

**A REPORT ON THE
THE STATUS OF THE UNBORN HUMAN**

Received by the Methodist Conference of 1990

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SUMMARY

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PREFACE

This report is offered to the Methodist people and the wider public as a contribution to the growth in understanding of the “unborn human”¹. It is not intended to be a firm statement of Methodist belief. The hope is that it will clarify the issues involved and make s more aware of the status of the unborn human before God and within the human family.

Christianity claims that God created humanity in his own image, and revealed himself in human form. Consequently, questions about the status of the human and the value to be attached to each human are matters of crucial importance, and are now raised in new ways regarding the status of the unborn human.

This report originates in advances in medical technology regarding the unborn human and the consequent need for society and individuals to decide what is the significance of the stages of human development from fertilisation to birth both before God and in human society. New techniques open exciting possibilities for understanding and treating disease and for overcoming infertility. But frequently they require difficult ethical decisions because they require the manipulation and possibly the destruction of what is clearly human material. The question is: what is the theological and ethical status of that material?

The number of people who may find themselves facing such decisions constantly widens. Parents, teenagers, clergy, doctors and nurses, couples seeking fertility treatment, research workers, lawyers, patients who might be offered treatment with fetal tissue, may all find themselves called upon to make decisions in this area. For many there is anguish in the process of arriving at the answer, in the decision itself and in living with the consequences of the decision. Part of the anguish is the uncertainty regarding the status of the entity about which decisions are to be made. Is it a human being, or human material only? Is it a powerless and voiceless individual entirely dependent on the goodwill of others, or is it a powerful entity – unable to exercise responsibilities but fully able to take all that it needs for its own development?

Both Christian faith and scientific enquiry stress the essential integration of all components of the universe. Every action in some way affects the whole. Actions taken in relation to the unborn human will have an effect on society for better or for worse. Given the possibility of “test-tube babies”, surrogacy, artificial insemination by donor (AID), abortion, genetic research and embryonic and fetal tissue transplants, decisions must be made but they are not purely private decisions; the well-being of human society and of creation are also involved.

The Methodist Conference of 1986, in response to a memorial from the Warrington Circuit recognising this situation, instructed the Faith and Order Committee, in consultation with the Division of Social Responsibility, to set up a working party to prepare a report on “the status of the unborn child”.² After discussion with the Warrington Social Responsibility Representative it was clear that the phrase “unborn child” was not meant to prejudge the outcome of the discussion. Consequently it was accepted that “unborn human” was a less contentious phrase; it is therefore used throughout the report.

This report seeks to address the following questions

- What is the present ethical, medical and legal situation concerning the unborn human?
- What is the status of the unborn human before God and how do we as Christians understand and act on this?
- How can parents, research workers, medical personnel and others involved in making decisions about the future of unborn humans, be assisted, counselled and supported in the choices they have to make?
- To what extent is the care of each unborn human the responsibility of the wider society as well as the individual parents and how should that responsibility be exercised?

There have been several significant studies and reports in this field in the last decade. Work of a closely related kind is being undertaken at the present time by the Conference Commission on Sexuality, and in a Church-wide study of a draft Conference Statement on The Family, The Single and The Married. The issues dealt with in those reports are not repeated here.

Notes

1. The term “unborn human” is used throughout this report to cover all stages from fertilisation to birth.

2. **Memorial 102**

The Warrington Circuit Meeting (Present: 22. Vote: unanimous) expresses its concern at the absence of any recent official statement concerning the status of the unborn child (i.e. the status from the moment of fertilisation to the moment of birth). In view of major developments which have taken place in the last ten years in the field of medicine, we feel the existing statement on this matter in the 1976 Statement on Abortion is no longer adequate to meet the needs of research workers, doctors, nurses and the general public who seek Christian guidance for their work, nor does it meet the need for the Church to speak truth to those who would exploit the new advances for personal gain.

The Circuit Meeting therefore asks the Conference to direct the appropriate Connexional Committees to prepare a report on the status of the unborn child for consideration at Conference 1987.

Chapter 1

CONTEXT OF THE METHODIST STATEMENT ON ABORTION (1976)

1.1 Background to the 1967 Act

1.1.1 During the Sixties there was a widespread debate in society and in the Churches, on the advisability of reforming the law on abortion. Previously abortion was almost universally condemned, as it was in the Methodist Declaration of 1964. Attempts were made to change the law in the period immediately before and after World War II. The arguments in favour of reform varied:

- The uncertainty of the existing law discouraged women in need from seeking medical advice
- The high incidence of back-street abortion, frequently resulting in severe medical and psychological complications and sometimes death for the mother.
- The argument on the grounds of equality. There seemed to be “one law for the rich, another law for the poor”.

1.1.2 In 1965 a committee of the Board for Social Responsibility of the Church of England published *ABORTION: an ethical discussion*. The committee rejected the absolutist position and discussed abortion in terms of a conflict of rights, as between those of the mother and of the fetus. The authors illustrated their approach by reference to three particular cases:

- In which the pregnancy constitutes a grave threat to the mother’s life or health,
- In which there is a **calculable** risk of the birth of a deformed or defective child (this was written before pre-natal diagnoses had become a reliable and acceptable technique, see Appendix III)
- In which the child had been conceived as a result of rape or some other criminal offence.

Rather than procure their own Bill, the committee amended one already before the House of Lords prepared by Lord Silkin (1965).

1.1.3 Lord Silkin’s Bill, while retaining the principle of the illegality of abortion, allowed termination on one of four grounds:

- Grave risk to life or physical or mental health of the mother,
- Grave risk of the birth of a defective child,
- Adverse health or social conditions (including the existing family) which would make the mother unsuitable to care for the child,
- Pregnancy resulting from a criminal offence.

There would be an upper limit of 16 weeks of pregnancy (see Appendix III) for the latter two grounds.

1.1.4 The Anglican committee expressed their acceptance of abortion only on the following grounds:

when "...if the pregnancy were allowed to continue there would be grave risk of the patient's death or if serious injury to her health or physical or mental wellbeing."

They also accepted that "account may be taken of the patients' **total environment, actual or reasonably foreseeable.**" No upper time limit was given. These recommendations differed significantly from Lord Silkin's in that rape and fetal abnormality were not grounds for abortion, except in as far as they affected the woman's wellbeing.

1.1.5 Subsequently Mr David Steel tabled a Bill which contained elements of Lord Silkin's Bill in that specific grounds for abortion were laid down. In addition the mother's social environment could be taken into account, as proposed in the Anglican report. In an attempt to restrict the number of abortions, the phrase "greater than if the pregnancy were terminated" was added in the House of Lords to the Bill's definition of the risks to mothers and their existing children which were to become valid grounds for abortion. Since early abortion poses less risk to a mother than continuing a pregnancy to term, this had the unintended effect of permitting doctors to authorise abortion, in effect, on demand. The amended Bill became the Abortion Act of 1967 (Appendix I).

1.1.6 In 1966 the Methodist Conference had vigorously debated the subject of abortion, and passed a motion which contained and approved of key concepts similar to Mr David Steel's Bill.

1.2 Post 1967

1.2.1 The steady rise in the number of abortions, particularly on women from overseas, led to growing concern about the way the Act was being interpreted. (Abortions on women from abroad comprised about one third of the number in England and Wales in 1974. Changes in the laws in Western Europe and in the USA in the late 70s and early 80s have significantly reduced the number of foreign women seeking abortion in Great Britain.) In 1972 a Government Committee of Enquiry on the working, but not the basis, of the Act was set up (The Lane Committee), to which the Methodist Church gave written and oral evidence, and which reported in 1974. Their Report has never been debated in Parliament, although many of the administrative recommendations have been implemented.

1.2.2 The Committee concluded that the passing of the Act had exposed many personal problems in the lives of contemporary women. But by facilitating a greatly increased number of abortions, its passing had relieved a vast amount of individual suffering. The Act had focussed attention on the paramount need for preventive action, for more education in sexual life and its responsibilities, and for the widespread provision of contraceptive advice and facilities.

1.2.3 The Committee was against "Abortion on Demand" but it was also against tightening the criteria for abortion in the Act. It therefore required that the consent of the woman's medical advisers should continue to be obligatory before an abortion could be legally performed. The Committee urged that appropriate counselling should be available for all patients and adequate after-care for all women who had an abortion.

1.2.4 In the twenty one years since the passing of the Act in 1967 there have been fifteen unsuccessful attempts to change it: three of the involved major parliamentary debates. As far as opinion polls can be relied upon, the public are broadly in favour of the present position.

1.2.5 In 1970 a Roman Catholic layman and ethicist, Dr Daniel Callahan, published *Abortion – Law, Choice and Morality*. This careful and extensively researched book began life as an attempt to defend the traditional Roman Catholic position. In the course of writing it became a powerful attack on that position. His approach is summarised in the following quotation, “Abortion is at once a moral, legal, sociological, philosophical, demographic and psychological problem, not readily amenable to one-dimensional thinking”. This book had a significant influence on the joint Anglican-Methodist and Methodist groups mentioned below, and the second paragraph of the Methodist Statement (see below) reflects the above quotation from Callahan.

1.3 The 1976 Methodist Statement (See Appendix II)

1.3.1 Late in 1975 the Division of Social Responsibility produced a consultative document, *Abortion – the issues involved*, which was widely studied throughout the Connexion. The document was based on an unpublished joint Anglican-Methodist study. There was overwhelming support for the provisional judgements expressed in the consultative document. These formed the basis for the *Statement on Abortion* which was approved by the Family Life Committee, the Executive Committee and the Board of the Division of Social Responsibility. The 1976 Conference, consisting of 576 representatives, adopted the Statement with only five dissentient votes. Later that year, the Division published *Abortion Reconsidered: The Methodist Statement and its background*. This document has no official status.

1.3.2 The Statement argues that, from conception, the unborn human never totally lacks human significance, but that its significance manifestly increases; abortion therefore becomes more unacceptable as pregnancy proceeds but is not thereby ruled out.

1.3.3 The Statement then considered when and on what grounds a pregnancy might be terminated.

- “No pregnancy should be terminated after a aborted fetus would be viable”
- With two exceptions, all abortions would be best restricted to the first twenty weeks of pregnancy. Furthermore there are strong arguments on physical, psychological and practical grounds for carrying out the termination in the first three months of the pregnancy.
- The exceptions are where there is a direct physical threat to the life of the mother, and when information about a serious abnormality in the fetus becomes available after the twentieth week.
- Environmental factors may be taken into account, though only when a termination is envisaged during the first twenty weeks of the pregnancy.

1.3.4 The Board of the DSR endorsed the use of the Statement as the basis of its responses to the various private members’ bills, in the preparation of a leaflet, *Counselling Families with Genetic Disease*, and in its responses to the Warnock Report and related issues.

1.4 Until the 1970s the status of the unborn human as largely discussed in terms of abortion. Since then the rapid developments in genetics and in techniques for treating infertility and genetic disease have shifted the focus of discussion so that, for additional and pressing reasons, the whole question of the status of the unborn becomes impossible to avoid, even during the earliest stages of life. To these we now turn.

Chapter 2

THE SCIENTIFIC BACKGROUND

2.0 Introduction

It is no exaggeration to say that the birth of the first “test tube” baby, Louise Brown, in 1978 heralded the dawn of a new era in human reproduction. There has also been much greater public awareness of these developments, due to greatly increased publicity, and also much public concern about the ethical issues involved (see Chapter 3). In this chapter are outlined some of the scientific and technological developments in this field, the moral and ethical questions they raise and the present guidelines and procedures for monitoring these developments.

2.1 Basic biology – the normal process

The time from fertilisation to birth (about 38 weeks on average) can be divided into pre-embryonic, embryonic and fetal periods. The term “pre-embryo” is often used to refer, during the first 14 days after fertilisation, to the entity brought about through the fusion of egg and sperm. The term “conceptus” is also used of this entity, but its use is not restricted to the first 14 days. The embryonic period lasts from 14 days to eight weeks after fertilisation. During this period, the part of the conceptus which eventually becomes the child (as opposed to the part from which the placenta and membranes develop) is known as the embryo. Before 14 days this part cannot be distinguished from the rest of the conceptus; after eight weeks its form is recognisably human and it is termed a fetus. The term embryo is often used more loosely, to cover not only the future child between 14 days and eight weeks after fertilisation but also the whole conceptus before 14 days; but as the latter gives rise to placenta and membranes as well as child it seems less confusing to refer to it by the distinctive term pre-embryo, which is therefore used throughout this report.

2.1.1 The pre-embryonic period

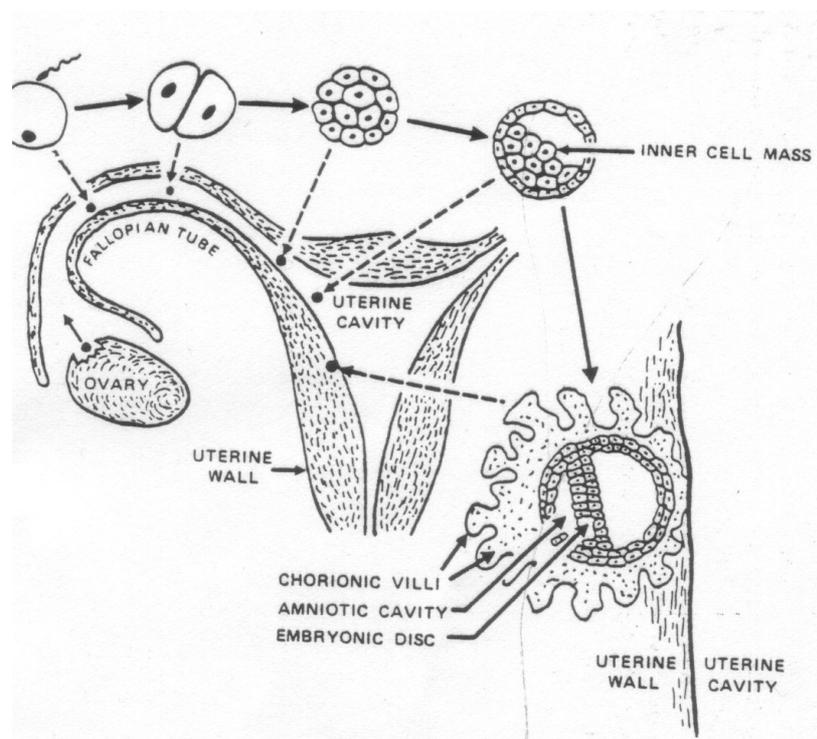
It is usual to think of human life as beginning at the moment of fertilisation, by which we mean the penetration of the outermost part of an egg (ovum) by a sperm. Very shortly before this happens (and typically about halfway through a menstrual cycle), the ovum concerned will have become detached from the ovary in which it has developed and then been sucked into one of the two Fallopian tubes which lead from the ovaries to the uterus. This tube, which sperm reach via the uterus, is the site of fertilisation. Tube, ovary and uterus are shown diagrammatically in Figure 1, as is the development of the pre-embryo.

Ova and sperm normally contain about half as much genetic information each as other human cells do – i.e. 23 chromosomes instead of 46. After the sperm has penetrated the outer part of the ovum, it takes about 24 hours for the two sets of 23 chromosomes to come together. When they do, the fertilised ovum immediately divides into two in the same way that other living cells do – i.e. each of the 46 chromosomes splits into two, and the two sets of chromosomes then move apart before the cell itself divides so that each daughter cell also has a set of 46. This first cell division is followed by many others. By about four days after fertilisation the pre-embryo has become a hollow ball of 50-60 cells, about 10 of which form an **inner**

cell mass bulging into the central cavity of the ball. Four or five days later another cavity (the amniotic cavity) opens up like a blister between the inner cell mass (now known as the embryonic disc) and that part of the outside of the ball to which it has hitherto been attached. This leaves the embryonic disc (the future embryo) joined only round its edge to the outer ball of cells.

While the inner cell mass and the amniotic cavity have been developing in the pre-embryo, the pre-embryo as a whole will have travelled down the Fallopian tube and arrived in the uterus, becoming attached to the uterine wall by about 6 days after fertilisation and fully embedded (implanted) within it during the second week. From the outer ball of cells of the pre-embryo, branching projections (chorionic villi) then grown out into the uterine wall, where some of them will eventually form part of the placenta. Through them the unborn human is fed with the oxygen and nutrients it needs to grow and develop. The outer ball of cells is also destined to form the wall of the **amniotic sac** – the fluid filled bag which the amniotic cavity becomes, and which cradles the unborn human in the uterus until the end of pregnancy.

Figure 1 – Diagrammatic cross-section of uterus, ovary and fallopian tube, and of ovum / pre-embryo at five points on its journey to the uterine wall.



2.1.2 The embryonic period

At the time of implantation, the embryonic disc is a featureless flat plate, but at the end of the second week a ridge (the primitive streak) appears on this plate, close to its edge and point towards its centre. This change marks the beginning of the embryonic period. Until then, one cannot be sure that the pre-embryo will not give rise to more than one embryo (in which case more than one primitive streak will appear). The streak shows where the bottom end of the embryo will develop. Its appearance is quickly followed by numerous other changes, which over the next six weeks transform the featureless embryonic disc into the recognisable shape of a tiny human being.

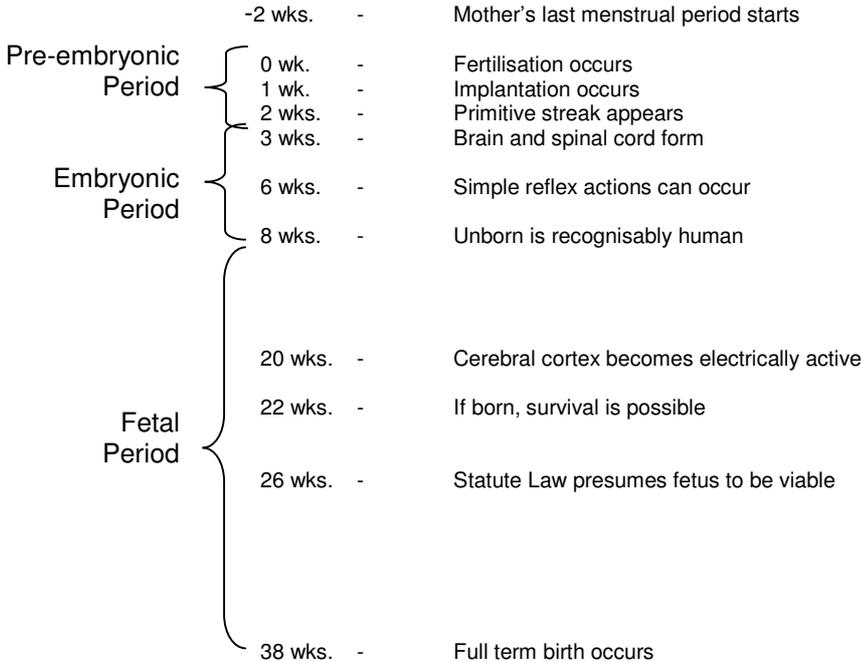
One of the first of these changes is the appearance of the **neural plate**, a raised area on the embryonic disc which can be distinguished from about 18 days after fertilisation. This will eventually form the nervous system (brain, spinal cord and nerves). It normally develops into a tube and becomes covered by other tissues during the fourth week; the main nerves start to grow out from it early in the fifth week; and it seems that these nerves must begin to function within the next few days since some simple reflex actions – involuntary movements in response to touch – have been described as early as the sixth week.

2.1.3 The fetal period

The fetal period begins about 8 weeks after fertilisation and 10 weeks after the onset of the mother’s last menstrual period (from which the length of gestation is conventionally measured), by which time the unborn human has developed enough to have the form of a tiny baby. During the remaining weeks of pregnancy (30 on average), the fetus can expect to grow from about 4cm to 50cm in length and the tissues of its constituent parts will be equipped by progressive changes in their microscopic structure and behaviour to carry out the functions required of them after birth. These changes will include the beginning of electrical activity in the cerebral cortex – a phenomenon which seems from observations in later life to be essential to consciousness, and which has not been reported before the third month of the fetal period. About 14 weeks into the fetal period (i.e. at 24 weeks gestation or 22 weeks from fertilisation) the tissues will have developed enough for the fetus to have a chance of surviving if born prematurely and given modern neonatal intensive care.

The relationship in time of all these events is depicted in figure 2.

Figure 2 – Timescale of prenatal life



2.2 Some Common Abnormalities

2.2.1 Infertility

At least one tenth of all women who wish to conceive have not done so after trying for two years. If treated by methods other than Artificial Insemination by Donor (AID), Gamete Intra-Fallopian Transfer (GIFT) and *In Vitro* Fertilisation (IVF), about half of these women are likely to conceive; a quarter are likely to fail to do so because of defective sperm function, in which case IVF, GIFT or AID may be offered; and most of the rest will have damaged Fallopian tubes or unexplained infertility, for which IVF and GIFT respectively are particularly recommended. However, success rates with IVD and GIFT are still quite low: see Chapter 2.3.1 and 2.3.2.

2.2.2 Spontaneous pre-natal death

Approximately 15% of pregnancies that progress far enough to be recognised clinically, end in miscarriage (i.e. spontaneous abortion) and another 0.5% in stillbirth. (The distinction between miscarriage and stillbirth is legal rather than biological: the birth of a dead fetus is classified as a stillbirth if it occurs after at least 28 weeks gestation, which the law regards as the lower limit of viability, and otherwise as miscarriage). However, studies of pre-embryos (e.g. from Fallopian tubes and uteri removed at hysterectomy) suggest that at least 40% and perhaps more than half of these are too abnormal to survive, in which case the number failing to implant or succumbing too quickly after implantation to produce clear signs of pregnancy must be greater than the number in which later miscarriage or stillbirth occurs. Some of these cases are so abnormal that even the word “pre-embryo” is a misnomer, since all that develops from the ovum is a hollow ball with no embryonic disc. Although most such hollow sacs succumb quickly, occasionally one will develop into a hydatidiform mole – a kind of tumour.

2.2.3 Congenital defect

Although prenatal death is the usual outcome when the unborn human is affected by a major abnormality, a small proportion survive pregnancy: about one in 40 liveborn children have malformations which cause death or substantial handicap either inevitably, or if untreated. About one fifth of these cases can be blamed on specific causes, of which there are three main kinds – (a) abnormality of the chromosomes affecting the amount of genetic material in each cell (e.g. Down’s syndrome); (b) a defect in one or two genes – individual items of genetic information, of which there are thousands on the average chromosome; (c) exposure in early pregnancy to one of several harmful agents, which include a few infections (e.g. German measles), a few chemicals (e.g. Thalidomide), and intense atomic radiation. Most of the other four fifths of malformations are thought to be caused by the cumulative effects of a variety of factors, genes and features of the pre-natal environment, on the developing embryo.

Among the legal abortions carried out because of a risk that the unborn human is severely handicapped, chromosomal abnormality is reported as the main problem in 15%, other genetic defect in 4%, exposure to harmful agents in pregnancy in 23% and malformation of the central nervous system (attributed in most cases to multiple factors) in 27%. Most of the pregnancies in which genetic defects other than

chromosomal abnormalities are feared, are probably terminated because of evidence that the risk of handicap is high, rather than because a handicap has been diagnosed. However, most of the central nervous system defects and chromosomal abnormalities and some of the other genetic defects report will have been firmly diagnosed by one or more of the tests mentioned in Section 2.4 – mainly ultrasound and amniocentesis, the latter often prompted by an abnormal blood test result.

2.3 Infertility Treatment

The most dramatic developments in the field of infertility treatment involve procedures carried out with gametes (eggs and sperms) outside the bodies of the would-be parents. The best-known of these procedures is fertilisation “*in vitro*” followed by insertion of the pre-embryo in the Fallopian tube or uterus, but transfer of unfertilised eggs and semen to the Fallopian tube or uterus, but transfer of unfertilised eggs and semen to the Fallopian tube is also practised.

2.3.1 *In vitro* fertilisation (IVF)

This is the so called “test tube baby” technique. The woman’s ovaries are stimulated by hormones to produce several eggs which are removed surgically from her body and mixed with sperm from the husband in a special fluid in a dish or test tube. By microscopic examination of the mixture of the eggs and sperm it is possible to see whether the eggs have been fertilised. Those which have may either be placed in the woman’s uterus or womb (the usual procedure) or be inserted in the Fallopian tube so that they can travel to the uterus by the natural route. If the pre-embryo successfully implants in the wall of the uterus, then pregnancy is established and subject to any mishap, will continue normally to the birth of a baby.

This technique is now well established and has been performed many thousands of times. However despite the wide publicity given to it, only a minority of couples are suitable for attempted IVF treatment and even among these, the success rate is still quite low: in the main British units, about seven attempts at IVF were made for every live birth which resulted in 1987 (see Appendix III).

A refinement of IVF for which techniques are now being developed experimentally, is the micro-injection of a single sperm into the egg while it is outside the body. Such a procedure could provide some hope for many couples whose infertility is caused by defective sperm function. When there are few sperm, or their mobility is subnormal, they are unable to penetrate the outer surface of the egg, the zona pellucida, so that fertilisation does not take place.

Zygotes produced by micro-injection might, however be expected to be at increased risk of abnormality – firstly because the element of competition between sperms, which is present in normal fertilisation and which may select out sperms with various defects, is removed, and secondly, because micro injection might damage the egg and so affect the cell divisions which follow fertilisation. As there are not tests for either of these risks, the dangers inherent in this technique can only be evaluated retrospectively.

2.3.2 Gamete Intra-Fallopian Transfer (GIFT)

This method of attempting to treat infertility has become popular since the Warnock Committee reported in 1984. It has also been referred to as T-SET (Tube Sperm-Egg Transfer). In this procedure, the eggs are collected as for IVF and a number of these eggs are then mixed with the sperm and introduced into one or both Fallopian tubes through a cannula (or fine tube) in the hope that fertilisation will take place in the Fallopian tube itself and that the resulting pre-embryo will travel down the tube to the uterus.

The advantage of this method is that it allows fertilisation to occur in its natural environment where the secretions of the Fallopian tube may aid the process and the subsequent implantation in the wall of the uterus. An additional advantage is that it is simpler to perform than IVF, and cheaper. However it can only succeed in women who have at least one Fallopian tube present and functioning. This therefore rules out a substantial proportion of infertile women. Also this method may lead to the dangerous condition of an ectopic pregnancy (i.e. one within the tube itself) if a blocked tube is inadvertently used.

IVF may be performed first, and GIFT used where fertilisation occurs but a pregnancy fails to ensue. The procedure is now well established and is offered under the NHS to suitable couples. Its success rate is similar to that of IVF or rather higher.

2.3.3 Gamete and pre-embryo storage

Both pre-embryos and sperms can remain viable if frozen and thawed under suitable conditions, and the search is on for a satisfactory method of freezing and thawing unfertilised human eggs. Opportunities to treat pre-embryos and eggs in this way arise because the hormone treatment given before IVF or GIFT is attempted generally leads to more eggs being produced than are needed immediately. When IVF is attempted all these eggs may be mixed with sperm to maximise the chance that some will be fertilised. However it is usual not to implant more than three or four pre-embryos because of the risk posed by a pregnancy with several embryos, both of them and for the mother. The surplus pre-embryos may then be frozen to very low temperatures in liquid nitrogen and, at a later date, be thawed out and implanted in the uterus if the pre-embryos already implanted fail to develop, or if the parents want further children. Decisions about the "ownership" of the pre-embryos, disposal of unwanted ones, and their possible use for experimentation, all raise contentious moral questions.

The idea of freezing unfertilised eggs and disposing of those no longer needed is less controversial ethically than the freezing and possible destruction of pre-embryos. This is because eggs do not have a complete set of human genes and are not therefore, on their own, potential human beings. However, human eggs have so far proved difficult to freeze and thaw, and might be at high risk of producing abnormal embryos if fertilised after such treatment. Investigating this possibility would involve *in vitro* fertilisation of eggs which had been frozen and thawed, and testing the resulting pre-embryos for abnormalities. This is an example of the deliberate production of human pre-embryos in order to experiment on them - a source of ethical problems to which we return in Chapter 6.2.3. If, however, human eggs could

be frozen, thawed and fertilised safely, surplus ones obtained in the course of IVF and GIFT treatment could be kept in an unfertilised state for later use if required.

Egg storage could also be useful for fertile couples in cases where they might wish to delay having children without the increased risks of chromosomal abnormalities which eggs produced by older women have, or where a woman was about to undergo a treatment such as radiotherapy, which might damage her ovaries or her eggs.

The storage of frozen semen (for possible use in artificial insemination) is not a new technique. However, awareness of the risks of transmission of the human immunodeficiency virus (HIV, the 'AIDS' virus), and the hepatitis B virus, has increased the demand for donors to be screened for these and other sexually transmissible infections. Some countries now insist that all donor semen should be stored frozen for three or six months and only used if the results of the serological screening remain negative during this period. The questioning of donors about any heritable disorders among their relatives, and a check for any possible abnormalities, are other safeguards against the creation of damaged embryos.

2.3.4 Gamete and pre-embryo donation

If one or both of a couple are incapable of becoming genetic parents, the ways in which they can become social parents are essentially the same as they have always been [c.f. Genesis 16:2; 30:3; 38:8]. If the man is infertile, a situation far more common than is usually admitted, the female partner can bear a child by another man. If it is the woman that is infertile, the man's sperm may be used to fertilise the egg of another woman. In both cases it would be the original couple that reared the child. Where both are infertile it is possible to rear a child of other parents, the usual situation in adoption. The introduction of gamete and pre-embryo donation has however, provided new techniques for people to become 'social parents in each of these ways.

The first of these techniques to be introduced was artificial insemination, which made it possible for a woman with a sterile partner to become the genetic parent of a child without the necessity of sexual intercourse outside their partnership. Conversely, if the woman is unable to produce her own eggs, it is now possible to employ GIFT or IVF using eggs from a donor. These may be fertilised by her partner's sperm. These procedures allow the woman to bear, as well as rear, a child fathered by her partner, of which she is not the genetic mother.

In pre-embryo donation a woman receives a pre-embryo of which neither she, nor her partner, are the genetic parents. If the couple keeps the child, the genetic situation is the same as in adoption, but the child will have developed within the partnership before, as well as after, birth. An alternative possibility is that the genetic parents of the pre-embryo might arrange for it to be implanted in a surrogate mother because the genetic mother was unfit or unwilling to carry the baby to term, with a view to the child being returned to them after birth for rearing.

None of the methods discussed in this section is a 'treatment' of infertility. What each does is to get round the problem by using gametes from fertile donors. Very few people have begun to work out the pastoral, psychological and social

implications of these techniques. However there are some important exceptions, especially Robert Snowden who has done research into families where a child has been born by AID.

All these methods raise moral questions. There is the issue, in gamete donation, of the genetic parents not being married to one another. In surrogacy there is the question of the rightness of one woman being asked to carry a child for another. These procedures raise other ethical questions, such as whether sperm donation to a single woman or lesbian couples should be sanctioned; whether close relatives of would-be social parents should be acceptable as donors of gametes or pre-embryos; whether a donor's identity should always be concealed, or his or her genetic child have the right to that information. In addition, what view should be taken of the use of frozen gametes from deceased people, or of people wishing their children to be particularly gifted and so choosing frozen gametes from donors with outstanding physical or intellectual attributes?

2.3.5 Fetal reduction

It has already been noted that several eggs are commonly transferred in GIFT, and multiple pre-embryos are introduced in IVF. This is done to increase the chances of a successful pregnancy since each individual egg or pre-embryo has only a relatively small chance of surviving. It is also unusual for a woman's ovaries to produce several eggs simultaneously when she is successfully treated for infertility by hormones alone. In all these cases, if more than one egg is fertilised and develops normally, the result is, of course, a 'multiple pregnancy' ending in the birth of two or more children. This is a relatively common event after infertility treatment.

The risks of maternal complications and of fetal and infant death and handicap increase with the number of fetuses in a pregnancy. For this reason the number of surviving fetuses in a multiple pregnancy (usually but not always one due to treatment for infertility) is sometimes deliberately reduced to one or two, by for example injecting the remainder with high-doses of potassium chloride by a needle passed through the wall of the abdomen and uterus. Because of the risks involved with pregnancies with several fetuses, and the moral and possible psychological problems associated with 'fetal reduction', the Interim Licensing Authority for *In Vitro Fertilisation* now recommends transferring no more than three eggs or pre-embryos (or in exceptional circumstances, four) at any one time.

2.4 Pre-natal diagnosis

It is a generally accepted part of modern obstetric practice to test whether certain life-threatening or severely handicapping disorders are present in fetuses believed to be at significant risk of these conditions, and to offer to induce abortion when such tests are positive. The list of conditions for which it is possible to test is rapidly growing, and could conceivably come to include all genetically determined attributes, normal as well as abnormal, if the current international project to analyse every human gene is brought to fruition. The most widely used tests are ultrasound and amniocentesis.

Ultrasound, which produces an X-ray-like picture of the fetus, is now employed very widely to monitor fetal growth. To detect many abnormalities by this method one has to wait till 18-20 weeks gestation or later, and to use the most sensitive equipment

and skilled operators; but some major defects can be detected earlier and under less rigorous conditions.

Amniocentesis, the removal of a sample of the amniotic fluid which surrounds the fetus within the uterus can be done from 15 weeks gestation onwards, but causes about one in 250 women to miscarry. The fluid contains dissolved substances such as alpha-fetoprotein (AFP), and cells which are genetically identical to those of the fetus. The level of AFP is abnormally high in most cases of neural tube defects (the most important group of defects of the central nervous system, which includes spina bifida). The cells can be examined for chromosomal abnormalities (e.g. Down's syndrome) and an increasing number of other genetic defects (e.g. Duchenne muscular dystrophy, cystic fibrosis), but must first be cultured for 2-3 weeks to allow the cells to multiply.

Two less widely used methods of obtaining cells for chromosomal and genetic studies are:

Fetoscopy (inspection of the fetus and often removal of a sample of fetal tissue through a fine fibre-optic tube, generally at 17-18 weeks, and

Chorionic Villus Biopsy (when a chorionic villus in the placenta is sampled, generally at 9-12 weeks).

Tissues obtained by Fetoscopy can also be tested for German measles infection. Fetoscopy is about ten times more likely than amniocentesis to cause miscarriage, but chorionic villus biopsy is likely to become about as safe as amniocentesis and is beginning to replace this for chromosomal and genetic studies. It enables such studies to be completed much earlier in pregnancy, not only because of the earlier time of sampling, but also because the sample does not have to be cultured for 2-3 weeks before examination.

The possibility of detecting chromosomal and genetic abnormalities even earlier in pregnancy has been opened up by the demonstration that the development of pre-embryos produced by *in vitro* fertilisation can be stopped by freezing, and started again by thawing them. This has prompted research into the feasibility of taking a pre-embryo at its eight-cell or 16-cell stage, removing and culturing one of its cells and examining its chromosomes and/or selected genes whilst freezing the rest of the pre-embryo (which remains capable of developing into all of the structures that form from the pre-embryo – embryo, placenta etc.). The pre-embryo would only be thawed and replaced in its mother's uterus if no chromosomal or genetic abnormality was found.

Except for ultrasound it is unlikely that any of the above tests for abnormalities will be offered in all pregnancies in the foreseeable future. At the present time amniocentesis (followed by the offer of an abortion if the fetus is found to be abnormal) is commonly recommended to three main groups of pregnant women:

- Those whose family history indicates that their children are at high risk of one of a growing list of genetic disorders;
- Those in their late 30s or 40s (since the risk of certain chromosomal abnormalities such as Down's syndrome increases with maternal age;

- Those whose blood contains an unusually high level of AFP (as it generally does when the fetus has a neural tube defect).

Many hospitals routinely measure the level of AFP in the blood of pregnant women. Those in whom this level is high are then invited to undergo amniocentesis and amniotic fluid AFP measurement as a test for neural tube defect. In conjunction with maternal age, the measurements of AFP and other compounds in the blood are also being used increasingly to identify fetuses whose cells should be examined for evidence of Down's syndrome (in which the AFP level in the blood tends to be **below** average). Neural tube defects cannot be detected by examining cells in the way that chromosomal and genetic defects can, so there is no immediate prospect of the time at which they can be diagnosed being reduced much below 17-18 weeks gestation (when the AFP tests are most accurate).

Although policies of testing fetuses for abnormalities and offering abortion if the tests are positive have been widely accepted, some condemn this practice on ethical grounds. There is more general anxiety lest the practice be extended to allow even moral fetuses to be eliminated if tests showed that their gender or other characteristics did not match their parents' wishes. The idea of isolating and culturing cells from pre-embryos (cells from each of which a complete individual might develop if conditions were right), raises a further ethical problem: is this not essentially the same as cloning, the production of more than one individual from one pre-embryo?

Although cloning happens naturally when identical twins occur, doing it artificially would arouse strong criticism, not least because of the practical and psychological effects on all concerned. People would appear to become units of mass-production.

2.5 Fetal transplants

Normal fetuses from induced abortions, and fetuses in whom defects which make early death inevitable have been diagnosed prenatally, are both potential sources of organ and tissue transplants. Most of the fetuses in the latter group have anencephaly – absence of most of the brain (including the cerebral cortex, which seems to be essential for conscious thought) and of the part of the skull which overlies it.

The types of transplants generally obtained from these two groups of fetuses are rather different. Recent interest in the aborted normal fetus as a source of transplants has focussed mainly on the possibility that if early fetal brain cells were transplanted under the right conditions to the brains of sufferers from disorders such as Parkinson's disease, schizophrenia, Alzheimer's disease and epilepsy, these cells might bring relief by carrying out correctly functions in which the sufferers' own brain cells are failing. Fragments of brain tissue from aborted fetuses have already been transplanted to patients with Parkinson's disease, but whether this does any good is still an open question. Anencephalics, on the other hand, are more likely to be used as sources of complete organs – kidneys, hearts, etc. Such an organ or organs from an anencephalic which is not too immature may be life-saving if implanted in an infant whose own organ(s) of the same kind cannot function properly.

Given parental consent, the practice of transplanting tissues and organs from fetuses and newborn infants who have no prospect of individual survival, in the hope of benefiting other human lives (and incidentally enabling part of the donor to go on living), has been warmly welcomed on ethical grounds as giving a positive aspect to such otherwise negative events as abortion and perinatal death. However, the use of aborted fetuses as donors has been condemned as condoning abortion by those who believe that abortion is never justified.

Other contentious issues are:

- Whether it is permissible to improve a transplant's chance of surviving by removing it before the donor's death (which has been defined in this context as an irreversible loss of function of the organism as a whole);
- Whether pregnancy should ever be initiated and then terminated in order to provide a fetal transplant;
- Whether the prospect of obtaining a fetal transplant should be allowed to affect the clinical management of a pregnancy, e.g. by influencing the methods to be used in performing an abortion, or the choice between terminating an anencephalic pregnancy and allowing it to continue until the fetal organs are fit to transplant to a newborn recipient.

These three questions were answered in the negative in guidelines produced in 1988 by the British Medical Association, and in 1989 by the government-initiated Polkinghorne Committee on the Research Use of Fetuses and Fetal Material. Both bodies also took the view that brain and other nervous tissue transplants should consist only of isolated cells or tissue fragments.

2.6 Research on the unborn

This includes experiments both on fetuses (from induced abortions, miscarriages and stillbirth) and on pre-embryos.

2.6.1 Experiments on fetal material

These have quite a long history: more than 50 examples were listed in 1972 in the Peel report on the use of fetuses and fetal material in research. Many such studies only involved observing aspects of fetal physiology as pregnancy proceeds, examining the naked-eye and microscopical structure of dead fetuses, or culturing fetal cells. Most of this work is no different in kind from the research habitually carried out on other human subjects, although (as with young children), the person who must give consent before the work is done is not the one being investigated, but his or her mother.

There are however, at least three kinds of research on fetuses which appear to raise more specific ethical questions. The first is the transplanting of human fetal material to members of other species. This has been done with tissue from the brain in studies exploring the basis for transplanting brain tissue between humans (see 2.5) and arouses anxiety because the recipients can be regarded as partly human and partly not, at a cellular level.

Secondly, there is the carrying out of experiments on fetuses in the uterus that are already scheduled of abortion – experiments which would not be carried out on other fetuses because they might affect them adversely.

Thirdly, there is experimentation during the first few hours after abortion, on fetuses which are not yet viable, but can sometimes be kept alive for long enough for such experiments to be done. Although the Working Party knows of no examples of experimentation in anticipation of abortion, experiments on live fetuses have certainly been carried out after abortion, e.g. to explore the possibility of developing an artificial placenta to save the lives of very premature babies. Both these kinds of experiments are repugnant to many people, but others welcome them as saving the aborted fetus's life from being entirely wasted.

The Polkinghorne Committee (q.v. 2.5) recommended in 1989 that research and treatment which are carried out on living embryos and fetuses should from the time of implantation onwards be regulated by “principles broadly similar to those which apply to treatment and research conducted with children and adults.” Even for research on dead fetuses and fetal material the Committee laid down several conditions – notably that (a) the prospect of embryonic or fetal material being used in research should not influence the clinical care of any pregnancy, (b) the research should not involve those concerned with the case as carers, (c) the mother should have consented in writing without being offered any financial inducement, and (d) the local ethical committee¹ should also have sanctioned the work, after satisfying itself of the validity of the research, the lack of any other way of meeting its aims, and the adequacy of the investigators' facilities and skill. The Committee did not support the notion that “the act of inducing abortion is one of such moral reprehensibility that it taints beyond acceptability any possible beneficial material so obtained” but recognising that some do hold this view, it also decided that no doctor or nurse should be compelled against his or her conscience to participate in such research.

2.6.2 Experiments on pre-embryos

Like most major medical advances, IVF could not have been introduced without research first on experimental animals, and then on human material. For example, the only way to identify the conditions under which human fertilisation and development of the pre-embryo could occur outside the body was to see what happened when human eggs and sperm were brought together under different conditions. Similarly, continued experimentation is the approach most likely to lead to improvement of the successful pregnancy rate following IVF. Most current research involving pre-embryos is being done either to this end, or with a view to

¹ There is normally one Local Ethical Committee for each District Health Authority. Its main functions include (a) adjudicating on the acceptability on ethical grounds all proposals for research on humans which originate from staff of the Authority or local GPs, and (b) monitoring the projects it approves. The Department of Health recently recommended that such a committee should have between eight and twelve members, drawn from both sexes and a wide range of ages, and including hospital and medical staff, nursing staff, general practitioner(s) and two or more lay members. Members are appointed by the Health Authority, which should first consult relevant professional bodies or (when selecting lay members) the Community Health Council. Committees are expected to seek expert advice when matters arise which are not covered by their own expertise. It is not yet clear that Ethical Committees are acting consistently throughout the Health Service and some within them question the precision of their terms of reference.

making it possible safely and accurately to examine pre-embryos for genetic defects, as envisaged in 2.4.

The pre-embryos used in these studies generally result from the fertilisation of eggs obtained from candidates for IVF or GIFT. Some of these pre-embryos are produced with a view to implanting them, and become available for research because successful IVF has occurred in more than the three or so eggs that need to be implanted. Others are brought into being either solely to enable them to be used in research of the above kinds, or in the course of experiments in which the effectiveness of a contraceptive vaccine is being assessed by observing how successfully it prevents IVF. The production of embryos in the course of research raises larger ethical questions than experimentation on surplus embryos. The latter may even be regarded as giving purpose to otherwise wasted lives, although some take the view (as Enoch Powell did in his Unborn Children (Protection) Bill), that it is abhorrent not only to produce by the use pre-embryos "other than to procure the birth of a normal human child".

The Government-initiated Committee of Inquiry into Human Fertilisation and Embryology (The Warnock Committee), took the view in 1984 that experiments on human pre-embryos *in vitro* during the first 14 days after fertilisation should be permitted if approved by a statutory licensing authority. At the time of writing, the present session of Parliament is expected to choose by a free vote between this option and a ban on all experiments, even on pre-embryos. Meanwhile, all workers in this field are expected to have their programmes approved by the Voluntary Licensing Authority (now the Interim Licensing Authority) for Human *In vitro* Fertilisation and Embryology, which was set up in 1985 under the auspices of the Medical Research Council and the Royal College of Obstetricians and Gynaecologists.

The Authority will not approve any work that involves modifying the genetic constitution of a human pre-embryo, placing one in the uterus of a member of another species, growing one beyond 14 days (excluding any time when development has been halted by freezing), or attempting to produce a genetic copy of an individual by substituting a nucleus from one of his or her body cells for the nucleus of an unfertilised egg. Other research on human pre-embryos, whether or not they have been produced for this purpose, is considered by the Authority on a project-by-project basis, and may be approved, provided the parents and local ethical committee agree and the information required cannot be obtained by work on other species.

The Authority regards studies of the penetration of animal eggs by human sperm (which may benefit the treatment of male subfertility) as acceptable, provided that development does not proceed beyond the first two cell divisions. It insists that a pre-embryo resulting from, or used in, research should not be transferred to the uterus (unless the aim of the research is to achieve the birth of a normal child to a particular individual), but should be disposed of by methods approved by the local ethical committee, and that frozen pre-embryos should not be stored for more than two years without review, or for more than ten years in all.

2.7 Post-coital contraception and abortion

The term “post-coital contraception” covers methods of birth control which act by causing the death of the pre-embryo or embryo but which are not usually regarded as methods of abortion since they are applied before pregnancy is known to exist. Intra-uterine contraceptive devices (IUDs) probably fall into this category, despite being usually inserted with the aim of ensuring that pregnancy will not result from future acts of coitus rather than from an act that has already taken place. Although some research suggests that such devices may prevent fertilisation, it is generally thought that they do not interfere with this process so much as with implantation of the pre-embryo.

IUDs which include some metallic copper are particularly effective and are sometimes inserted after coitus to prevent implantation. Alternatively, ‘morning-after pills’ may be taken at this stage. Like IUDs, these hormonal preparations make the wall of the uterus unreceptive to the pre-embryo and can be used rather later than their popular name suggests: the most widely recommended of them is meant to be taken within three days of coitus in two doses twelve hours apart. Preparations are also being developed which will interfere with the uterine wall’s ability to accommodate the pre-embryo, even if they are taken during the second week after coitus.

Another method of post-coital contraception is ‘menstrual regulation’ – the use of methods similar to those by which diagnosed pregnancies are terminated (e.g. suction through a narrow tube passed up into the uterus) to ‘restore menstruation’ in women in whom this is a few days overdue. However, intra-uterine suction carries a significant risk of infection and is widely held not to be justified when pregnancy has not been diagnosed.

For terminating known pregnancies, the use of suction during the first three months and of other approaches by way of the vagina and cervix (e.g. dilation of the cervical canal, often followed by extraction of the fetus by instruments) in later pregnancy has been popular throughout the period since abortion was legalised in this country; but injections with drugs (especially prostaglandins) which cause the uterus to expel the fetus have replaced surgical removal through the abdomen (as in Caesarean section) as the other commonly used method here. A further option now available through hospitals and selected clinics in France, although not yet in Britain, is the abortion pill “RU486”. If such a preparation became generally available, it might encourage a more trivial attitude to abortion by making this easier, especially in early pregnancy.

2.8 Conclusion

This brief review shows that new discussion is necessary. Furthermore, if solutions are to be found to the moral and ethical questions raised, the crucial question of what it is to be human must be explored. To that matter we now turn.

Chapter 3

MORAL THEORIES AND CONTEMPORARY UNDERSTANDINGS OF THE STATUS OF UNBORN HUMANS

3.0 Introduction

As humans we have a tendency to hope that the perplexing choices we sometimes have to face will be able to be resolved by turning to some simple standard of reference. The status of the unborn **human** has been the subject of such hopes. Some people have tried to develop one or other of the existing moral theories to provide such a standard, others have looked to the concept of human rights in the hope that here there would be a way of addressing the problem that would provide clear answers, yet others have hoped that careful understanding of the process of human development would provide a clear empirical point from which the status of the unborn human could be determined. In this chapter each of these approaches is examined; all are useful, all have something to add to our understanding but none is finally conclusive. In the end it has had to be recognised that individuals have to make choices based on the best evidence available, and that as individuals we have to take responsibility for the choices we make. The report therefore invites readers to recognise that we are not able to solve these problems by the application of abstract principle, but have to deal with real people and their needs.

3.1 Moral theories

There are two main categories of moral theory. The first group asserts that answers to moral questions ultimately depend solely on the consequences of the action or proposed course of action. This category of moral theories is thus called **consequentialist**. The *Methodist Statement on Abortion* (1976) contains consequentialist arguments (Para. 3...In considering the matter of abortion the Christian asks what persons...are involved and how they will be affected by a decision to permit or forbid abortion. Para. 12...It is right to consider the whole environment within which the mother is living or is **likely** to live). The most important members of this consequentialist category are those which can be grouped under the heading **utilitarianism**. In the utilitarian approach, morality is about maximising good and minimising evil. These are the criteria for judging the rightness and wrongness of actions or principles. The good to be maximised is generally “the greatest happiness of the greatest number” (Jeremy Bentham, 1748-1832, English philosopher), and consequently suffering is to be minimised.

The second group of theories derive from asking “what is my / our **duty** in this situation?” – and are known as **deontological** theories, from the Greek **deon**, duty. The major religions require obedience to rules that make no reference to consequences. The Ten Commandments are an example of this second approach. These religions attempt to justify their deontological requirements firstly by stating that God has commanded the people whom he has created to obey his laws, and thus those who would obey God have no option, and secondly by appealing to **Natural Law**, which, they say, undergirds what is said to be our duty.

There is an important objection to any deontological theory based on “obedience to God”: what if God is said to command cruelty, injustice and wanton destruction

(examples of all of which may be found in the Old Testament)? Secondly, the appeal to Natural Law also runs into difficulties (what is natural to one person is not to another), and the difficulties of deducing an obligation from a state of affairs.

In practical applications, too, these theories run into problems. For example, if the fetus is to be regarded as inviolate, how do we respond when the life of the mother is threatened by the continuing pregnancy, or when the pregnancy is the result of rape or incest, both of which are criminal offences? Many who take an otherwise absolutist position would make exceptions on these grounds, but once exceptions are made the attraction of an appeal to a simple injunction vanishes. An example of this process is seen in the famous case (1938) of Mr Alec Bourne, an obstetric surgeon. He had terminated the pregnancy of a girl who had been criminally assaulted when three months under the age of fifteen, and was charged under the Act of 1861, Mr Bourne was acquitted and the Judge decided that, in English law, "preserving the life of the woman" is not to be rigidly construed as "preserving the woman from death".

In an attempt to provide a non-religious basis to moral theories based on absolute duty and an appeal to natural law, the German philosopher, Immanuel Kant (1734-1809) maintained that rational agents (or persons) intrinsically possessed an absolute moral value (in contrast with inanimate objects and "beasts"), which rendered them members of what he called the kingdom of "ends in themselves". It followed that no person should be treated without their free consent as a means to the happiness of others. For this reason, Kant would presumably have regarded the abortion of a fetus for the good of others as impermissible unless satisfied that the fetus failed the test of "rational being". Kant's moral philosophy has been criticised for being too austere, for being absolutist, for leaving no place for a positive duty to others, for over-emphasising individual rights at the expense of the community.

Although criticisms of deontological moral theories can be made, consequentialist theories are also open to objection. How are the consequences of the proposed course of action to be assessed? Thus, there is no doubt that the Abortion Act of 1967 relieved much suffering and virtually eliminated "back-street" abortions, but at the same time the annual abortion rate rose from 50,000 in 1969 to 150,000 in 1987.

Utilitarianism can lead to an over emphasis on the community or society at the expense of the individual, and no consideration at all for the fetus if its presence is an inconvenience to the parent(s). What is meant by "happiness" (or "satisfaction") in the Benthamite phrase? Utilitarianism leaves little place for disinterested respect for each other as individuals, and for honest, fairness and justice for their own sakes.

Despite these criticisms, both types of moral theory have much to be said for them. In an attempt to combine the insights from these two groups of theories and to overcome some of their inherent difficulties Gillon (Philosophical Medical Ethics, 1986) suggested four principles which could be used to aid the analysis of medical ethical problems. He proposed that those with responsibility in any given situation should:

- Respect the autonomy of the other parties
- Seek the good of the parties
- Avoid doing harm
- Attempt as just an outcome as possible

By autonomy (from the Greek meaning self rule) is meant the capacity to think, decide and act on the basis of such thought and decision freely and independently.

Examination of these principles reveals that they are phrased in abstract form and yet can result in mutually contradictory conclusions. This is particularly so where one of the parties has great power over the other, as in the case of an unwanted pregnancy – where there is a clash of interests or rights. Hence the importance of considering human rights in this context.

3.2 Rights

The complexity of rights language can be baffling. It has been argued that there are inalienable rights, grounded in God and his relation with the world, or perhaps in nature itself and human responsibility for it. The claim is an intriguing one and there is a huge literature on the topic, much of it concerned with the resolution of apparent conflicts of rights. In the case in point, for example, both mother and child have rights; how are they related? And if both mother and child have rights, does the embryo have rights and how are they to be compared and contrasted with those of the mother?

A further basis of rights is justiciability, that is the basis of rights in law. A person or community has rights, but they are only the rights which are capable of being defended in law. Thus the state has the right to tax the citizen, and the citizen has the right to vote. The problem with this for deciding the status of the unborn human is that the cases where an unborn human has been able to bring an action in law are few and far between, and none at all in the United Kingdom. The embryo has therefore in principle no justiciable rights.

Neither of these approaches reduces the need for a theological perspective. This report, indeed, claims that the fact of God's creation of the world, and of the human in his image, gives a unique status to all that is human (see Chapter 4). However, reference to rights language does not reduce the problem of the status of the unborn to simple terms, it merely sets one set of claims against others. In the light of the best information and clearest thing we have to learn to make decisions which take account of the less than ideal circumstances in which all concerned find themselves. A corollary of this is the full acceptance of the consequences of their decisions. It is this which constitutes the morality in decision-making and avoids the anarchy of mere convenience and self-deception which would lead to moral anarchy. See the reference to Gillon's four principles above.

3.3 The relationship between moral status and biological development

Views on this issue can be classified according to the point in development from which they suggest that there is an absolute moral obligation not to kill the products of human conception. The main developments on which they focus are fertilisation; formation of the primitive streak ("individualisation"); attainment of the capacity to feel pain and / or pleasure ("sentience"); attainment of the capacity for life outside the uterus ("viability"); birth; and the acquisition of such attributes as self-awareness, thought and rational behaviour ("personhood").

3.3.1 At fertilisation

The view that the unborn human has from its very beginning as much right to live as an adult is particularly associated with the Roman Catholic Church, although by no means confined to it. Roman Catholic teaching declares that in principle this “right to life” applies to all humans who have souls; but there are long-standing differences among Roman Catholic theorists as to when ensoulment (also called hominisation) occurs, and Roman Catholics are taught to behave as if ensoulment and fertilisation coincided. This means not attempting to destroy any unborn human, even by using methods such as the intra-uterine device with a view to preventing implantation if fertilisation occurs.

As justification for this policy, the *Declaration on Procured Abortion* (1984) states that “From the time that the ovum is fertilised, a life is begun which is neither that of the father nor of the mother; it is rather the life of a new human being with its own growth. It would never be made human if it were not human already.” This is often taken to imply that what confers the right to life is membership of the human species, which includes newly fertilised egg and adult alike. A similar view is held by many Protestants. J. Foster writes: “I have said that the fetus is a human being and by this I mean that it is a human being right from conception, right from the time that the mother’s egg is fertilised, when the egg and sperm combine to form a single cell.” (J. Foster ‘Personhood and the Ethics of Abortion’ in *Abortion and the Sanctity of Human Life*, ed. J. H. Chamier, Paternoster 1985).

A rather different argument which leads to the same conclusion is that since the unborn human has the potential to be a human adult it should be treated as if it were an adult. It has been further argued, particularly in Roman Catholic circles, that because the unborn human has more potential than its mother (whose potential has already been partially realised) and also because it is “innocent”, its life should be preserved even at the expense of its mother’s, if a choice has to be made between them.

This basing of the right to life on membership of the human species appears to offer a clear-cut solution to the many ethical problems associated with the unborn human. However, a possible serious flaw in this argument is that this concept fails to do justice to the biological and social realities of human development.

3.3.2 At individualisation

One Roman Catholic scholar, Norman Ford, stated recently that for the first two weeks after fertilisation it seems “to be quite unreal to speak of the presence of a distinct human individual” in the mother’s uterus (‘When did I begin?’, 1988). The grounds for this view are biological (see Chapter 2.1). In the early first-week pre-embryo, each cell is totipotent, i.e. it has the potentiality of developing into a separate and complete human individual if separated from the other cells. The pre-embryo as a whole has therefore the potentiality to give rise either to one individual (which usually happens) or to more than one (as when identical twins occur). Furthermore, only a minority of the pre-embryo’s cells will form the body of that individual or individuals: the majority will form the placenta through which the individual is nourished and the fluid-filled sac in which he or she is cradled.

The cells which are to form the body become identifiable during the second week, when they come to constitute the embryonic disc; but even this structure is at first a featureless flat plate from which one individual or two (identical twins) or even more can develop. The number of individuals to be formed only becomes apparent on about the fifteenth day with the appearance of the primitive streak (streaks, if there is to be more than one embryo), which is the first step in the laying down of the plan of the body and arguably the earliest point at which the products of conception can be said to include a distinct human being or beings, even though these products have always been human.

This was broadly the view taken in the Warnock Report, which concluded that the pre-embryo had not as strong a claim to life as the embryo and fetus and that therefore responsible experimentation (followed by destruction) should be permitted on the products of *in vitro* fertilisation during the pre-embryonic period (i.e. the two weeks before the primitive streak stage) but not subsequently.

It can of course be argued that to locate the beginning of individualisation at precisely two weeks is an over-simplification, since although primitive streak formation occurs around the fifteenth day it must both be somewhat variable in its timing and be preceded by biochemical changes which should also be regarded as part of individualisation. More fundamentally, some claim that the acquisition of human rights cannot be related to individualisation (or indeed to any later developmental milestone) because development is a continuum.

3.3.3 At attainment of sentience

The view that all sentient beings are morally equivalent was put forward by Bentham. He did not claim that all sentient beings had an inviolable right to life. Rather he claimed that the killing of such beings was justified if it satisfied the utilitarian maxim of “the greatest good of the greatest number” by improving the overall balance between pleasure and pain among all those affected. One argument that has been advanced against the aborting of three-month-old fetuses is that they appear to be sentient. The basis for this belief is the movements seen in fetuses during abortion at this age, which have been interpreted as responses to pain.

It appears likely that these movements are no more than reflex actions – reactions to stimuli in which the part of the central nervous system which is related to consciousness and this to sentience is not involved. Indeed, it seems that there can be no consciousness without electrical activity in the cerebral cortex, which has not been detected before the fifth month (Chapter 2.1.3). Older fetuses may of course be to some extent sentient; but it can be argued that this on its own makes no stronger a case for them having an absolute right to life than for all sentient animals having such a right. However, the need to avoid causing fetal pain should certainly be borne in mind whenever any fetus that may be sentient is aborted.

3.3.4 At attainment of viability

It is sometimes argued that the unborn human should have full human rights as soon as it acquires the capacity to live outside the uterus. Attainment of this capacity – viability – has therefore been widely supposed to confer a new status on the fetus. The Infant (Life Preservation) Act of 1929 embodied this view by prohibiting the killing

before birth of “a child capable of being born alive” (i.e. a viable fetus) except when the mother’s life is at risk. The Act also established that evidence that a woman had been pregnant for 28 weeks or more was *prima facie* proof that her fetus was viable. This was widely assumed to mean that the Act did not apply before 28 weeks. However, this assumption was not upheld in a recent civil case where the court ruled that any fetus which could breath and so live apart from its mother was covered by the Act.

The earliest time in pregnancy at which a child can be born and survive has, of course, been getting earlier, owing to the advance of medical technology – and this may be expected to confer viability on even more immature fetuses in the future. Viability therefore, is not just an inherent biological property. The age at which it is attained is affected by the available expertise, so that the 26-week old fetus of a London executive would be considered viable, whereas that of an Ethiopian peasant would not. This suggests that the viability of any fetus at a particular point in time is an unsafe criterion to use in determining what our moral obligations to it should be.

3.3.5 At birth

The view that the right to life is not fully acquired until birth is implicit in the position of many of those who press for “abortion on demand”. They argue that since the fetus depends totally on the mother for life, it has much the same status as any part of a woman’s body. The mother is thus seen to have the same right to determine what should happen to it as she can expect to exercise over the rest of her body, for example her appendix or a tumour.

A variant of this view regards the unborn human as part of the mother’s body over which she has rights up to a defined, although arbitrary, stage of pregnancy. This view is implicit in the laws of countries which allow abortion on demand below a certain stage of gestation – three months in West Germany and the United States, for example. Even the acceptance of post-coital contraception implies that so long as a woman’s offspring are only pre-embryos she has the right to determine whether they should live or die.

An important reason for not equating the unborn human with the other parts of its mother’s body is its distinct genetic constitution and capacity to become a totally separate individual if allowed to develop. There are also the questions of the involvement of the father and of the doctor. The father of the unborn human must be considered to have some rights and responsibilities at least on moral grounds, even if these are not enshrined in law. Also, to exercise her “right to abortion” the woman needs medical help. Unless regarded merely as a technician, the doctor is entitled to have a say in what is to be done, just as in any other medical situation on which he or she is consulted.

3.3.6 At attainment of personhood

The Division of Social Responsibility publication *Abortion Reconsidered* emphasised the importance of personhood. Based on the theological insights into our relationship to God as a “Person” the authors argued that “person has become the primary human category for moral reflection”. With regard to the abortion debate, the question “Who are persons?” was stated as “What persons, or beings who are

properly to be treated wholly or in part as persons, are involved, and how will they be affected by a decision to permit or forbid abortion?" The report went on to state that:

"any definition of a person must at least involve reference to an individual being, possessing independence and able to respond to relationships. The fetus progressively develops the potential to exhibit these qualities. To regard the fetus fully as a person at an early stage of the pregnancy, however, is to reject all normal meanings of the concept of a 'person'. Certainly, the early fetus will normally develop to viability and birth. The loss of a fetus is therefore never totally without significance, but such a loss in early pregnancy does not amount to the death of a person."

As is implied by the phrase "at least" in the list of criteria of personhood given in this quotation, these are by no means the only criteria which it has been suggested that a human must satisfy in order to be considered a person. The primacy that the Statement gives to personhood echoes Kant's view that persons are the category of beings to whom we owe moral obligations; but Kant's definition of a person was "a rational, willing agent." Earlier, John Locke (1632-1704) had defined a person as "a thinking intelligent being that has reason and reflection and can consider itself as itself, the same thinking being in different times and place; which it does only by that consciousness which is inseparable and as it seems to me essential to it." (*Essay Concerning Human Understanding*, ed. J. W. Yolton, 1972, p. 280.) Others suggest that one must be capable of making moral judgements, must know that conduct can be either good or bad, to be considered a person.

On such criteria, personhood is not acquired until after birth. As Gillon writes, "very young infants, and humans with severely damaged or severely defective brains, may be able neither to think nor to be self aware, and if the Kantian requirement of rational agency is to be met, many older children and some adults will fail to fall into the net of personhood." (*Philosophical Medical Ethics*, 1986.) The view that persons are the only beings to whom we have moral obligations therefore suggests that infants and some older human beings as well as embryos and fetuses need not be treated as though they had an inviolable right to life, thus opening the door to infanticide and euthanasia. Once on this "slippery slope", it is argued, it may all too easily become a matter of political and economic expediency to deny human rights, including the right to life, to any who do not meet the expectations of those in power. The history of human society, infected as it is by human sin, provides many examples of how easily this can happen.

3.4 Conclusion

Each of these various attempts to get to grips with the question of the human raises many additional questions. In effect they all appear to want to solve the problem by reference to some external criteria which might be objectively determined, either by definition or enquiry. Whatever external authorities or criteria we choose to accept, we cannot escape the exercise of personal judgement and the acceptance of personal responsibility.

Chapter 4

THEOLOGICAL REFLECTIONS

4.0 Introduction

The biological and medical discoveries outlined in Chapter 2, and the developments in medicine and surgery that are made possible by them are like the discoveries of Copernicus and of modern psychology in that they face theology with a completely new situation. We do not believe that any of the absolutist positions outlined in the previous chapter do justice to the complexity of the situation with which we are faced: they overlook some facts and values whilst making other values absolute.

The complexity stems from, among other things, the sheer quantity of new knowledge, the variety of unborn human material, the difficulties of moral discernment, the conflicting views competing for our support, and the ambiguity of tradition and Scripture.

There is, in fact, little biblical material that bears explicitly on the specific issues involved, and traditional teaching can in some cases be shown to be based on inaccurate understanding (as, for example, that a woman is the passive recipient of the life-giving male seed). Isolated texts can be ambiguous and point in different directions. In this situation we have to turn to what is at the heart of our faith, to the doctrines of creation redemption and resurrection. We shall not find in them a pre-determined theological system that will provide ready-made answers, but reflection on them will help to point the issues and reveal appropriate ways of exploring them.

4.1 Creation

Central to all Christian faith is the belief that God is love. Creation is an act of love in which God creates and sustains the objects of his love. He loves everything that he has made, but in creation humanity has a special place because only humanity made in the image of God and to humanity is given dominion over the earth (Genesis 1.27f, Psalm 8.5-8). What creation in the image of God means, and whether the image is borne by humanity as a whole or by each individual, is not spelled out in the creation story in Genesis, but it has to do with reflecting the nature of God and thus must surely involved the ability to make choices and to live in relationship with God. Humanity has been given the freedom and responsibility to know God, to learn of his will, and to choose whether to work with him towards that future which he has prepared for the whole of his creation (Romans 8.12-21).

Although it is only human beings who have the awareness and the creative freedom that belong to the image of God, some human beings have them at most in limited ways – infants and some severely handicapped people, for example – and others have in varying degrees lost them through accident or depravity (Romans 3.23; but they are all still part of the human community which is the special object of God's love and the bearer of his image. The limitations of individual human beings do not exclude them from the humanity that is "made little lower than God" (Psalm 8.5). Their value does not depend on their individual abilities or even their individual potential; it depends on their being created and procreated from and within the human community. The aborted fetus, the unviable embryo and the "spare" embryos

produced *in vitro* are also created and procreated in the community' they are human material and they have a special relation to humanity. They are flesh of our flesh, the flesh taken by the incarnate Word (John 1.14, Romans 8.3, Hebrews 2.14-17). It is our conviction that the special place of humanity in creation requires a "high" view of this human material. This means that decisions about it are never trivial: they must be taken responsibly, but they are not, on the other hand, pre-determined.

Dominion over the creation, the other special gift to humanity, has to be understood in the light of Christ's authority. Although he is the One into whose hands the Father has given all things, he takes the form of a servant (John 13.3-14, cf Philippians 2.5-11); when humanity, therefore is given authority over the earth, it is firstly not absolute authority because the earth is the Lord's, and secondly it is authority not to exploit but to serve. Human beings should not make arbitrary choices, but follow the will of God. They are stewards, not owners.

4.2 The human situation

The gift of free choice enables humanity to become partners with God in creation. God uses the artist and the craftsman to create beauty and to make things for human use; he reveals new truth through the scholar and the scientist and in the act of procreation he uses woman and man to bring into being a person who would not otherwise have existed. By his loving and creative choice, God has given human beings responsibility and has thereby limited his own power over the world. While this is necessary if human beings are to be creative, it also makes it possible for them to make destructive choices, as the continuation of the story of Adam shows. In this story, which is a paradigm of the human situation, human beings seek a mastery that God has not given them and attempt to order things by values other than God's; this disobedience breaks their relationship with God, and distorts their relationships with each other and with the rest of creation (Genesis 3.1-19).

Through the God-given ability to choose, humanity chooses what is destructive both of its own well-being and of that of other created beings, but even so the love of God is not changed in quality and because it is unchanged it is revealed in new ways (John 3.16, Romans 5.8). God continues to love and seeks to recall humanity to his way by taking on the pain of human existence (Hebrews 4.14f, 5.7-9). He himself becomes part of the human community, thereby showing the depth of his love for it and investing it with new value (Romans 8.17).

Sin, nevertheless, remains a reality within the human situation. Jesus is rejected and crucified, and the long history of the world since then shows both the acceptance of Jesus' values and the distortion and rejection of them. As in the Adam story human relationships with God, with each other and with creation are broken and twisted. No-one wholly escapes this entail; our decisions are made with warped judgement in sin-laden situations (Romans 1.18, 1 John 1-8).

4.3 The Christian hope

The rejection and death of Jesus are not the end; death is followed by resurrection and the gift of the Holy Spirit. Indeed, the whole act of God in Christ, which includes rejection and crucifixion, is resurrection, the giving of new life to those who were dead in sin (John 10.10); it is the act of a resurrection God who not only brings good

out of evil, but also sets free and empowers his people to do the same. Even if no-one wholly escapes the entail of sin, those who are in Christ do not have to be completely bound by it. When people are responsive to the Spirit, guided by love, sensitive to the whole revelation of God recorded in the Bible, using their God-given reason and open to each other, to new truth and to God, they can make good decisions, and their wrong decisions can be met with forgiveness and the possibility of redemption.

The new knowledge given by modern biology is within the loving purposes of God and the guiding power of the Holy Spirit. The developments of modern science and medicine are instruments of God for human good (even if they can be misused); they are part of the answer to ages of prayer for healing and arise from God's gift to us of inquiring minds and the capacity for wonder. Even if we live in a sinful situation God lives in it with us. Our relationship with him may be distorted but it is not broken because he is still at work in creation and redemption. There is in every situation the possibility of good.

4.4 Human response

Love, central to God's nature and his dealings with humanity, is also the heart of the human response to God (Mark 12.29-31 etc.). We love because he first loved us, and our duty to our neighbour is to love as God loves us (1 John 4.19-21, etc.). The principle of love enables us to make rules of behaviour, but it itself is not modified by any higher principle, even that of obedience to God, because love is obedience to God. We cannot avoid making decisions; that is the inescapable consequence of God's love and the gift of choice. All decisions about the human "material" must be made in the light of the centrality of love as defined by the nature and activity of God, but that does not mean that there are not difficult decisions to make, or that new knowledge may not make it necessary to change the everyday rules by which we live. It is not self-evident, for example, that the commandment "You shall not kill" applies to the fertilised ovum: to say that it does or does not is an ethical decision of the sort we are discussing. That other positions exist and are held by good people who are seeking to do the will of God should remind us that to take a particular stand is a matter of choice, whether the stand be "absolutist", liberal, radical or situational, whether it gives primacy to women's rights, the rights of the fetus or the just requirements of society.

4.5 Making decisions

The recognition that the unborn human is of value to God does not therefore free us from having to make difficult and painful decision where the values of two or more lives are in conflict. The knowledge that God loves the unborn human does not mean that that particular life has absolute priority over other individual lives, nor that the context of the whole of human society can be ignored. That there is a conflict between the right to life of different members of the human community is part of the tension of living in a fallen world. Any decision must be made in the knowledge that we are dealing with something which has special value to God. We have not been given any rules to follow, but the freedom and the ability to analyse sensitively new ethical situations, both in the light of our knowledge of God and his will for the world, and in the light of modern medical knowledge. Consequently we must aim to make these difficult judgements responsibly and humbly, relying on the mercy of God.

The Bible emphasises God's particular concern for the vulnerable and powerless in human society (Leviticus 19.9-14, 33-34, Ezekiel 34.16). Jesus himself has a special mission to the weak (Luke 4.18, cf Luke 1.52f). This is not because God loves the weak more than the strong, but because they have a special need of protection. The unborn are a very vulnerable part of the human community and are dependent on the community for protection, but they are not unique in this; sometimes the fetus dominates the situation and threatens the mother.

Biology now makes it very difficult to talk of a single moment when a new human life comes into existence, and theology has moved away from Greek thought, which saw human beings as souls inhabiting disposable bodies, to reflect the biblical teaching that our personhood is the totality of body, mind and spirit. This means that we cannot say that at x days the human fetus has no soul and so is of no more significance than, for example, the placenta, but at $x + 1$ it has been ensouled and so is entitled to full human status.

Furthermore, the focusing of the debate on the existence of souls has resulted in a devaluation of the human body. Human bodies are important: God himself became human at the Incarnation and took a normal human body and the gospels record Jesus healing physical illness. Resurrection is not merely for souls, but for human beings clothed in a new resurrection body. Our body is to be "a temple of the Holy Spirit" (1 Corinthians 3.19).

The unbroken development that makes it difficult to say that any particular moment is the beginning of a new human life does not mean that there are not significant stages. This development is not simply biological; the relationship of the unborn to the human community is also developing and changing, not least because as it develops it arouses new emotions in people related to it.

The complexities of the problem of the status of the unborn should not be allowed to obscure the needs of other members of the human community, to whom there is an obligation of love. There is a great deal of biblical material that shows God's concern for the unborn, even for the as yet unconceived (Jeremiah 1.5), but in general it is there to emphasise the concern God has always had for the person addressed, who is now an adult. God is no less concerned for the born than for the unborn. The Annunciation shows God's concern for Mary as well as his will for and foreknowledge of a child she is to bear (Luke 1.26-38, cf Matthew 1.18-23). The woman pregnant with an unwanted fetus has her own great needs, which are to be met with love. Love here involves deep concern for her well-being, which is to be shown in pastoral care and counselling which helps her to become more aware of what is involved in the decisions that face her. Such pastoral care is not less a part of our duty to the vulnerable than is our concern for the unborn, and it must not be overlooked or undervalued.

A proper concern for the whole human context, for the human community of which the unborn are part, must take many things into account, balance conflicting needs and accept the resulting tensions. There are many people with needs to be considered, for example the couples from whom the unborn material has come and the couples whose earning for children new knowledge might satisfy, sufferers from dehumanising brain diseases who could benefit from the experimental use of unborn

human material, people whose handicaps cause so much suffering that they and those who love them say that it would be better if they had not lived, and those who in their disability have enriched human life. We also have to take account of the way these matters are ordered in our society, the need to work for legislation that reflects what we believe to be the Christian attitude to these moral issues, and the experience of those who have to carry out society's requirements.

4.6 Conclusion

We have constantly referred in the foregoing to the decisions that have to be made concerning the unborn. There are decisions about matters of fact, decisions about principles and decisions about what action to take. We have concluded that the unborn is human in that it is part of the whole human community, but we have to wrestle with the question whether the image of God is borne by all human material or only by human beings individually. And we have to decide, for instance, whether we should treat all unborn human material as if it were fully personal, whether human material can be used as a means to an end, however good. Whether it has the same status regardless of origin and state of development. We have also as members of society to ask what is the proper task of the law in these matters.

These are the sort of questions that face us. They do not admit easy answers but we are inquiring, responsible agents in a world in which we are entitled and, indeed, obliged to explore, to ask questions and to make moral judgements. Nothing can take this responsibility from us.

This chapter has looked at some of the theological considerations that must inform our decisions. We have spoken of the love of God in creation and redemption, of the responsibility given by God to humanity to share in the work of creative love, in Christ's servant ministry, his healing work and his protection of the weak. We have emphasised the possibility of resurrection, which enables humanity with God's help to learn from experience, to make new starts and to bring good out of evil. We have emphasised that love, love for all humanity, is also central to the human response. It is also the gift of God that humanity can learn new truth, and it is new truth that today faces us with new possibilities and the need for new decisions.

This report is written in the context of the Church which is a community of believers, with different gifts and abilities; they are responsible for each other and have to support each other in situations of suffering and the making of difficult decisions. As scientists, doctors, nurses, lawyers, teachers, pastors, theologians, as church members, citizens and people involved in family relationships, we have responsibilities given us by God and we must grasp the opportunity of guiding the life of our community towards that future which God wills.

Chapter 5

HOW SHOULD THE UNBORN HUMAN BE REGARDED?

5.1 An attempt to grapple with the moral situation

It is clear from the arguments presented so far that human beings cannot escape the responsibility of exercising their free will. Choices have to be made, and this requires thought and debate, and the realisation that, on occasions, wrong decisions may result. Attempts to find relief from the responsibility for making choices, such as by seeking to point to external authorities may seem attractive, but the result is often de-humanising.

Like others, Christians must accept the moral responsibility for their decisions, and not think that it can be avoided by reference to definition, moral theory, or personal convenience. The facts must be uncovered and the will of God sought. The Christian must be prepared to accept the implications of his or her judgement. Personal decision-making must not be seen as an isolated process. The whole Christian community, with its collective reflection and resources, is of immense importance. The entire process of decision-making, for the Christian, sets his moral thinking and choosing in the context of God's redemptive love.

5.2 How should the unborn human be regarded?

In considering the status of the unborn human two sets of facts must be affirmed:

First, the product of the coming together of human sperm and ovum is obviously itself human. It is also distinct, in that it has the beginning of an existence independent of the parents contributing the gametes. It is thus, morally, in a different category from such body tissue of either parent as a blood cell, a finger, or a tumour.

Secondly, however, there is the undeniable fact that this combination of cells has to undergo very considerable biological development before it becomes even potentially capable of human consciousness and therefore of human identity. It is only after some 14 days that the appearance of the so-called primitive streak makes these developments possible.

The significance to the unborn human of being in a state of development – of becoming a person – and the significance of being human will be considered in this order.

5.2.1 The significance of becoming a person

It is difficult if not impossible to define exactly the beginning or ending of any stage of the human life cycle. It cannot be precisely stated when a person may be called "adult". There is sometimes a dilemma as to when a person may be considered to have died, as bodily functions can continue after brain death has occurred. Similarly, the beginning of human life cannot be pinpointed. However, significant stages in the development of the unborn human are discernible, even if it is not possible to define them exactly.

Many of these stages have already been outlined and their relationship to moral status explored in Chapters 2.1 and 3.3 respectively. Significant from the point of view of making moral and legal decisions could be:

1. the penetration of the sperm through the outer layer of the egg (the zona pellucida)
2. the joining of the genetic material of sperm and egg (syngamy)
3. implantation of the fertilised egg into the wall of the uterus (which takes about seven days to complete)
4. the beginning of the laying down of the primitive streak at around 14 days, after which “twinning” is no longer possible (individualisation).
5. the beginnings of the development of the spinal cord and central nervous system
6. “quickenings”, when the mother is first aware of the movement of the fetus. (This may not have any biological significance as far as the fetus is concerned, though previously it had moral and legal implications for the mother. Of comparable impact on the parents is the first glimpse of the fetus during the prenatal scan.)
7. the stage at which the fetus is viable if taken from the uterus
8. birth, when the fetus naturally becomes biologically independent of the mother.

In stating these it is not intended to imply that all the events have equal significance, but all have been used as “markers” by various people wrestling with the question of when human life begins.

It may be argued that it is even possible to go back one step further and to ask about the status of the human gametes. In Biblical times the semen was thought to have significance and its wastage condemned (Genesis 38.9). (It must be remembered that at that time the semen alone was thought to be the source of life, the woman only providing the environment in which the life could develop.) Modern science has shown that both the egg, when extruded from the ovaries, and the sperm are genetically distinct from the body or somatic cells of the woman and man.

However, both egg and sperm are primarily instructions for the making of a human being, rather than constituting a human being him or herself. The same may be said of the pre-embryo; but with the appearance of the beginning of the primitive streak, about fourteen days after fertilisation, a change of major significance occurs. At that stage it becomes certain whether any unborn human or humans, and if so how many, are being formed. At that point it becomes possible to speak of a biological entity capable of carrying human consciousness, conscience and identity.

The current understanding of the biological fact that fertilisation and development are a continuous process forces the conclusion that it is not possible to define the

moment when a new human person begins. This was emphasised in the statement found in Expression of Dissent B of the Warnock Report: "Public concern about the public concern which led to the establishment of this Inquiry is often expressed in the form of the question "When does life begin?". This cannot be answered in a simple fashion. An ovum is a living cell as is a spermatozoon; both can be properly described as alive. The cluster of cells which is the embryo is likewise alive. But this is not what people are really asking. Their real question is: "When does the human person come into existence?". This cannot be answered in a simple fashion either. The beginning of a person is not a question of fact but of a decision made in the light of moral principles. The question must be defined still further. It therefore becomes "At what stage of development should the status of a person be accorded to an embryo of the human species?". Different people answer this question in different ways. Some say at fertilisation, others at implantation, yet others at a still later stage of development. Scientific observation and philosophical and theological reflection can illuminate the question but they cannot answer it." (p.90, *Report of the Committee of Inquiry into Human Fertilisation and Embryology*; London: HMSO 1984).

5.2.2 The significance of being human

There are many reported situations where people grieve over a natural miscarriage or induced abortion. There are also women who have developed a kind of "bonding" to their eggs fertilised *in vitro* and subsequently frozen. This awareness, experienced by parents, that there is "someone" to relate to even though the human is unborn, reinforces from an experiential viewpoint the Christian understanding of the value of the unborn human.

For any Christian group the theological understanding of the issues involved is crucial (see Chapter 4). When it comes to considering the value to God of the fertilised human egg, the fact that it is human must be of prime consideration. This is true whatever stage its development may have reached. The attempt to find a moment in the process of fertilisation and subsequent development after which the entity may rightly be considered human in the full sense of the word is to miss the point. Human material is involved throughout the whole process and for that reason, when dealing with ethical questions, human status must be afforded to it. This requires that the language of human relationship be applied to the discussion of the moral questions that arise. Thus, it is inappropriate to refer to even the earliest stages of human development as being a "blob of cells" and attaching to this description words like "mere", or "just" or "only" if it is thought that by so doing such structures are somehow shown to be non-human. A "blob of cells", when it results from the union of male and female human gametes is a human blob of cells and that makes a difference. A human world of caring and concern includes human blobs of cells in a way that, for example, it does not include the buds of a camellia or the larvae of the cabbage white butterfly.

It is important here to remember the nature and complexity of the relationships surrounding the unborn human, The fertilised egg does not exist in isolation. The parents contribute the gametes, but they are part of a wider family and of society. Also in situations where medical intervention occurs, there are the relationships with the doctors, the scientists and the other professional people involved in caring for

and supporting the parents. Christians emphasises that there also exist relationships with God, who is the Creator and Sustainer of all.

This complex network of relationships is not static. All are changing, not only in relationship to one another, but also because the egg changes when it is fertilised and as it develops. Human beings must take responsibility for the differing valuations they give to these relationships and the way in which these affect their decision-making.

Chapter 6

WHAT THIS DISTINCTION MAY MEAN FOR SOME REAL LIFE SITUATIONS

6.0 Introduction

From what has been stated about the theological significance of the human unborn, this report might be expected to come down absolutely against abortion and any form of destructive treatment of the fertilised human egg. However, for the reasons outlined in Chapter 5, the Working Party could not themselves support such an 'absolutist position'. Although the human unborn always does have significance, the value of the unborn and its right to life has to be weighed with respect to the legitimate needs and rights of other, when confronting real ethical dilemmas in which there are conflicts of interest. One significant consequence of such a conclusion is that it is not possible, in the view of the Working Party, to offer simple criteria about what is right or wrong. Human beings are given moral responsibility by God. It is dehumanising to seek to rob people of their responsibility, even if the motives for doing so may appear to be good. However, people do not live in isolation, and all need guidance and loving support in any decision making process. This is especially true when dealing with what are often agonising moral choices concerning the future of the unborn human. How, then, is this to be worked out in practice? Examples are now discussed, which it is hoped will give some guidelines.

6.1 Issues associated with abortion

6.1.1 Introduction

The Biblical principle 'Thou shalt not kill' is generally taken to be a guiding Christian ethic. However, even with adult human beings, there are circumstances where killing, although wrong, is seen to be the lesser of two evils. Because abortion involves the killing of an unborn human, most, if not all, Christians would argue that it is, in principle, wrong. However, unless a position is taken which states that abortion is wrong in every circumstance, without exception, difficult choices about the rightness or wrongness of a particular situation have to be worked out.

6.1.2 Abortion if the mother's physical health is threatened by continuing the pregnancy

If it can be clearly shown that to continue with the pregnancy is likely to cause the mother's death an abortion may in the circumstances be the right course of action. This is based on the assumption that the life of the adult woman is of greater significance than that of the unborn. Here judgement have to be made between the value of an adult person compared with the value of the unborn. Many thinking people would agree with this decision, even if they were against abortion in principle. This case, which is relatively straightforward, is mentioned first to illustrate the point that, where there are conflicts of interest, judgements have to be made.

6.1.3 Abortion for 'Social Reasons'

In a situation where the mother's life or physical health are not directly threatened by the pregnancy could an abortion ever be right? Before making a decision a number

of considerations need to be taken into account.

First, as many of the relevant facts as possible should be discovered. The views and welfare of the mother, the father, if known, and the wider family, as well as the interest of society at large, must all be borne in mind. The biological and psychological knowledge available should be discussed so that all areas fully aware as possible of the likely consequences of whatever decision is eventually taken. (The possibility of adoption of an unwanted baby is discussed in the Methodist Report on *The Family, the Single, and Marriage*.)

An unexpected pregnancy may highlight the existing social and environmental problems faced by parent(s) and existing children. The temptation to see the pregnancy as the problem and consequently not seek solutions to socially based worries which, if resolved, would make it possible for the pregnancy to proceed, must be resisted. It is important that all are aware of the fact the fetus is a genetically unique human entity which, if allowed to develop normally, will eventually grow into an adult. Thus the choice to abort will involve the death of a potential human person and this fact must be faced.

However, this does not mean that abortion for 'social reasons' is always 'wrong'. There are social circumstances where the death of the fetus is a lesser evil than the consequent suffering of those involved if it is allowed to be born. For example, a child conceived as a result of rape or incest may be utterly repugnant to the mother, thus making bonding impossible, or a child born with severe handicap may attract all the emotional energy of the mother, leaving siblings deprived, and if later institutional care is needed for the handicapped child, parents may experience great stress and sense of failure.

Secondly, it must be recognised that the decision has to be made – and within a time constraint – and that those making it have to accept responsibility for their action. God has given us moral responsibility from which we cannot escape. Being human means accepting this truth. No external authority can relieve us of this. The teaching of the Church and / or the Bible can and must guide and inform Christians, but these cannot take the decision from us.

Thirdly, it must always be remembered that, although God does give us moral responsibility, he does not leave us to carry the awesome burden alone. Even if a decision is made which is later seen to be wrong (or right but for the wrong motives), it is vital to remember that God still loves us and offers his forgiveness. It is so important to remember this truth, for often the knowledge available at the time when the decision must be made is just not adequate to assess what the consequences will be. Christians believe that it is still possible to cope by trusting that God is also involved, by the Spirit, in our decision-making and its consequences. God's love and forgiveness are always at work and ultimately nothing can separate us from this love in Christ. The Church must have an even greater responsibility to those who are not Christian and who do not share this hope.

Some may interpret these arguments as indicating that abortion on demand is being advocated. This is far from the case. The position taken by some feminists and others is that the woman has an absolute right over her own body and that the unborn human is just part of her own body is not supported by the biological

evidence. The fetus is human and is genetically distinct from the mother. The issues is,. Therefore, far too serious to allow the pregnant woman to report to a doctor and to request a termination with the certainty that this will be granted without question. This is especially true when the hormonal effects of pregnancy and the fear-reaction that an unwanted pregnancy brings can seriously distort a person's thinking. Some legal framework must therefore be provided to prevent this abuse of human responsibility.

6.1.4 Abortion if the fetus is abnormal

Section 2.4 outlines the various tests that can be offered to diagnose possible abnormalities. Most of them carry some risk to the unborn human. Therefore it must be decided whether the test is justifies, as there is some danger that a normal fetus could be aborted. Adequate counselling should always be provided. The decision to perform a particular test will depend on the severity of the possible deformity, the mother's (and father's and others involved) attitude to having a deformed baby and the risk involved in the test. There are clearly great advantages in obtaining accurate information as to the state of the fetus as soon as possible since if an abortion is decided upon this is best performed as early as practical. If an abortion is not hosen the parents and others can then begin to prepare, psychologically and practically, for caring for the handicapped baby in the most effective way.

The dilemma whether or not to abort an 'abnormal' fetus focuses on what is considered to be 'normal' for a human being and what are considered to be unacceptably high levels of suffering or handicap. Christians have insights which are helpful in making moral judgements in this difficult area.

First, all that is human is of special value to God. Thus, to claim that even severely abnormal babies such as Anencephalics are not really human beings, as Professor John Mahoney, S.J. does, is, in the Working Party's opinion, not helpful. (He argues on this basis that taking their organs for transplant is permissible (Institute of Medical Ethics Bulletin 45, p. 11). It may be that taking organs from anencephalic babies is justified in certain circumstances. What is being pointed out here is that the anencephalic baby is human and any decision about it must take that into consideration.)

Secondly, there are the issues of the 'quality of life' not just of the family into which the baby will be born but also for the baby him- or herself. The whole notion of 'quality of life' is a complex one. Many of the couples who find themselves in the situation of knowing that the mother is carrying an abnormal fetus will already have a child who has or is suffering from the disease. Consequently they will be well aware of the pressures created and also will have known sufferers as real humans able to relate, love and be loved. They will also know that 'quality of life' is not something that is on a constant level. Suffering for the individual and stress for the family will be far worse at some times than others. Prospective parents with little knowledge of what bringing up a diseased or handicapped child could mean will need to be provided with as much information as possible before they can be expected to make a decision.

Another issues that may well become more common in the future is the problem when a mother is carrying the human immunodeficiency virus (i.e. is HIV positive) or

has the symptoms of AIDS. It is known that the virus can be transferred to the fetus. In addition to the problem of the quality of life for the mother and baby (including the attitude of society to them) there is the risk of spreading the infection further.

Although in normal circumstances human life is to be valued in its own right, there are, in the Working Party's judgement, occasions when it is acceptable to abort the unborn human in order to minimise suffering if this is what the parents, having been fully informed and supported, feel is right. It is not easy to give hard and fast rules as to when this is the case, but an example might be the particularly distressing disease, haemoglobin Bart's hydrops syndrome. (This is a genetically inherited disease affecting the haemoglobin of the blood and is a common cause of stillbirth in South East Asia. There is no known cure and the defect is always fatal.)

Those parents who do choose not to opt for an abortion and who decide to care for a handicapped child should be given as much love and support as possible. This is not always easy in practice. Society does not care as it should and may be critical of such parents. Also there is the additional problem of confidentiality, which may mean that those who are aware of the situation are very limited in number. Parents seeking to care for a handicapped child should not be made to feel guilty about bringing such a child into the world.

As science advances, it is likely that new diagnostic tests will emerge. As well as providing information of possible deformity or disease, these could be used to select certain characteristics desired by the parents. For example, hair colour, eye colour and perhaps, in the future, even features such as intelligence, athletic or artistic ability.

Already some selection is being made on the basis of the sex of the fetus. It is known that in some cultures, where a male child is greatly to be preferred, female fetuses are being aborted. This is to be condemned from a Christian perspective, which believes in the equal value to God of women and men. The consequences of 'selection of sex' are enormous. The longer term effects on the mother and others involved are not known. The balance of the sexes could be seriously upset, affecting future marriages and reproduction. There could be profound psychological effects on women in general, who are going to see themselves as of lesser value. Any society or group within a society that is prepared to kill potential individuals who are thought to be less desirable than others must be strongly resisted.

Christians must provide a clear expression of the value of all human beings before God so that a framework is established to allow those developing and offering pre-natal diagnosis to think through the moral implications of the use to which the new knowledge gained may be put.

6.1.5 Post-coital intervention

Some mention of the forms of contraception which are believed to prevent the implantation of a fertilised egg (see Chapter 2), is appropriate, as these may be considered by some to be a form of abortion. Couples who choose to use these methods should at least be made aware of the likely way in which they work. This may seem to be obvious, but there are intelligent women who use the coil who had never been told how it is believed to function.

There is, of course, a significant difference between these methods and abortion in the usual sense of the term. In the latter situation the fertilised egg has implanted and the woman is making a conscious choice to terminate a known pregnancy. In the former cases there is no knowledge whether fertilisation has occurred or not. Also, it must be remembered that a high percentage of fertilised eggs are believed to be wasted, for unknown reasons, without any mechanical or hormonal interference. (See Chapter 2.2.2)

The development of new drugs which are capable of inducing an abortion without the recourse to surgery, such as RU486, make a legal framework even more important. Otherwise a situation could conceivably occur in which the abortion-inducing drugs could be bought across the counter by a pregnant woman without any reference to medical or counselling help. The drug itself can cause physical side effects. Equally, if not more importantly, there are the psychological effects upon the woman of realising that she is pregnant and the stress of facing the situation that causes her to seek an abortion. However, the legal framework must be such that human responsibility is enhanced and not removed. It must also be sufficiently understanding of the woman's needs to prevent the recurrence of the trade in 'back street' abortions with all its evil aftermath.

6.2 Issues associated with infertility

6.2.1 I.V.F. for married couples

The Working Party could see nothing intrinsically immoral in the fertilisation of a woman's egg by her husband's sperm in an artificial environment and then transferring the egg to the wife's uterus, where, hopefully, it will develop into a normal baby. Infertility does cause great stress and difficulty for many couples (see Chapter 2.2.2), and to help them to have a child of their own who will be greatly loved and bring joy to many seems an appropriate Christian response. However, there are a number of moral and pastoral issues even in this straightforward situation, which need to be fully explored by all concerned.

Wagner and St Clair (*Lancet*, 1989, ii: 1027-1030) claim to have evidence of risks to the woman of IVF treatment and embryo transfer. The Working Party is not in a position to assess the seriousness of these claims but it is important that all reliable evidence is presented to the couple before a decision to undergo IVF treatment is taken.

There is also the question of the resources deployed to provide the IVF service in a world where there is already the threat of over-population and where so many babies die through the lack of proper nourishment and medical care. Of course, these problems are far greater and more complex than a direct choice between feeding the hungry and performing IVF. There are certainly many far less worthy forms of human enterprise than IVF, such as military expenditure and greedy materialism! It is, nonetheless, a fact that IVF is more often conducted through private clinics and the cost to the couple for IVF or GIFT at a well known clinic in November 1989 is £1660, plus the cost of drugs for ovarian stimulation. It could be questioned whether such help should be more easily available to those infertile couples who can pay for it. IVF

is now offered through some NHS clinics and here the question could be whether it is right for society to fund such a procedure.

There is also the question of the publicity surrounding IVF falsely raising the hopes of infertile couples. IVF is only suitable for some couples, and even for them the chance of having a child after one course of treatment is only about 15%. (See Appendix III.) The psychological pressures of knowing that the procedure is available and may be the couple's last chance of having a baby could cause considerable stress. Counselling may not always be sought, or available. No one knows whether there will be any long term deleterious effects of the raising of hopes and continual disappointment if IVF fails. Conversely, if the couple do not pursue the lengthy investigations and procedures involved in IVF, etc., and remain childless, no one knows what will be the result in later life of regretting not having tried all the possible options.

6.2.2 Fetal reduction

Where a multiple pregnancy occurs, there is a greater risk to the development of all the fetuses and to the mother's health. One possible solution is to kill one or more of the fetuses whilst in the womb in order to give those remaining a greater chance of developing normally. (See Chapter 2.3.5)

In the judgement of the Working Party, fetal reduction should be undertaken only very reluctantly, and then only if the presence of multiple fetuses is felt seriously to threaten the life of the mother or the possibility of the fetuses surviving. This is because fetal reduction deals with unborn humans who have evidently passed beyond the stage of individualisation. The Working Party would support measures to prevent multiple pregnancies, such as the present voluntary ban on inserting large numbers of fertilised eggs into the uterus.

Where fetal reduction has to be practiced those involved should be given adequate counselling. There is evidence that grief and guilt reactions frequently follow the procedure. No one yet knows the long term psychological effects on the parents or the surviving children where fetal reduction has been practised, and the families out to be followed up and help given if necessary.

6.3 Questions concerning the production of 'spare' fertilised eggs

Various problems arise from the fact that in most IVF procedures more eggs are fertilised than can be safely introduced into the womb. What is to happen to the 'spare' pre-embryos?

There are at present three possibilities:

1. Disposal
2. Frozen storage for possible future use
3. Immediate use for research and experiment

What is thought to be right will depend on what status the pre-embryo is believed to have. Some see no difficulty in disposing of any surplus, since at this time there is no primitive streak and therefore no embryo (see Chapter 2.1.1). There is also the added consideration that, if the pre-embryo is to be highly valued, how is this to be reconciled with the apparently great 'natural' wastage? (See Chapter 2.2.2.)

On the other hand, there is much anecdotal evidence that parents may think of the pre-embryo as 'their baby'. This is the case although they presumably know that it is 'just a few cells' and are aware that, even if placed in a womb, it will not necessarily grow to become a baby.

The storage of frozen pre-embryos gives rise to further dilemmas. Will the couple (or woman) experience remorse or guilt if they have to order the destruction of their pre-embryos or, if they donate them to another couple or for research, will they later come to regret it? If the frozen pre-embryos are kept for possible implantation in the woman who produced the ova, will the couple feel 'patients' in as much as a genetic part of them is in the hands of the infertility clinic? This may add to the couple's feelings of vulnerability or dependency, or may make them go on with further attempts at having a child when it might be better to give up and seek other options.

There are also problems about what to do with the stored pre-embryos if one of the partners dies or if the marriage fails. Such a situation has already arisen in the USA, where custody of the frozen embryos was contested in the Divorce Courts. (See *Bulletin of Medical Ethics* 1989, No. 53:9.) Such problems were predicted in the Warnock Report, but the legal difficulties are generally avoided by using precise consent forms. The mental and emotional stress, however, should be recognised and support given. Such complications reinforce the need to counsel couples before they embark on any IVF programme. Agreement on the future of frozen pre-embryos should always be decided with the medical staff. Even when this is done adequately, however, it is not easy to predict how the couple's feelings will change in years to come, especially if there is bereavement or marriage breakdown.

The morality of using donor material to help an infertile couple is more complex because of the possible difficulties of the relationships of all those involved. Little research has been done in this area, apart from some very careful studies by R. and E. Snowden on families where children are born as a result of artificial insemination by donor. No difference can be discerned, in principle, between donating eggs or embryos and donating sperm. In all cases thorough counselling should be provided beforehand and be available in later years, as the way the donation is regarded may change with hindsight. The welfare of the unborn human should be the paramount consideration in all possible cases of gamete or pre-embryo donation.

6.3 Research on human embryos and fetuses

6.3.1 Production of human embryos for research purposes

Any attempt to legalise the creation, for research purposes, of pre-embryos or fetuses, either by *in vitro* fertilisation or by natural reproduction, should be strongly opposed. The products of human conception always have human significance, and deliberately to create unborn humans as a means to an end, however worthy, is

contrary, in the Working Party's view, to the Christian ethic of respect for that which is human.

6.3.2 Experiments on 'spare' pre-embryos resulting from IVF programmes

Those wishing to prevent research on pre-embryos produced in the course of the IVF programme argue against it on one of two grounds. Either they have an absolutist view that the pre-embryo is a human being; alternatively, a slippery slope argument is used. "If experimentation on the pre-embryo is allowed, then before long the medical scientists will be experimenting on babies." Those arguing in this way fear the consequences for those involved and society at large.

There is, on the other hand, an ethical case for permitting experiments on 'surplus' pre-embryos on the ground that in this situation there is no conflict between the right to life of the individual and the good of the community. On this view the good of the community stands alone for two reasons:

- a. the surplus pre-embryo has no prospect of any life beyond that which it already has. This otherwise wasted life is given purpose if used for experiments which might benefit humanity.
- b. the pre-embryo is not an individual since 'individualisation' does not occur until the end of the pre-embryonic period, i.e. after 14 days. Therefore it cannot be known whether, if the conditions were favourable, the pre-embryo would develop into one, two or more individuals or none.

It must, however, be remembered that the 'surplus' pre-embryo is still part of the human community. It is clearly human material which has human parents and may have the capacity, at least in some circumstances, to become an individual. If experimentation is to be allowed, the pre-embryo should be respected accordingly. Any research work should be properly authorised and controlled by an Ethics Committee, and only be permitted if there are likely to be real benefits to the human community from the knowledge gained. It should not be permissible to produce pre-embryos which contain living material from both humans and other species (chimeras and hybrids), nor to clone pre-embryo cells to produce genetically identical individuals (although it may be acceptable to culture one cell of a pre-embryo for diagnostic purposes while the rest is frozen), nor (in the present state of knowledge) to modify a pre-embryo's genetic constitution.

In any possible experimentation on the human pre-embryo the parents must give full and informed consent. The pre-embryo should not be kept alive long enough for there to be any suggestion that individualisation could have occurred and should be disposed of reverently.

The development of IVF has placed those responsible for decisions concerning the fate of pre-embryos in uncharted psychological waters. This is as true for the scientists handling them as for the parents whose gametes created them. Pre-embryos have significance as part of the human family and this fact should always be borne in mind when decisions are made as to their creation or disposal. Where

possible the techniques of IVF should be refined so that excess fertilised eggs are not produced.

6.3.3 The use of human fetuses and fetal material in research and treatment

Provided that a fetus has not been conceived with the intention of using it for donation or research, and has been either naturally aborted or an abortion carried out for good medical reasons, there can be no moral objection to its use to benefit others, e.g. by transplantation and related research (see Chapter 2.5). In principle, there is no difference between the use of aborted fetal material for research or transplantation and the use of tissue from a person recently deceased.

However, the conditions laid down by the Polkinghorne Committee (see Chapter 2.5 and 2.6.1) must be met. In particular:

- a. The informed consent of the mother (and others with a direct involvement) is essential, and seeking this will need sensitivity.
- b. Those involved in the research or transplantation should be separate from the team caring for the mother.
- c. The needs of the mother must come first – e.g. any abortion must not be delayed for the sake of research, and should be carried out by whatever methods are in the mother's best interest even if these result in the aborted fetus being unusable.

6.3.4 Other issues

Moral issues raised by surrogacy, sperm or fertilised egg donation to single or lesbian women to allow them to become mothers, are outside the range of this Report. However, it must be stressed in the light of the value that this Report gives to the unborn human that its welfare must be given due consideration. The perceived need of the potential parent(s) cannot be accepted as the supreme determinant.

6.4 Conclusion

It is clear from the above discussion of some of the real cases confronting people today that the acceptance of the unborn as human has wide-ranging implications. These are not only for the prospective parents and those involved in medical practice and in scientific research, but also for society, especially in its educational and legislative roles. Particularly relevant for the readers of this Report are the implications for the life of the church as it seeks to support and offer guidance and to interpret the will of God in the light of the person and teaching of Christ.

Chapter 7

IMPLICATIONS FOR PASTORAL CARE AND PUBLIC POLICY

7.1 The Church

The Church may be involved in the issue of the status of the unborn human through its members, or official publications, or through seeking to offer Christian love, counselling and / or guidance to those having to make the sometimes agonising moral decisions about the treatment of the unborn human. The Church's approach to the issues under discussion must be based on a theological understanding of the status of the unborn human.

The church must also:

- a. accept that knowledge and skill are God-given and therefore not to be set aside or ignored. It is not possible to return to 'the state of innocence' before the knowledge was gained.
- b. take seriously the biological facts as far as they can be known, the full range of medical and technical options, and all the human emotions and relationships involved.
- c. encourage all those involved – including parents, would-be parents, other family members, friends, health care workers, scientists and politicians – to recognise that their humanity requires them to face up to moral decision-making for themselves. People must be equipped to address for themselves the ethical issues and to deal with the moral dilemmas these raise.

We have to accept our responsibility for the judgements we are making and must also call on other groups with influence in these areas to take these theological considerations into account.

All this has implications for the Church both nationally and locally.

7.1.1 The Church in the nation

Nationally the Church has to take responsibility for:

- i. Raising the awareness of its congregations of the issues involved in and resulting from the theological significance of the unborn human and keeping those congregations informed about developments at governmental and medical levels. Within the Methodist Church this could perhaps be achieved through the regular bulletins provided by the D.S.R. and the possible use of other media, e.g. videos for small discussion groups. Provision of suitable study material may only be practical on an ecumenical level.
- ii. Making training available for clergy, pastoral assistants and counsellors so that they can enable those who have the responsibilities of making

decisions about the fate of individual unborn humans to explore all the implications. Associated with this would be the setting up of more chaplaincies in infertility clinics. Also there is a need to provide a list of those experiences in this field who could be called upon to help with training and discussion.

- iii. Engaging in public debate with a view to bringing theological considerations to bear on government decision-making; and collaborating with other groups with which the Church shares concerns.
- iv. Providing support and opportunities for mutual consultation for those lay members of its congregations involved professionally in these areas and encouraging the involvement on local ethical committees of those with a theological education.
- v. Informing local church pastoral committees and / or other counselling groups about how to contact those specialists available to give advice in difficult cases, and of the existence of national support groups.
- vi. Pressing for research into the social, psychological, and spiritual effects on parents and family members of procedures involving unborn humans.

7.1.2 The local church

The image of the Church as an extended family is a positive one. Where a local church is seen to operate in this way it can have a profound impact upon a community. As a family, the local church should:

- i. Create an accepting and welcoming environment into which all can come – parents under pressure; the childless or infertile couple; the single parent, etc. – perhaps for discussion and guidance, perhaps simply for friendship and support.
- ii. Provide practical help for those who decide to have the child that has been conceived, but are already under emotional or financial pressure; and for those who decide to keep and care for a handicapped child.
- iii. Provide support and counselling for those who decide to have an abortion. It needs to be understood that bereavement counselling in this situation may be necessary many years after the event.

Particular local responses may take a variety of forms, depending on resources and awareness of needs, but could consist of:

- i. Voluntary home-help and baby-sitting schemes;
- ii. Opening and staffing the church as a family centre;
- iii. Families within the congregation taking in a handicapped child to allow the parents to have a break;

iv. Developing a group for the childless.

The offering of the type of care outlined above can be seen as an integral part of the mission of the church to portray a loving, enabling God for whom not only the unborn human but also the family and community within which that child is to be born are of great value.

7.1.3 Language concerning status

Christians have a duty to seek to develop a language which encourages the exercise of responsible choice in the light of the knowledge available. In principle the prophetic and gospel injunctions to act justly and mercifully, and to love our neighbours as ourselves constitute a basis for this process of decision-making. The philosopher Gillon in *Philosophical Medical Ethics* (see Chapter 3.1) formulates autonomy, doing good and not doing evil, and being just, as a set of principles which might unite a broad spectrum of opinion in this area. These offer the possibility of agreement across a broad spectrum of opinion. The Christian will recognise their origin. In applying them when dealing with specific issues in the context of the relationships involved, such as those between the pre-embryo, the mother, the scientists wishing to experiment, and those involved in abortion decisions, the values revealed by Christ concerning the true nature of human relationships will be paramount.

The language concerning the status of the unborn human must involve its relationships with those around it, including its relationship with God. Because these relationships cannot be discerned with total certainty and are constantly changing, as is the developing fetus itself, the language must inevitably lack absolute precision. This may cause uncertainty, giving those involved in the decision making process a sense of unease. Perhaps it would be less traumatic if it were not so, but this seems to be the honest position.

7.2 Counselling

The Working Party believe that those intimately involved with situations such as an unwanted pregnancy, or apparent infertility or the possible diagnosis of a handicapped child, need appropriate long-term counselling both before and after taking the discussions involved. Counselling is necessary because of the general ignorance of the options available and of the implications of pursuing them. Such counselling is seen as valuable not only for the parent(s), but also for the supporting family and friends and for those involved in the medical profession.

This counselling may be provided, either by the church, the community or the state. Christians have a particular responsibility to provide counselling in the light of their faith and understanding as God-given. Once they themselves have accepted their responsibility for the welfare of the unborn human and his or her family within our society, then they need also to encourage others to do the same and so to press for the establishing of appropriate counselling and support structures. Ideally, supportive counselling should be available for all facing decisions concerning the unborn human.

The counsellor in these situations needs to be someone with expertise and time to help those involved become aware of the alternatives before them and the implications that taking various decisions would have, not only for the unborn human and the family, but also for the wider community. Because of the fallenness of humanity there is no possibility of making a perfect moral decision. The situation in which many have to decide often generates a self- or family- centred viewpoint. Thus, drawing attention to the vulnerability of the unborn human and its significance for God, may enable those counselled to resist the temptation to subject the unborn human to their own selfish motives.

However it must be stressed that the counsellor is not there to make decisions on behalf of those counselled but rather to enable them to explore in depth for themselves what are difficult and important issues. In law it is recognised that ultimately decision must lie with the parents to whom the original biological material belonged. There is also the responsibility before God, though scientists, doctors and counsellors cannot be absolved from the responsibility for their actions or failure to enable parent(s) to explore the issues fully. Non-specialists also have an important role to play in offering friendship and so making possible informal conversations within which parents are enabled to share their inner fears and confusions.

7.2.1 Abortion counselling

Often decisions concerning abortions have to be made under pressure of circumstance such as those of a mother who is a teenager under great emotional stress and who has no husband to support her financially, or one who is already suffering from depression, or unable to cope with existing family, or whose husband refuses to discuss the possibility of another child being born. Ideally, the counsellor would attempt to alleviate the pressure and so allow a breathing / thinking space, but this is often not possible.

Issues to be taken into consideration include the real existence of the unborn human, the health of the mother, the welfare of other siblings, and the support available in family and community.

No amount of counselling can remove the sense of guilt of a woman who feels that a termination is wrong yet for good reasons cannot go ahead with her pregnancy. However, skilled help can minimise the psychological trauma of such a decision. In other situations too, the decision, whatever it is, will often be followed by a sense of guilt, or self-recrimination on account of not having decided to do the opposite. In this situation the Christian counsellor can point both to the inevitability of this happening, and to the existence of a loving God who has already dealt with the fallenness of humanity in Jesus Christ, and who offers forgiveness which involves a blotting out of the past and looking towards the future.

However, for some women and men there will continue to be a deep sense of pain at having terminated life no matter how strong were the justifications for doing so. For them it is a real experience of bereavement heightened by a sense of guilt and bitterness towards the people and circumstances that made the decision necessary. The sense of guilt also makes the feelings more difficult to share with others. Here there is a need for continuing family, church and community support which is only

possible as the wider community is encouraged to explore the issues and implications involved.

7.2.2 Antenatal screening

Counselling needs to be available for all pregnant mothers, as serum AFP screening (a blood test at 16 weeks used in the detection of neural tube defects – in particular spina bifida) is now done routinely in many areas of the country. No mother should have this or any other of the growing number of tests for fetal handicap without understanding why and without giving consent. She should be entirely free to refuse an initial test and further testing, and it should be understood that a positive test engenders extreme anxiety in the parents. It is essential that there are good communications, rapid retesting, further tests available, if necessary, and sympathetic counselling at every stage.

Some parents will know about the possible condition which is being looked for and are likely to have appropriate support from friends and relatives. It is much more difficult if parents have no knowledge at all about the possibility and nature of handicaps when such an abnormality is picked up on a screening test, for then the parents have to be given a lot of information and must make rapid decisions. This situation often leaves them feeling bewildered and confused. If their decision leads to a late abortion, the crisis reaction is comparable to that experienced after a perinatal death. Counselling and support at such a time are vital.

Other parents may decide against aborting a fetus in whom an abnormality has been diagnosed. How will this affect their relationship with it? Will they regard every difficulty in the child as due to the defect for which they rejected an abortion? Should they be told the sex of the fetus, which might influence their decision about abortion? Parents in whom the tests prove negative may well feel that a perfect baby is ensured, all worries are over. But, on the other hand, many conditions cannot be diagnosed so for a few this sense of security will be misplaced. For all these reasons, Medical Practitioners need to be skilled in how they pass on test results and be aware of the effect their information may have on the parents and family. Nor is there any place for the anxiety provoked by “if you do not hear anything you will know the results are all right”.

The importance of screening-related counselling services and the effects of screening on the family has been neglected compared with the development of the technology of screening.

Long-term counselling and support are needed for the parents who decide against aborting an abnormal fetus, and for those who on moral grounds decide not to have the test and so produce a child with a handicap which could have been diagnosed antenatally. It is a continuing struggle to ensure that adequate services are available for the handicapped and their families. Is society going to place less priority to these services as a result of the tests being available? Is social pressure going to make the parents who have a handicapped child feel guilty? Such questions must be faced and answered in our society.

7.2.3 Infertility

When a couple discover that they are unable to produce a child, often after many years of trying and waiting and accumulated disappointments, the offer of treatment brings with it tremendous hope and a tendency to overlook the adverse implications of such treatment. The task of the counsellor is to draw attention to these issues, recognising that from the start he / she is caring for a couple already deeply hurt by their failure to be, in their own eyes, a “normal” couple.

The success rate in this field is relatively low and perhaps the greatest task of counsellors and friends is helping the couple cope with the building up of their hopes and then the crushing disappointment which may come. Adoption as an alternative may need to be explored. Sadly, the tendency to crave what we cannot have aggravates the situation for some parents.

7.3 Education

Much that has been referred to in earlier sections of this chapter will involve education, both formally and informally within the church, by the church in the community, and within the home. But it is crucial that a more complete range of the processes of education should be taken into account.

7.3.1 The National Curriculum

First, no child should leave school without a knowledge of biology, sufficient to enable him or her to take responsibility for the body's health. In this context it will be appropriate that the facts of human reproduction are learnt. In this respect it is good to note that the National Curriculum will make it necessary for all children to be taught the sciences until the age of 16. We should therefore be able to avoid, for example, that while girls might continue with Biology, boys might reasonably give it up or even never start it at all. Even at this stage we believe it is necessary to learn about the stages of the unborn human's development and such matters as the possibility of infertility.

An education programme for schools, however, will be incomplete in this area or even counter-productive if it does not take account of moral values, the role of human relationships and the family. The very fact that there are no indubitable moral imperatives easily applicable and objectively enforceable makes this all the more important. Christians have much to say in this context and we should do so with boldness but humility. One of the ways in which we fulfil our responsibility for our children is by the way we understand and interpret to them the experience of human relationships.

As is apparent earlier in this document, technical developments, whether in the area of birth control or with reference to ways in which we can cope with infertility or procure abortions, make it crucial that these issues are sensitively brought into discussion so that a language is developed in which discrimination and judgement may be made. Courses of this kind will be difficult to create, involving as they do cross-curricular themes, careful planning and delivery. Also to be taken into account is the impact made by the attitude, environment and cultural climate in which these

matters are discussed. It is quite clear, therefore, that responsibility cannot be left to schools, though schools do need and will benefit from the critical support of the Christian community in what they do. Sunday Schools, Youth and Fellowship groups each provide opportunities for the exploration of these issues.

7.3.2 The media

Secondly, the media are frequently criticised and blamed for the way in which they diminish the human and trivialise serious matters. There is, no doubt, some truth in that, and proposed changes in broadcasting in the United Kingdom do not give us confidence that standards will be maintained, let alone improved. However, this should not lead us to ignore the opportunity which is provided by the development of the media. The technology offers us huge opportunity. This ranges from the production of a particular programme which will inform of scientific advances or technical developments and thus keep our understanding of the paradoxes and complexities sharp and relevant, to discussion tapes for groups in which individuals who have had to make difficult choices discuss their reasons and share their experience. We have hardly begun to exploit the opportunities here.

7.3.3 Education and professional bodies

Thirdly, the United Kingdom has done far too little to encourage interaction between professional bodies. Teachers are too frequently isolated within their classroom, yet many of the difficulties which they experience they share with social and health service workers. Changes in the local financial management of schools have made the problems of head teachers and governors more like those faced by, for example, hospital managers and health authorities. This should encourage these groups to come together in fruitful discussion of our responsibilities as a community. In this way they would keep one another informed of developments and also enhance their capacity to understand and take decisions.

The church could take the initiative here to stimulate conferences and to produce materials. In order to do so effectively the church would need to develop or adapt or hire appropriate accommodation. The German Evangelical Academies provide just such neutral grounds for inter-action between professional bodies. That pattern is not implementable in the United Kingdom. We need to find our own way of doing it.

7.3.4 Parent-teacher relationships

Fourthly, in this area of education, as perhaps in no other, the relationship of teachers and parents is crucial. Parents need to know what is being taught at school. Teachers need to have worked with parents to know how best to interpret and develop and understanding of the material. Both parents and teachers need to have that easy relationship which gives pupils confidence.

7.3.5 Education for parenthood

Fifthly, education for parenthood is widely discussed. It would be right to see courses more widely available in schools. However, education for parenthood, education in relationships, the discussion of the moral and personal issues which arise from developments in our understanding of genetics and in medical practice,

should by no means be confined to school and formal education. A much wider provision of appropriate seminars, discussions, courses and conferences needs to be made available through adult and continuing education.

7.3.6 Ethical education in medicine and medical sciences

Finally, there is the area of professional education. Doctors, nurses, biologists and all those involved in medical care and research need to be given more help during their training and subsequently to develop and maintain an ethical perspective in relation to all their work, including that which involved unborn humans. Within the medical profession it is internationally accepted as an ethical principle that all medical practitioners should practice “with compassion and respect for human dignity” and “maintain the utmost respect for human life from its beginning” (International Code of Medical Ethics and Declaration, Geneva, World Medical Association, 1983); and in the United Kingdom the General Medical Council’s Recommendations on Basic Medical Education (1980) affirm that “instruction should be given in the principles of medical ethics”, especially by “day-to-day teaching...in the clinical context” which “gives the student an opportunity to discuss the issues involved in normal clinical practice. His attention should also be directed to the ethical responsibilities of the medical profession in clinical investigation and research, and in the development of new therapeutic procedures.”

It is always possible for medical teachers and students to act as if each patient is no more than a machine, malfunctioning because of a fault in one component or another which the doctor has to identify and if possible repair; and one who views adult patients like this can be expected to take at least as low a view of unborn humans. All those involved in both undergraduate and postgraduate medical education must therefore be repeatedly reminded that the knowledge, attitudes and skills which this education most needs to impart, include not only a knowledge of medical science and the skill to apply this knowledge, but also the attitude of respect for all that is human, and the skill to counsel patients sensitively and non-directively on all health problems including those addressed in this report.

The same attitude of respect needs to be imported when training other scientists and technicians for work on human material; and the development of this attitude and of the counselling skills discussed earlier in this chapter should figure also in the education and training of nurses, other health staff, and social and pastoral workers (including ministers of religion).

Though many have a somehow lost confidence in the role of education, its importance can hardly be over-emphasised. A Methodist Church with its universal commitment to education could substantially contribute to its rediscovery.

7.4 Conclusion

Consideration of the status of the unborn human has led us to issues other than the biological and medical. There are social dimensions relating to the raising of awareness, education and support (personal and financial) in which the Church nationally and locally has opportunities and responsibilities. There are moral responsibilities in these areas no less imperative than our responsibilities to the unborn.

SUMMARY

This report originated in the developments in medical science and medical technology. It has been presented as a Methodist contribution to the search for understanding of the status of the unborn human, rather than as a definitive statement of Methodist beliefs. It has attempted to move away from established positions and to look afresh at the relevant material.

In this endeavour, chapters have been included covering present scientific and medical knowledge, the main moral theories and theological considerations relevant to the discussion, and contemporary understandings of the status of the unborn human.

There are several key elements of reasoning of this report:

- i) the significance of our understanding of God making humans in his own image and revealing himself in the human Jesus, the Christ;
- ii) the recognition that real choices have to be made by people concerned with the unborn human, choices that cannot be avoided by resort to external authority;
- iii) the love and forgiveness of God in Christ which gives us hope even if we make mistakes or do wrong;
- iv) recognition of the principle of love as the highest of all principles in guiding all our decision-making and our rules of behaviour, for God is love (1 John 4.8).

All these must be brought to bear on our understanding and decision-making with regard to the unborn human.

In the light of these reflections, some of the practical outworkings, given the present knowledge, in the worlds of medicine, the Church, education and the law, have been reviewed.

From the evidence presented it is clear that the unborn human is part of the whole human community. The unborn human is never without significance in its own right, and decisions regarding it are therefore never trivial, but must be made with respect for its human nature and awareness of dimensions which not only affect an individual or a single family but also affect society at large. Decisions made in this area, therefore, are not the responsibility of the mother alone, or even of the mother and father. Society, and especially the Church, must face their responsibility for enabling the consequences of these decisions to be lived with.

APPENDICES

APPENDIX I - The Law of England relating to Abortion

Centuries ago, without the intervention of Parliament, the Courts found in what they believed to be ancient custom of a prohibition against attempting to procure miscarriage. But the offence could be committed only after the child had “quickened in the womb”. An attempt to procure an abortion before this stage had been reached was not an offence.

It seems to follow that the rule was based on the assumption that, after quickening, the fetus was a living being, but not prior to that time. A statute in 1803 made it an offence to administer poison to a woman with intent to procure a miscarriage, but a distinction was drawn between a woman “quick with child” and any other woman. In the former case the death penalty was prescribed, while in the latter the punishment was transportation.

The Offence Against The Person Act of 1861 seems to have been regarded as a statute largely codifying the existing law. Sections 58 and 59, which deal with this subject, evoked no discussion in Parliament. Section 58 declares:

Every woman being with child who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other means whatsoever with the like intent, shall be...liable...to imprisonment for life.

Section 59 deals in substance with assisting an offence under Section 58.

The woman herself commits no offence unless she is in fact pregnant, while anyone else who seeks to procure a miscarriage is guilty of an offence whether the woman is pregnant or not. There was no obvious reason for the distinction, and the Courts held that a woman could be guilty of aiding and abetting another person even although she was not pregnant.

The offence is committed only if the act is done “unlawfully”. Clearly it was contemplated that it might be done lawfully, although there is no record of the Courts having considered exactly what was imported by the word until 1939.

In 1929 Parliament passed the Infant Life Preservation Act, which provides:

(1) Subject as hereinafter in this section provided, any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction...provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.

(2) For the purposes of this Act, evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be prima facie proof that she was at that time pregnant of a child capable of being born alive.

This provision applies only to a “child capable of being born alive”. These words have been construed to mean a child capable of surviving after separation from the mother although, as the section makes clear, it applies only where the child has not in fact been separated. (otherwise, the offence would be homicide.) At the time when it was passed, the Act seems to have been intended to protect children shortly before delivery.

In 1939 a Dr Bourne was prosecuted under the 1862 provision. The circumstances were such as to occasion the maximum sympathy for the doctor. The girl was aged 14 and was pregnant in consequence of rape. The parents consented to the operation and the doctor performed it without charge. The judge directed the jury that the word “unlawfully” in the 1861 provision “imports the same meaning expressed by the proviso in...the Infant Life Preservation Act 1929”. He went on to say that the words “for the purpose of preserving the life of the mother” should be construed in a reasonable sense to include cases where the mother’s life might well be endangered if the pregnancy were to continue.

Already, therefore, prior to 1967, the law recognised two essential distinctions. It distinguished in the 1929 Act (although not in the Act of 1861) according to the stage which the pregnancy had reached. And it recognised a test of what was and what was not an unlawful abortion, the test being that set out in the 1929 Act.

Such was the state of the law prior to 1967. The Abortion Act of that year provides:

- 1 – (i) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner, if two registered medical practitioners are of the opinion, formed in good faith –
 - (a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or the injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or
 - (b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.
- (ii) in determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) of section (1) of this section, account may be taken of the pregnant woman’s actual or reasonably foreseeable environment.

The Act contains a “conscience clause”, absolving anyone who has a conscientious objection from any obligation to participate in an abortion, unless to save the life of a pregnant woman or to prevent grave permanent injury to her.

The Act defines “the law relating to abortion” as sections 58 and 59 of the 1861 Act. It seems, therefore, that the intention was to provide an exclusive criterion of what was lawful within those sections, and nothing is now likely to be deemed lawful which does not fall within the tests prescribed in the 1967 Act.

The Act does not provide a defence to a prosecution under the Infant Life Preservation Act, so that, although it is not by its terms restricted to the earlier stages of pregnancy, it does not apply to the destruction of “a child capable of being born alive”.

Subsequent attempts to restrict the operation of the 1967 provision to a precise period from the inception of pregnancy have been unsuccessful, so that statutory guidance continues to consist of subsection (ii) of section (1) of the 1929 Act.

There are no restrictions in law on the use of a fetus for research purposes. The Warnock Committee recommended in 1984 that a statutory licensing authority should be established to regulate research on *in vitro* fertilisation. The authority would provide guidelines to which research must conform as a condition of being licensed. And the Committee recommended that it should be a criminal offence to undertake research without a licence.

The recommendation has not been implemented, but the Medical Research Council and the Royal College of Obstetricians and Gynaecologists have sponsored an Interim Licensing Authority. Its decisions are, of course, not supported by criminal sanctions.

APPENDIX II - The Methodist Statement 1976

INTRODUCTION

1. The question of abortion continues to exercise the thought, conscience and compassion of men and women. The area of the debate at this stage is limited to the period between conception and birth.

2. Abortion has at once moral, medical, legal, sociological, philosophical, demographic and psychological aspects. In addition, the Christian will seek to bring to the discussion insights and emphases which derive from his faith.

THEOLOGICAL ASPECTS

3. The Christian believes that man is a creature of God, made in the divine image, and that human life, though marred, has eternal as well as physical and material dimensions. All human life should therefore be revered. The fetus is undoubtedly part of the continuum of human existence, but the Christian will wish to study further the extent to which a fetus is a person. Man is made for relationships, being called to respond to God and to enter into a living relationship with him. Commanded to love their neighbours, Christians must reflect in human relationships their response to God's love. Although the fetus possesses a degree of

individual identity, it lacks independence and the ability to respond to relationships. All *persons* are always our 'neighbours'; other beings may call forth our loving care. In considering the matter of abortion, therefore, the Christian asks what persons, or beings who are properly to be treated wholly or in part as persons, are involved and how they will be affected by a decision to permit or forbid abortion.

4. It is of the essence of the Christian Gospel to stand by and care for those who are facing crises and to help them to make responsible decisions of doctors and nurses who find themselves unable to take decisions about their situation. It also respects the conscientious part in carrying out abortions.

5. In considering the question of abortion, Christians must never overlook the reality of human sin. This impairs judgement with the result that the abortion decision may be made in a context of selfishness, carelessness or exploitation. Human sin is also seen in attitudes and institutions which foster any debasing of human sexuality or are complacent to social injustice and deprivation. In facing these dimensions of failure and sin, Christians will work for an experience of spiritual renewal and a deeper understanding of the nature of human responsibility in the response made to abortion.

THE ISSUES INVOLVED

6. On one side of the abortion debate is the view which seeks to uphold the value and importance of all forms of human life by asserting that the fetus has an inviolable right to life and that there must be no external interference with the process which will lead to the birth of a living human being. The other side of the debate emphasises the interests of the mother. The fetus is totally dependent on her for at least the first twenty weeks of the pregnancy and, it is therefore argued, she has a total right to decide whether or not to continue the pregnancy. It is further argued that a child has the right to be born healthy and wanted.

7. Both views make points of real value. On the one hand, the significance of human life must not be diminished on the other hand, abortion is unique because of the total physical dependence of the fetus on the mother, to whose life, capacities or existing responsibilities the fetus may pose a threat of which she is acutely aware. It is necessary both to face this stark conflict of interests and to acknowledge that others are also involved – the father, the existing children of the family, the extended family and society generally.

8. From the time of fertilisation, the fetus is a separate organism, biologically identifiable as belonging to the human race and containing all the genetic information. It will naturally develop into a new living human individual. A few days after fertilisation, implantation (or nidation) has taken place; it is significant that in the period before nidation a very large number of fertilised ova perish. At some time after the third month, the 'quickening' occurs – an event which is of significant, perhaps crucial, moment for the mother. Not earlier than the 20th week, the fetus becomes viable, i.e. able to survive outside the womb if brought to birth.

9. There is never any moment from conception onwards when the fetus totally lacks human significance – a fact which may be overlooked in the pressure for abortion on demand. However the degree of this significance manifestly increases.

At the very least this suggests that no pregnancy should be terminated after the point when the aborted fetus would be viable. This stage has been reached by the 28th week and possibly by the 24th or even earlier. It would, in fact, be best to restrict all abortions to the first twenty weeks of pregnancy except where there is a direct physical threat to the life of the mother or when new information about serious abnormality in the fetus becomes available after the twentieth week. There is indeed also a strong argument on physical, psychological and practical grounds to carry out abortions in the first three months wherever possible.

10. Because every fetus has significance, the abortion decision must neither be taken lightly nor made under duress. It is for this reason, as well as in her own long term interests, that the mother should receive adequate counselling. This should enable her to understand what is involved in abortion, what are the alternatives to it and what are the considerations she should weigh before asking for termination. The skills of social workers and the particular technique of counselling, as well as the responsible medical judgement of doctor and consultant, must therefore be engaged. The provision of this service should be a duty laid by administrative regulations on those approving abortions whether in the NHS or the private abortion clinics. This is another reason why abortion on demand is to be rejected.

THE ABORTION ACT 1967

11. It is again to preserve the awareness of the significance of the fetus that the present form of the Abortion Act 1967 is of value. It retained the basic statement that abortion is unlawful, but indicated criteria which sufficiently altered the situation as to make abortion permissible. The intention behind the Act is therefore to be welcomed as it reflects a sensitivity to the value of human life and also enables serious personal and social factors to be considered.

12. These factors include, for example, the occasion when a pregnancy may pose a direct threat to the life or health of the mother. The probability of the birth of a severely abnormal child (where this may be predicted or diagnosed with an appreciable degree of accuracy) also provides a situation in which parents should be allowed to seek an abortion. It is right to consider the whole environment within which the mother is living or likely to live. This will include the children for whom she is already responsible and there will be occasions when she is unable to add to heavy responsibilities she is already carrying. Again, there are social conditions in our country which are offensive to the Christian conscience, particularly those connected with bad housing and family poverty. These conditions must be improved; meanwhile it is clear that abortion is often sought as a response to the prospect of bearing a child in these and similarly intolerable situations. In the particular circumstances indicated in this paragraph, abortion is often morally justifiable.

13. The Abortion Act is nevertheless imperfect and requires clarification and amendment either by legislation or administrative regulations. Abortions should be limited to the first twenty weeks of pregnancy save in the exceptional cases to which reference has been made. Counselling must be offered in all cases. The profit motive must be reduced. There must be further consideration of the clause which allows abortion when the risks of continuing the pregnancy are greater than the risks in terminating it. This clause can be interpreted to justify abortion on demand.

Unless the medical profession or suitable administrative regulations can ensure that this clause is not used alone to authorise abortion on demand, the difficult task of amending the Act at this point must be attempted. There is little doubt that the responsible interpretation of the Act and the proper provision of abortion is more likely to be secured if a high proportion of terminations are carried out in NHS hospitals and not in private abortion clinics. The Methodist Church urged this in 1966. It again emphasises its concern.

14. Abortion must not be regarded as an alternative to contraception, nor is it to be justified merely as a method of birth control. The termination of any form of human life can be regarded superficially and abortion should not be available on demand, but should remain subject to a legal framework, to responsible counselling and to medical judgement. The Church, with others, must help to provide more adequate counselling opportunities. Society must also be sensitive to the burden it places on medical personnel, and not least upon nurses, by permitting abortion very freely. It must fully respect the conscience of those in the medical profession who feel unable to carry out terminations; though, on their part, they have a responsibility to put women who approach them in touch with alternative sources of advice.

15. The problems raised by abortion can be finally resolved only by a new and sustained effort to understand the nature of human sexuality and to encourage expressions of sexual relationships which are joyous, sensitive and responsible, and which do not tend to exploit others. Christians believe that in conception and birth, parents are pro-creators with God of new human life. They also affirm in the whole of their sexual relationships that identity-in-mutuality which is inherent in marriage and which argues so strongly for the permanence of the marriage commitment. In an imperfect world, where both individuals and society will often fail, abortion may be seen as a necessary way of mitigating the results of these failures. It does not remove the urgent need to seek remedies for the causes of these failures.

APPENDIX III - Statistical Background

***In vitro* Fertilisation and Gamete Intra-Fallopian Transfer**

The fourth and most recent report on the Interim (formerly Voluntary) Licensing Authority for Human *In Vitro* Fertilisation and Embryology lists 40 clinical centres approved by the Authority in the United Kingdom. It also brings together results from 34 of these centres for 1987, when attempts were made at these 34 centres to carry out *in vitro* fertilisation in 7,488 women during 8,899 menstrual cycles. In 5,592 (63%) of these attempts, one or more ova were obtained, fertilised and transferred to the mother's uterus. The number of live births / 100 attempts varied from 15.5 in five of the six largest centres to 3.1 in the eight smallest. The percentages of attempts which had a successful outcome will have been lower than these figures, since the children born were not all from different attempts – some were twins and triplets.

The Licensing Authority also report that gamete intra-fallopian transfer was carried out on 2,658 occasions in 2,288 women in 1987 and that implantation and embryo formation occurred on 498 (18.7%) of these occasions. The number of live births was not given.

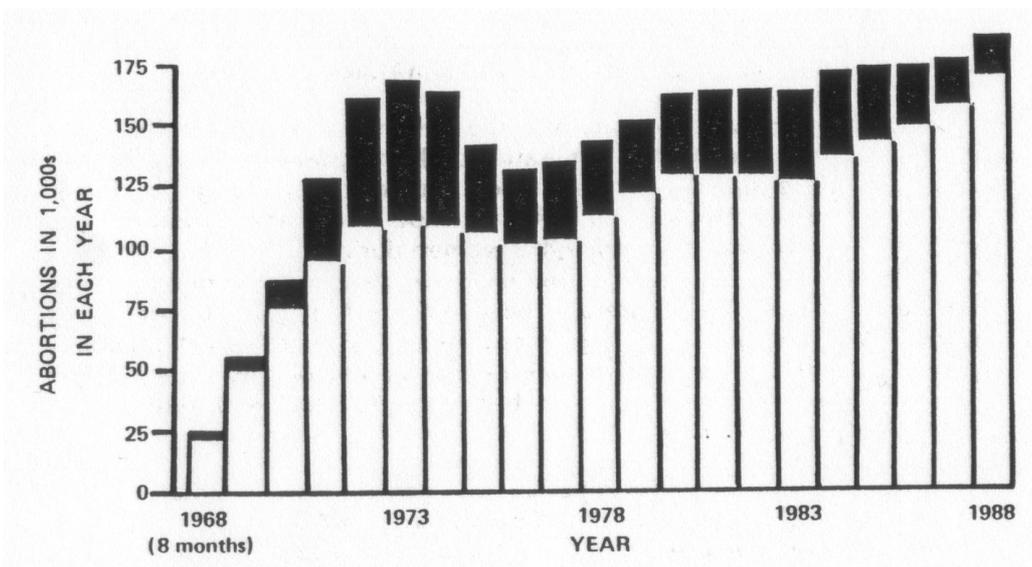
Prenatal Diagnosis

In 1985, amniocentesis to determine whether fetus had abnormalities for which abortion should be offered was carried out in at least 23,375 cases (about 3% of all pregnancies) in England and Wales – 4,478 on which the alpha-fetoprotein level in the amniotic fluid was measured because the level of this substance in the mothers' blood was high (suggesting a neural tube defect), and 18,897 others in which the chromosomes were examined (e.g. because the mother was relatively old and therefore more likely to bear a child with Down's syndrome).

Legally Induced Abortions

According to the Office of Population Censuses and Surveys, 183,798 legally induced abortions occurred in England and Wales in 1988 – 168,298 in residents and 15,500 in non-residents. Of the non-residents, 21% came from Scotland, Northern Ireland, the Channel Islands and the Isle of Man, 25% from the Irish Republic, 20% from France and 21% from Spain. The annual total for residents is now at an all time high, having increased by nearly a third since 1983 (the last year when a decrease was recorded), whilst the non-resident figure (which had been rising prior to 1983) is less than half as high as it was then, and lower than at any time since 1970 (Fig. 3). The recent increase in the resident figure has been particularly great for private patients, who accounted for 53% of cases in 1988, as against 47% in 1983.

Figure 3 – Legal abortions in England and Wales among residents (unshaded) and non-residents (black) by year.



Among residents, about three quarters of legal abortions (129,904 in 1988) are carried out on single, widowed, divorced or separated women. Girls below the age of consent (3,568 in 1988) account for just over 2% of all resident cases. Among all pregnancies conceived during 1986 (excluding those ending in miscarriage), legal abortion is estimated to have been carried out in 7% of those conceived within marriage, and 136% of others, including 54% of those where conception occurred below the age of consent. Among non-residents undergoing abortion, the proportion

who are single, widowed, divorced or separated, is slightly higher, and the proportion below the age of consent, slightly lower, than for residents.

The grounds given for abortion only include risk to the woman's life in 0.3% of residents, and substantial risk of handicap in the child in 1.0%. The only grounds given in virtually all other cases (i.e. 98.7% of the total), are the continuation of pregnancy would involve a greater risk than termination, to the health of the woman and / or any existing children. The most recent statistics available as to the health problems of such women give a breakdown by 'principal medical condition' of the residents who underwent abortions in 1987 in whom medical conditions were reported. Among 140,843 of these women whose 'principal medical condition' was not a fetal abnormality, it was classified in over 99% as a mental disorder – neurotic in 72.5%, depressive in 26.6% and other in 0.2%. Among abortions in non-residents, the proportions carried out because of risk to the mother's life, or risk of serious handicap in the child are even smaller, and mental conditions account for an even higher proportion of the medical conditions reported.

Most abortions in residents are carried out well before the time (around 24 weeks gestation) when the fetus has developed sufficiently to stand any chance of surviving outside the body. In 1988, 87% took place before 13 weeks, 8% at 13-16, 4% at 17-20, 1% at 21-24 and less than 0.02% at 25 weeks and over (Fig 4.).

Figure 4 – Legal abortions in England and Wales in 1988 among residents (unshaded) and non-residents (black) by gestation length. Abortions for which published date relate only to four-week periods (5-8 and 9-12 weeks) are plotted as if they were equally divided between the two halves of these periods.

Abortions in non-residents tend to occur later: 57% before 13 weeks, 18% at 13-16, 16% at 17-20, and 9% at 21-24 weeks in 1988. Abortions on the grounds of serious risk of handicap in the child inevitably tend to take place relatively late in pregnancy, since most tests for fetal abnormalities are done from 16 weeks gestation onwards. The most recent national statistics which allow this effect to be quantified refer to abortions among residents in 1987, and give less detail about gestation length than the above. There were 156,191 of these abortions, and risk of handicap in the child was one ground (more often than not the only one) for 1,862 of them. Abortion was carried out before 13 weeks in 44% of these 1,862 cases, at 13-19 weeks in 40% and at 20 weeks or more in 16%, whereas the corresponding figures for all other abortions are 87%, 11% and 1%. It follows that the proportion of all abortions with risk of handicap as a ground increases from 0.6% before 13 weeks to 4% at 13-19 weeks and 13% at 20 weeks and over.

Despite this association between late abortion and fetal abnormality, more than eight times as many abortions with risk of handicap as a ground, but less than half as many abortions after 16 weeks gestation, are carried out for NHS patients as for resident private patients.

APPENDIX IV - Bibliography

ARDITTI, Rita, et al (eds.)
Test-tube women – what future for motherhood?
Gainesville FL: Pandora 1984

A description of reproductive technology and a discussion of the ethics involved, from a feminist perspective, and in different cultural settings.

BRITISH COUNCIL OF CHURCHES AND FREE CHURCH FEDERAL COUNCIL
Choices in Childlessness
London: BCC and FCFC 1982

Report of a working party set up by the Free Church Federal Council and the British Council of Churches in 1979, exploring the issue of childlessness in a broad context, and concluding with a chapter of recommendations on the choices available in the light of the Church's life and teaching and the common good.

BOYD, Kenneth, CALLAGHAN, Bernard and SHOTTER, Edward
Life before Birth: Consensus in Medical Ethics
London: SPCK 1986

A study, by a group set up by the Institute of Medical Ethics, of attitudes to abortion and treatment for infertility; comparing official medical, legal and religious statements with current medical ethical practice and seeing signs of growing consensus.

CALLAHAN, Sidney and Daniel
Abortion – understanding differences
New York: Plenum 1984

A husband and wife, who disagree on the question of abortion, get together to put both the pro-life and the pro-abortion case.

CAMPBELL, Liz
Abortion – A Christian feminist perspective
New Blackfriars: September 1986

A brief overview of the arguments for a woman's right to pro-creative choice, put in the context of Christian feminist theology.

CHAMIER, J H (ed.)
Abortion and the Sanctity of Human Life
Paternoster 1985

CHURCH OF ENGLAND
Abortion – an ethical discussion
London: CIO 1965

A key discussion document in the earlier debate, which broke away from the traditional (Catholic) position.

CHURCH OF ENGLAND

Personal Origins – Report of a working party on human fertilisation and embryology
London: CIO 1985

The working party was unable to agree on the question of status, in the light of the different traditions within the Church of England, but stressed theological agreements underlying the utilitarian and the autonomous approaches to the problem. It aimed to provide guidelines for responsible decision making and pastoral care.

CIBA FOUNDATION

Human embryo research – yes or no?
London: Tavistock 1986

An informed debate on questions raised by research on the early embryo at a meeting of scientists, moral philosophers and theologians, doctors and lawyers.

DHSS

Report of the Committee of Inquiry into Human Fertilisation and Embryology.
Chaired by Dame Mary Warnock
London: HMSO 1984

The official report of the committee of inquiry set up by the British Government. See below under WARNOCK, Mary.

DUNSTAN, G R and SELLER, Mary (eds.)

The status of the human embryo
London: King Edward's Hospital Fund 1988

Essays, specifically related to the problem of status, from doctors and theologians (including a Jewish contribution), along with a clear biological account of the development of human life from gamete to infant, and the reasons for wanting research on the human embryos.

EDWARDS, Robert

Life before birth
London: Century Hutchinson 1989

A clear account of the research and development of the technique of *in vitro* fertilisation and how it can be applied in the diagnosis of genetic disorders. Modern embryology does not support the idea that there is one moment when human life starts, but rather describes a process of seamless change.

FORD, Norman M

When did I begin?
Cambridge: CUP 1988

A review of the philosophical, theological and scientific thinking as to when individual human life starts, by a Roman Catholic priest who argues that this happens when the embryo proper begins to take shape, about two weeks after conception.

FOSTER, J
Personhood and the Ethics of Abortion
In CHAMIER, J (ed.) above

GILLON, R
Philosophical medical ethics
Chichester: Wiley 1986

An excellent introduction by the medical director of Imperial College health service. The various philosophical systems, utilitarianism, deontology, etc. are explored in the relation to the "Arthur case", in which the late Dr Leonard Arthur, a respected paediatrician, was accused of attempted murder of a newborn infant with Down's syndrome.

JONES, D Gareth
Brave new People
Leicester: IVP 1984

Applies biblical principles to biomedical issues from a conservative standpoint

HAUERWAS, S
Suffering presences – theological reflections on medicine, the mentally handicapped and the Church
Edinburgh: T&T Clark 1988

A collection of essays, looking at the implications for the church of the moral decisions we take for and against allowing the fetus to live, where disability would result

HURSTHOSE, Rosalind
Beginning Lives
Oxford: Blackwell and Open University 1987

A fresh and stimulating discussion of the philosophical basis of current moral attitudes to the fetus, abortion and other wider issues. The author is critical of a tendency to over-simplify complex moral questions, and a failure to take into account the special position of women in the debate.

KELLY, Kevin T
Life and Love – towards a Christian dialogue on bioethical questions
London: Collins Liturgical 1987

Clear exposition of the different positions on bio-ethical issues taken by the Churches, with possibilities for future dialogue, by a Roman Catholic moral theologian with good ecumenical understanding. Includes a comprehensive bibliography.

KUHSE, Helga
The sanctity of life doctrine in medicine
Oxford: Clarendon 1988

A secular philosopher concludes that quality of life rather than sanctity of life should determine medical ethical decisions.

LANE REPORT

Report of the committee on the working of the Abortion Act
London: HMSO 1974

Although the statistical information is now dated, volume one contains a useful summary of the history of abortion from ancient times and the legal and theological background, as well as the position prior to the 1967 Act and the years immediately following its implementation.

LEE, R and MORGAN, D (eds.)
Birthrights – law and ethics at the beginning of life
London: Croom Helm 1989

A critical examination of the ethical basis of the legal regulation of matters surrounding birth, such as I.V.F. and surrogacy.

LOCKWOOD, Michael (ed.)
Moral dilemmas in medicine
Oxford: OUP 1985

An exploration of different ways of approaching and discussing ethical issues in medicine in general. Clear and informative. Non-theological.

METHODIST CHURCH

Abortion reconsidered – the Methodist Statement and its background
Edited by John Atkinson. London: DSR 1977

The earlier Methodist discussion, including the 1976 statement, at present the basis of the official Methodist position.

NORRIS, J M

When Does Life Begin? A consideration of the status of the human embryo *in vitro* and the ethics of recent advances in embryo research.
M.Phil. Thesis in Theology, 1988, University of Cambridge (Wesley House)

The author examines human life from three different perspectives – biological, individual and ensouled – and argues that fertilisation cannot be life's origin, rather that it begins not at a moment, but through a process in which every stage is significant. The human embryo is accorded a transitional status, valuing it more highly as it develops. Thus, IVF, some gene therapy and some research is morally justified.

O'DONOVAN, Oliver
Begotten not made?
Oxford: Clarendon 1984

Well-argued case for the moral illegitimacy of all artificial techniques of human fertilisation in the light of a particular understanding of what it means to be a human person.

PHILLIPS, Melanie and DAWSON, John
Doctor's dilemmas. Medical ethics and contemporary science
Brighton: Harvester 1985

A *Guardian* journalist and a doctor on the BMA's staff review five main areas of ethical concern (including 'life' and 'research') from a secular standpoint and conclude that abortion, but not experimentation on pre-embryos, is sometimes justified.

PIPES, Mary
Understanding abortion
London: Women's Press 1986

Written by a woman for women, giving advice on the medical, legal and practical aspects of abortion.

POLKINGHORNE REPORT
Review of guidance on the research use of fetuses and fetal material.
LONDON: HMSO 1989

ROYAL COLLEGE OF PHYSICIANS REPORT
Prenatal diagnosis and genetic screening – community and service implications
London: Royal College of Physicians of London 1989

Authoritative appraisal of the present state and future prospects of prenatal diagnosis.

SINGER, Peter and WELLS, Deane
The reproductive revolution – new ways of making babies
Oxford: OUP 1984

The authors look at possible future implications, moral and practical, of today's revolution in reproductive technology.

SNOWDEN, R and E
The gift of a child
LONDON: Allen and Unwin 1984

Sensitively written to help infertile couples to come to a decision about undergoing possible treatments, mostly concerned with artificial insemination.

STANWORTH, Michelle (ed.)
Reproductive technologies
Oxford: Polity, 1987

A survey of the variety of technologies associated today with reproductive and biomedicine, and an attempt to assess what effect they will have in the long term on childbearing, family life, and in particular on women.

WARNOCK, Mary
A question of life
Oxford: Blackwell 1985

The 1984 report of the Warnock Committee of inquiry into human fertilisation and embryology, which was commissioned to advise the Government on desirable changes in the law in response to the new technological and biological situation, with two added chapters by the chair of the committee.

BULLETIN OF MEDICAL ETHICS
JOURNAL OF MEDICAL ETHICS

Important articles, reviews etc. have appeared in these and other medical, ethical and theological journals over the last few years.

APPENDIX V - Membership of the Working Party

The Revd Dr Kenneth Wilson	Principal of Westminster College, Oxford, and Chairman of the Working Party
Mrs Jill Baker	Theology graduate, housewife and mother
The Revd Kathleen Bowe	Lecturer in Biblical Studies at Cliff College
The Revd Jill Bryant	Circuit Methodist minister, and Convenor of the Working Party
The Revd Brian Duckworth	General Secretary of the Division of Social Responsibility
The Revd Dr David Hardy	Methodist minister, formerly Research Associate in the University of Birmingham
Dr David Hutton	Senior Lecturer, Honorary Consultant in Haematology, Cardiff Royal Infirmary
Professor Ian Leck	Head of the Department of Public Health and Epidemiology, University of Manchester
Mrs Sheila Russell	Librarian at Queen's College, Birmingham and mother

Dr Jim Seakins

Research Biochemist, Institute of Child Health,
University of London: Hospital for Sick Children,
Great Ormond Street

Dr Mary Groves

General Practitioner. Member of the Working Party
from 1987 to 1988 when unfortunately demands on
her time led to her resignation

We are very grateful to Elisabeth Sabey for her secretarial support.