it could result in the formation of a genetic 'underclass' with 'uncorrected' genes - see the film GATTACA for a suggested scenario.

- **A clone** is a genetic copy of an individual and thus identical twins are clones. Identical twins form when the ball of cells which, comprises the early embryo splits in two. At such an early stage in development each half of the ball of cells is able to grow into an identical individual. However, it is now possible for some mammals to be cloned from adults (e.g. Dolly the sheep). This involves taking the genetic material from an adult cell (e.g. a skin cell) and inserting it into an egg of the same species, which has had its genetic material removed. If stimulated to divide, such an egg can grow into a ball of cells which, if implanted successfully into a womb, will grow into a genetically identical copy of the original (skin cell) donor. This is known as 'reproductive cloning'.

  - **Reproductive human clone** claims, by the Raelian cult, (and some individuals), to have made and brought people to birth are so far unsubstantiated. Cloning presents serious problems; there is a very low success rate with mammals that have been tried, especially with primates to which we are most closely related, and the process needs lots of human eggs which, are in short supply. If clones were produced there is good reason to suppose that they might suffer from developmental disorders and/or premature aging.

  - **'Therapeutic cloning'** would also involve the production of an egg containing donated genetic material but, instead of growing an identical individual, the proposal is to chemically control the growth of the resultant ball of stem cells (see below) to form a specific tissue. This might enable the replacement of organs/tissue in case of injury or disease e.g. nervous tissue to repair spinal injuries, kidney tissue to grow a new kidney, which would be genetically identical to the patient and thus not provoke immune rejection. There are reports from overseas of the successful production of human clones of around 100 cells and their creation is legal in the UK although only under licence from the HFEA. Their growth beyond an early stage, and any attempts at reproductive cloning, are currently unlawful in the UK.

- Nearly every cell in our bodies contains a full set of the genes necessary to make a human being but, as part of development, our cells become more and more specialised (e.g. to grow into blood cells, then into a specific type of blood cell). However, even in adult bodies, some of our cells retain some adaptability and can grow into one of several cell types; these are known as **stem cells**. Some work indicates that we can use these cells from adults and get them to grow a specific type of cell in order to replace diseased or damaged organs. However, the cells in the early embryo are much more adaptable and can be encouraged to grow into a much wider range of cell types. Research into these embryonic stem cells, which involves the destruction of early human embryos, is legal in the UK and holds the promise of dramatic treatments such as growing new nerves to restore mobility to paraplegics. If an embryonic clone of the patient's tissue is created from which stem cells are derived then the resultant tissue will not be rejected (see cloning above). However, success in developing treatments using adult stem cells derived from the patient's own tissues may indicate that therapeutic cloning will be unnecessary for many medical conditions.

One's view of stem cell research depends, as above, on how one thinks of the early embryo in terms of value and personhood.40 However, whatever our position, we must ensure that human embryos do not come to be viewed as merely 'life-saving tissue generators'.[41]

ABORTION

The use of abortion

More than any other issue abortion fuelled the public debate about medical ethics in the 1960's and 70's which continues today. The abortion debate itself has become a 'melting pot' for so many other issues at work in society today. It is both a complex and highly emotional subject involving medical, legal, theological, ethical, social and personal aspects. The fundamental questions it raises divide people throughout society, including Christians.

Down through the centuries abortion has always been a social issue; however, since 1945 it has taken on epidemic proportions. Previously it tended to be hidden and 'back street' with a few medical exceptions, but now the tide has turned as one nation after another has liberalised its laws (e.g. Japan 1948, England 1967 etc). In the UK it is carried out the request of the woman and the agreement of two doctors; in practice this 'on demand'. 'Under cover of an ostensibly medical judgement, many abortions are performed for social reasons.'[42]

Abortion figures for England and Wales

- In 2002 there were 185,400 abortions performed in England and Wales.
- The age-standardised abortion rate was 17.0 per 1,000 resident women aged 15-44 but it was highest, at 30.7 per 1000, for women in the 18-19 age group.
- 87% of abortions were carried out at under 13 weeks gestation; 57% were at under 10 weeks.
- The vast majority of abortions (94%) were on the grounds 'that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman'. The proportion of abortions on these grounds has risen steadily since 1992, with a corresponding reduction in use of other grounds. In 2002, only 1,900 abortions (1%) were on the grounds that there was a risk that the child would be born handicapped

Act of abortion

There is a range of methods used, dependent on the stage of pregnancy:

- **Medical, as opposed to surgical**, procedures use drugs to cause the womb to expel the developing foetus/embryo and comprise around 14%. (Note, however, that the use

[40] Watson, Paul & Attwood, David 1991 ***Researching Embryonic Values - A Debate*** Bramcote, Notts: Grove. Both writers present their differing cases on the status of the human embryo and respond to one another's arguments.
[41] As described by a contributor to a Horizon programme, BBC, 1999
[42] Simpson, R. 2002 ***Abortion: Choosing Who Lives*** Cambridge: Grove Books p. 10

of ‘the morning after pill’ does not cause an abortion but prevents the developing foetus from implanting in the first place.)

- **Vacuum aspiration** (generally used up to 15 weeks), which involves sucking the embryo/foetus out, breaking it up into pieces in the process, accounted for just over 80% of surgical abortions in 2002.
- **Dilation and curettage** (D&C; used after 15 weeks), involving cutting the foetus up, was used in about 4%.
- About 1% of abortions in 2002 involved first killing the foetus with a foeticide (mostly in later pregnancies).

Euphemisms are used all the time in writing and discussion about abortion to shield the horror and reality of the act; 'gametic material', 'product of conception' etc. Whenever this happens it should act as a warning. When we are openly afraid to speak the truth about our actions we must seriously question their validity.

Bible, Church and abortion

- No direct mention is made to abortion in scripture, presumably because it was an act so heinous to the Hebrew mind as to be unthinkable, and so unnecessary to comment on. Children were ‘a gift from the Lord'.
- 'A woman with child' has the emphasis of two people in unique union, not one on her own. In Amos 1:13 the 'Ammonites ... ripped up women with child in Gilead' (cf. also 2 Kg.15:16; Hos. 13:16). This act is seen as one of the worst possible atrocities in war, because it was a double murder, and because of the innocence of the victims.
- Church opinion, in the majority, has always been against it. The Christian position on abortion and infanticide was always contrasted with that of the pagan world:

    - The Didache was against it (150 CE)
    - Tertullian was against it (200 CE)
    - The Council of Ancyra (314 CE) excluded anyone who had had an abortion, from the Lord's Supper for ten years

Life and choice

In discussing this issue some key questions are:

- Are there circumstances in which, through ignorance or violence, a woman has the right and responsibility to terminate a pregnancy?
- Are there circumstances in which a woman's responsibility to control her own fertility have been taken away from her?
- How does one relate and evaluate 'right', 'responsibility' and the 'sanctity of life' to each other?

- **Medical reasons**

The health of the mother is clearly of paramount importance. It is the main platform in the medical argument for therapeutic abortion. Whether or not there are medical circumstances which make an abortion the only way in which to save a woman's life is an area of some debate (although e.g. a pregnant woman with cervical cancer would put her own life at risk if she carried on with the pregnancy and delayed treatment for the cancer):

- Everet Koop (Surgeon General to the Regan administration), 'There is no situation in which an abortion is the only way to save a woman's life. In pregnancy a doctor has two patients, the mother and the child; the responsibility is to get both safely through childbirth'. [43]
- Alan Guttmaker [pro-abortionist gynaecologist], 'Let's be honest, let's not lean on medical facts that are untrue. There is no situation in a pregnancy in the way of a disease or psychiatric illness that we cannot handle just as well with a woman pregnant as with a woman aborted'.[44]

Disabled children are special children. Accurate genetic screening can help us to know when a child might be deformed, but this should enable us to make special preparations for these children. They and their parents need special support. Disabled children have the right to life; their presence is a gift from God which demands we find resources from him (compassion etc.) to meet their needs. To abort disabled babies is not going to make the world a better place; we will be the poorer, and become spiritually deformed.

- **Social reasons**

- Family poverty can make pregnancy and childbirth a huge pressure. Poverty is a separate subject for which Christians must face responsibility. The act of abortion is not going to make the poor family richer. In fact they will be spiritually and emotionally poorer. There are other answers like contraception. They need substantial financial help. They need guidance, education and love.
- The end of a relationship can sometimes precipitate a request for abortion. In law the father of the unborn child has no rights. Consideration is needed here of the other people involved and space is required to discuss the measures to be taken and other options available.
- Pregnancy under age brings strong pressure for abortion. However, the psychological and physical damage of abortion can be enormous; while childbirth, even premature is a natural process. Abortion on young girls can lead to sterility. Many young girls have made fine mothers. At the very least the child can be adopted.
- Rape is an horrific crime. A rape victim needs a tremendous amount of love whether they become pregnant or not. Pregnancy from rape is not frequent; a study in USA of 2,700 cases of rape revealed that none resulted in pregnancy. However, pregnancy as a result of rape does occur and must be considered sensitively and not dogmatically:

  - An abortion is not going to make the woman unraped, and the baby she carries is half hers
  - Since 'life' is a gift from God, aborting the foetus may be seen as another type of rape
  - If the rape victim is surrounded with love, security, understanding there they may feel able to have the child. There are moving examples of women with deep bonds with children that have resulted from rape
  - We need the spirit compassion not legalism, however strongly we feel; bringing the person to a place of faith

[43] See Everett Koop ***'Whatever Happened to the Human Race: Study & Action Guide'*** Marshalls 1980 p43
[44] *ibid*

- **A woman's choice**

'Pro-choice' advocates often set out their case within the narrow argument of "women's rights", or "circumstances demand it" and so forth. However, it can be set against a broader historical, social and moral background.

For millennia, women in almost every human society have had their bodies, sexuality and fertility controlled by men and powerful social norms. A woman's fertility has been seen as the property of the family and community for whom she is expected to provide offspring; infertility becomes a social stigma. Alongside this, complications and death in childbirth have been high, linked to equally high levels of infant mortality that of course only increase the insistence and pressure for more children to be conceived and born; an unrelenting spiral of demand, control and anxiety. Historically the church has been a major influence in supporting this pattern.

Christians should celebrate the advances in medical science and the intellectual and theological challenges that have done so much to bring greater liberation to women. Nevertheless, the huge on-going negative spiritual, moral and social legacy of the exploitation of their fertility fails to be recognised. The 'pro-life' position is often experienced by women as just another means of attempting to control their fertility in another from; either by society generally, or patriarchy in particular, and as such is not Christian and has nothing to do with the gospel.

The 'pro-choice' community are correct in proclaiming that a woman's fertility is her own and not the property of her husband or society; Christians must celebrate and proclaim this. Consciously or unconsciously, women are still marked by the legacy of the exploitation of their fertility in much the same way as the black community continues to be spiritually and emotionally, not to mention socially, marked by the legacy of slavery even though it is no longer an actual reality in their experience. The church must identify and articulate this and ask, "How can the Christian community work with women to develop a positive attitude towards sexuality and fertility?" The gospel is about exorcising the effects of the patterns of the past and bringing people into an experience of wholeness and freedom, this must also embrace a woman's understanding and experience of fertility.

- **'Pro-life' and 'pro-choice'**

The biblical perspective seems to be unquestionably 'pro-life'. A woman's fertility is fundamentally her own, but the nature of its function inevitably does give it implications beyond her own person in terms of relationship with her sexual partner(s) and any child that might be conceived. They do not have a right over her, but she does have a responsibility towards them; at this complex interface the debate engages.

Christians who take a 'pro-life' position are voicing the right of the unborn child to live, but have a responsibility to also recognise and speak out about the broader background of exploited feminine fertility. Here is the common ground to which the two sides can be come much closer and try to hear each other, moving from the polarised positions of, 'a woman's right' and 'a foetus's right' towards a deep sensitive exploration of the mystery of female fertility and its nature and possibilities. The current debate on both sides is too shallow and abrasive; it is blind to the past, insensitive in the present and ignorant of the possibilities for the future. Christians should consider being both:

- *'Pro-life':* the biblical evidence places great value on the child in the womb; therefore their destruction is an awesome act with very real consequences.
- *'Pro-choice':* all our actions must be the result of responsible choice and faith; where a woman faces pregnancy in a genuine spirit of fear, for whatever reason, she must be given the dignity of being able to choose. This is not a licence for either convenience or ignorance, neither of which could be justification for abortion.

As a consequence Christians should actively work for real 'pro-life' bench-marks in law and a less casual approach to ending life in the womb; however, they should be equally active in stressing the spirit in which such principles are framed and interpreted, and supportive of women facing ‘crisis pregnancies’.

EUTHANASIA

Dying well

Although Christians know death has been defeated, its challenge still remains. It is still a solemn event. Death remains the great certainty. The choice is not between death and life, but dying this way or that. Yet for the Christian death, when it comes, can be consciously cooperated with. We can die well.

Modern medicine has eliminated much premature death but we still face many degenerative diseases, which bring a gradual and painful end, or a slow decline in mental faculties such that the patient’s sense of identity is lost. These are the circumstances, which bring calls for 'euthanasia'. Euthanasia comes from the Greek 'to die well'. It must be the hope of every doctor and every Christian that when the end comes every person will 'die well'. But does this mean sustaining life even if it is irreversibly fading? Is there a place to end a life that will continue, though painfully? Is there a place for 'mercy killing', or is this murder or suicide?

- **Patterns of the past**

Ancient cultures differed in their attitudes towards euthanasia and suicide; some philosophers called it courage to take your own life, others called it cowardice. Infanticide was widely practised with the deliberate killing or exposing of unwanted children. The coming of Christianity had a huge influence, Christians were against infanticide and suicide from the beginning, and would rescue abandoned children:-

- By the 10th century suicide was a crime in English law
- Prior to 1823 no suicide could be buried on consecrated ground
- Between 1946-55 some 5794 attempted suicides were brought to trial; 308 were imprisoned
- From 1961 some suicide in England was no longer a crime, though to assist another in taking their life was punishable

- **Pressure to change**

In most western nations it remains against the law to help another person to kill themselves. However, in recent years, the laws on euthanasia have been changed in some countries and there have been some significant legal cases in the UK, notably those concerning Tony Bland[45] and Diane Pretty, a woman paralysed from the neck down by motor neurone disease, who failed to get the courts to say they would not prosecute her husband for assisting her to take her own life.[46] These cases have given rise to an increasing public debate on the subject and pressure to change our current legislation and attitudes.

In the Netherlands, the American state of Oregon, and the Northern Territory of Australia, laws have been enacted to allow physician assisted suicide, although the Australian Act was overturned by the Federal Parliament some months later. It has been argued that, ethics aside, these are bad laws which in practice contribute to a 'slippery slope' where doctors fail to promote the alternative of palliative care, or make the decision for the patient.[47] However, more recent data from the Netherlands suggests that an initial increase in cases of euthanasia, upon legislation, may have stabilised at around 2.6% of all deaths, although to this must be added cases of physician-assisted suicide (0.2%) and, more worryingly, ending of life without an explicit request from the patient (0.6%).[48]

- **Types of euthanasia**

- **Positive euthanasia** is where active steps are taken to help kill a patient, usually by administering a high dosage of a lethal drug; it is the calculated 'causing of death'.

- **Passive euthanasia** is the refusal to administer or sustain means of support which could avert death; only more recently has this become an issue with the development of drugs and life support technology to sustain a person's life beyond their natural ability to live.

- **Infanticide** is where a disabled baby is given 'nursing care only'; the child is kept warm and comfortable but is given a drug to stop it feeling hungry, and death inevitably follows in a few days.

Doctor's dilemma

Sustaining life has taken on whole new dimensions in recent years. To what lengths should a doctor go in order to maintain a person's life? Can we rightly withhold treatment that we know would sustain life?

- **Wisdom and experience** are at the heart of the issue of when to administer and when to withhold treatment. The doctor does not want to meddle with the inevitable path of death and sustain a life beyond what is right. However, they may not know how a particular patient would have responded to certain treatment. (Some terminal patients

[45] See above, 'When is Death?', and Habgood, pp. 14-17.
[46] See Messer, 2002, p.152.
[47] Keown, J. 2002 *Euthanasia, Ethics and Public Policy* Cambridge: Cambridge University Press
[48] See the Lancet on line: http://image.thelancet.com/extras/03art3297web.pdf

have made surprising recoveries.) As far as possible, doctors must know the patterns and reality of medical conditions and the consequences of different treatments. The fact that something can be done does not mean it must be done.

- **Full infant care** of the kind given to any normal baby must also be given to an abnormal, but non-dying, baby. Where a doctor knows that a baby's congenital condition is such that no treatment can prevent the baby dying in the short term - only then should it be allowed to die naturally. The body of the child, in every way treated normally, is allowed to dictate the nature of the treatment or the pace of death.49 The baby is not 'helped' to die, and no subjective 'quality of life' criteria are used by the doctor to make final judgments. It is a decision made on medical evidence alone and the body's natural ability to sustain life. Where a baby with abnormality has genuine long term prospects of self sustained life, however disabled, surgery, medication and life support must be given to help it over the short term.

- **Use of painkillers,** which may be life shortening, but are administered to enable a terminal patient to die with dignity and comfort, is not euthanasia. The doctor knows whether their intention is to kill pain or to kill the patient. It is the responsibility of the doctor to bring comfort if they cannot bring healing, and in many cases this can only be done with powerful drugs. To deliberately and consciously hasten death is wrong. The fine line between the two must be identified but it will always exist. It cannot be legislated exactly for it lies with intention and responsibility.

- **Economics** will play an increasing role in the debate and development of thinking, and perhaps legislation, on euthanasia. Up to 90% of the NHS budget is spent on patients in their last months of life.50. To what extent is the doctor to be influenced in their decisions and actions by economic constraints? In terms of the elderly, they require more care and expense than younger people and their percentage numbers in Britain are increasing:

  - In 1901 there were 2.9 million people 60 years of age and over
  - In 1991 there were 11.9 million people 60 years of age and over
  - In 2021 there were 14 million people 60 years of age and over

- **Quality of life** is another point of debate. Should decisions over sustaining life be governed by a fundamental sanctity of life or by the subjectively assessed quality of life the patient currently has or could be expected to have? How do you assess quality of life; what are the criteria?[51] Someone in a 'persistent vegetative state' is not burdened, but their relatives and the medical staff might be - so whose quality of life?

Objections to 'mercy-killing'

- **Compassion:** It is argued that high levels of physical pain, the loss of bodily function and control, bring an indignity that only the kindness of a swift and painless death can restore. However, medical treatment, nursing care and love can reverse situations that

[49] See Everett Koop ***'Whatever Happened to the Human Race: Study & Action Guide'*** Marshalls 1980 p23-24
[50] Whipp, M. 2000
[51] See above in these notes

would otherwise be degrading. Euthanasia in offering 'kindness' may be unwilling to pay the greater price of compassion and reap its greater harvest.

- **Possibility:** 'Terminal' patients have often made startling recoveries. No one can be absolutely certain that what appears to be impending death is not reversible. Also, who knows what sudden medical breakthrough might offer a new avenue of treatment. Few things are 'final' in medicine, and this is the heart of the dilemma.

- **Mood:** During illness a patient's mood can change many times. A request for euthanasia at such a time may not reflect their real intentions. Furthermore, there is the danger that patients may request death solely on the basis of clinical depression.

- **Responsibility:** If mercy-killing is allowed in law then who should decide? It places a huge weight of decision on doctors and/or relatives, and a possible burden of guilt. Reports from the Netherlands suggest that it is also open to abuse by doctors or relations.[52]

- **Society:** Margaret Whipp suggests that the rise in support for euthanasia amongst the general public, and within churches, is a reflection of the 'strident mood of autonomy, so characteristic of modern societies' (p. 4). She also cites Cicely Saunders, a key figure in the hospice movement, as saying that 'When someone asks for euthanasia or tries to commit suicide, I believe in almost every case someone or society as a whole has failed that person.' Legislation to allow euthanasia would put great pressure on the old, the weak and the disabled to 'do the right thing' in the same way as women currently face pressure to abort embryos which appear to be disabled. It would lead to a further devaluation of life.

Hope and hospice

Superficially the campaign to legalise euthanasia appeals to well meaning people who do not wish unnecessary suffering upon others. Under the surface the implications are horrific. It cannot be justified theologically, philosophically or socially. The only way forward is the way of Jesus: coming to where people are with love and compassion, acting in kindness, instilling hope.

Practically we should support the hospice movement of which a former chairman of 'EXIT' said, "I didn't know you could do it. If all patients died something like this we could disband the Society ... I'd like to come and die in your home".

Christians working in this area must serve their patients to the best of their ability with medical skill, wisdom and love. The Christian community must recognise their needs and give prayer and tangible support. They must work in society to such an extent that there is scope for a more sensitive response to many of the questions medicine poses from the public at large.

[52] Whipp, 2000 pp. 15-16 and Keown p. 123.

'What a man (sic) is consists not only of what he does but also of how he endures. A fully human life is inescapably vulnerable....even suffering may by grace be woven into the texture of a larger humanity.... dying .. may be integrated into life, and so made instrumental to a fuller life in God'.[53]

Questions

1. Why is it important that Christians should be aware of the dilemmas of modern medicine and have a voice into them?

2. A fifteen-year-old girl comes to you seeking help in obtaining an abortion. What advice would you give? What action would you take?

3.Think back over recent years and identify three medical issues that have hit the headlines because of the social or moral challenges they have brought. Briefly describe each one and outline the concerns that they have raised. In each case explain your personal response and why; making it clear what questions concerns still remain for you.

Booklets published by Grove often provide a useful introduction to issues:

O O'Donovan ***'The Christian and the Unborn Child'*** 1986
N Messer ***'The Ethics of Human Cloning'*** 2001
R Simpson ***'Abortion: Choosing Who Lives'*** 2002. This includes details of the administrative procedures which women go through to obtain an abortion and statistics for the UK
P Watson & D Attwood ***'Researching Embryonic Values - A Debate'*** 1991
M Whipp ***'Euthanasia - a Good Death?'*** 2000

H & S Anson ***'Some mothers do have 'em... others don't'*** Eagle 1997
J Bryant & J Searle ***'Life in Our Hands: A Christian Perspective on Genetics and Cloning'*** IVP 2004. This gives a very good overview of the issues of personhood and genetic manipulation for the interested non-scientist.
Church of England Board for Social Responsibility ***'On Dying Well'*** (2nd Ed) Church House Publishing 2000. Good introduction with cases.
J Habgood ***'Being a Person'*** Hodder & Stoughton 1998. See especially pp. 37, 89, 155, 205-28.
DG Jones ***'Valuing People. Human Value in a World of Medical Technology'*** Paternoster Press 1999. Interesting examination of the issues by a doctor.
N. Messer ***'Theological issues in Bioethics'*** Darton, Longman and Todd. Contains theological readings on Christian views of life and death, healthcare and personhood 2002.
F Schaeffer & C Everett Koop ***'Whatever Happened to the Human Race?'*** Marshalls 1980
N Spencer ***'Health and the Nation'*** The Jubilee Centre 2001.
J Stott ***'New Issues Facing Christians Today'*** BCA 2000.
R Thomas ***'Grave New World'*** Salt and Light Ministries 2000

[53] pp. 21-22 *On Dying Well* (on reading list).

Web sites change but the following are often useful:

Antenatal Results and Choices website: http://www.arc-uk.prg
British Medical Association ethics page:
http://www.bma.org.uk/ethics/ethicswebresources.jsp
ESRC Centres for Genomics in Society e.g. egenis:
http://www.genomicsnetwork.ac.uk/egenis/.
http://genethics.ca
Human Fertilisation and Embryology Authority: http://www.hfea.gov.uk
Human Genetics Commission: http://www.hgc.gov.uk
National Information Resource on Ethics and Human Genetics (USA):
http://bioethics.georgetown.edu/nirehg/
Nuffield Bioethics: http://www.nuffieldbioethics.org
Anti-euthanasia (US) site with useful inks: http://www.euthanasia.com/index.html