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# Medical Ethics and Issues of Life and Death

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# *Medical Ethics and Issues of Life and Death*

## ABORTION

### 1. Introduction

The Church of England encourages its members to think through issues themselves in the light of the Christian faith and in dialogue with the Christian community. Inevitably there will be differences of emphasis or opinion between individuals. But there is a consistent Church of England position as expressed in reports and resolutions of the General Synod. In summary:

> *The Church of England combines strong opposition to abortion with a recognition that there can be - strictly limited - conditions under which it may be morally preferable to any available alternative.*

The theological basis of this is that the foetus is God given life, with the potential to develop relationships, think, pray, choose and love. So as the 1983 Synod Resolution put it:

> *All human life, including life developing in the womb, is created by God in his own image and is, therefore, to be nurtured, supported and protected.*

### 2. The Mother

The mother of the unborn child needs all possible understanding and help, especially if factors connected with the pregnancy are difficult. Successive resolutions have urged the need for compassion for the mother (1966) and have emphasised that she has interests which need to be taken into account (1974). It is the mother who is pregnant, it is she who will have to agree to an abortion if that proves necessary, it is she who will give birth if the pregnancy goes ahead and probably she who will bear the major responsibility of the future child's upbringing. Her feelings and wishes are to be fully recognised. At the same time sight should not be lost of the father's proper role and responsibilities in decision making concerning the child.

### 3. The Law

The 1967 Abortion Act permitted an abortion legally to be carried out if there is a risk to the life or health (physical or mental) of the pregnant woman, or if there is substantial risk of a child being born with physical or mental abnormalities. In 1991 a clause in the Human Fertilisation and Embryology Act lowered the time limit for abortion from 28 weeks to 24, except for severely abnormal foetuses or when the life of the mother is threatened, where there is now no time limit.

### 4. The present situation

While abortion on demand strictly does not exist, most people who want an abortion can get it somewhere, although often not on the NHS. Over 170,000 legal abortions are carried out in this country each year.

Resolutions of the General Synod have consistently sought to narrow the grounds on which abortion is carried out and have maintained that the law has been interpreted too liberally resulting in an unnecessary number of abortions. For example the 1993 General Synod resolution reiterated its view that:

> *The number of abortions carried out since the passage of the Abortion Act 1967 is unacceptably high.*

### 5. Resolutions of the General Synod of the Church of England

The position of the Church of England is often compared to that of The Roman Catholic Church. This according to the Catechism of the Catholic Church is that:

> *Human life must be respected and protected absolutely from the moment of conception. From the first moment of his existence, a human being must be recognised as having the rights of a person - among which is the inviolable right of every innocent being to life.*

This means that direct abortion is 'gravely contrary to the moral law'. The Church of England shares this general opposition to abortion. As the 1980 statement of the Board of Social Responsibility put it:

> *In the light of our conviction that the foetus has the right to live and develop as a member of the human family, we see abortion, the termination of that life by the act of man, as a great moral evil. We do not believe that the right to life, as a right pertaining to persons, admits of no exceptions whatever; but the right of the innocent to life admits surely of few exceptions indeed.*

However, as that statement makes clear, the moral legitimacy of abortion under some circumstances is recognised. The 1983 resolution of Synod, after expressing concern about the number of abortions in recent years went on to recognise:

> *That in situations where the continuance of a pregnancy threatens the life of the mother a termination of pregnancy may be justified and that there must be adequate and safe provision in our society for such situations.*

The most recent debate at Synod, in 1993, resulted in a motion which urged support for the medical profession:

> *In efforts to ensure that when abortion has to be undertaken, it is carried out as early in the pregnancy as possible.*

It also went on to say:

> *That in the rare occasions when abortion is carried out beyond 24 weeks, 'Serious foetal handicap' should be interpreted strictly as applying to those conditions where survival is possible only for a very short period.*

('Serious foetal handicap' is as laid down by the Human Fertilisation and Embryology Act). It should also be noted that Synod resolutions have urged protection for medical staff who, in conscience, decline to assist in abortions.

In their consideration of abortion members of the General Synod have been assisted by carefully considered reports prepared by advisers with appropriate theological, medical and legal expertise. However, General Synod resolutions inevitably leave many questions unanswered. The Synod has not attempted to resolve all the dilemmas which arise in this area, such as when the unborn child has been conceived as a result of rape or the foetus may be known to be at risk of serious handicap. In such cases Anglicans will be agreed on the need to have regard to 'compassion for the mother and a proper responsibility for the life of the unborn child' (in the phrase used in the Church Assembly in welcoming the BSR report, *Abortion: An Ethical Discussion*), but they may come to different conclusions about the proper course of action in particular cases.

**6. A serious and responsible view**

In an age dominated by slogans the Church of England's position is not as easy to communicate as the views of those who believe the mother has a total right to choose what she does with her own body or those who assert that the foetus has an absolute right to life. The Church of England rejects the oversimplification of the debate into 'pro choice' and 'pro life'. Its own view, as expressed through successive resolutions of General Synod, is clear, consistent and such as will

commend itself to many thoughtful people outside the church as well as within. At the present time in particular it believes:

1. The abortion law needs to be applied more strictly and the number of abortions carried out drastically reduced.

2. Every possible support, especially by church members, needs to be given to those who are pregnant in difficult circumstances. The 1975 motion of Synod is as relevant today as it was then when it commended:

> *For active support to members of the Church of England the efforts of those ... working ... to provide social help and compassionate care for mothers (before and after childbirth) and children.*

Sometimes this will involve helping those who have made a considered decision to have their child adopted find suitable adoptive parents, a role in which the church has long experience. The agonising moral choice which an individual may face cannot be considered apart from the attitudes of society which may put an unhelpful pressure upon them and the social conditions in which any baby born will be brought up. As the 1980 BSR statement said

> *We believe that the Church has a major task in helping our contemporaries reach a fuller understanding of our nature as sexual beings, the richness of experience it offers as well as the responsibility that it brings in its train. The Church must also stand in opposition to the restricted life chances, poverty and in particular inadequate housing and social services which continue to limit and stunt too many people's lives.*

**7. Abortion and the 1997 General Election**

This briefing paper was published at the start of the year in which it was known there would be a General Election. The Board recognised that Christians might want to question Parliamentary candidates on their views on abortion. In particular, a candidate's views on the two points made above might be relevant. For most members of the Church of England, however, abortion will be but one of a whole range of issues, many of which also have a moral dimension, which are relevant to their decision about how to vote in any election.

(The resolutions of General Synod together with further background discussion are available in Abortion and the Church, available from Mail Order Department, Church House Bookshop, Church House, Great Smith Street, London SW1P 3BN at £2.95)
update April 1999

Further reading:
There is a list of suggested further reading on page 22 of ***Abortion and the Church: What are the Issues?*** This includes a much earlier (1965) report from the Board for Social Responsibility, ***Abortion: An Ethical Discussion***, (now out of print but available in some academic libraries), and ***Life and Love*** by Kevin Kelly (Collins, 1987), which discusses different Christian approaches to bioethical questions.

**EUTHANASIA**

The Church of England encourages its members to think through issues themselves in the light of the Christian faith and in dialogue with the Christian tradition. Nationally and locally, the Church of England seeks to support its members in their explorations in discipleship through encouraging participation in social institutions where moral and ethical issues arise. The Board for Social Responsibility seeks to help Christians and others to reflect on these difficult issues. For many years it has contributed to thinking about questions of life and death. In 1965 it published a booklet entitled, *Decisions about Life and Death*. In 1975 it published *On Dying Well: An Anglican Contribution to the debate on euthanasia* which will be reprinted in 1999. The Christian principles which informed those contributions to the debate have remained unchanged. However, when the Law Lords delivered their judgement in the tragic case of Tony Bland in 1993 the point was made that developments in medical science raised new questions which previous discussions of the law in relation to murder could not have envisaged. Parliament was urged to examine these questions. When the House of Lords Select Committee on Medical Ethics invited views on these points the House of Bishops of the Church of England submitted a joint statement with the Roman Catholic Bishops of England and Wales. That statement, which is reproduced here, is a clear statement of our Churches' approach to these questions.

**A JOINT SUBMISSION FROM THE CHURCH OF ENGLAND HOUSE OF BISHOPS AND THE ROMAN CATHOLIC BISHOPS' CONFERENCE OF ENGLAND AND WALES TO THE HOUSE OF LORDS SELECT COMMITTEE ON MEDICAL ETHICS**

**Foundations**

1. The arguments presented in this submission grow out of our belief that God himself has given to humankind the gift of life. As such, it is to be revered and cherished.

2. Christian beliefs about the special nature and value of human life lie at the root of the Western Christian humanist tradition, which remains greatly influential in shaping the values held by many in our society. They are also shared in whole or in part by other faith communities.

3. All human beings are to be valued, irrespective of age, sex, race, religion, social status or their potential for achievement.

4. Those who become vulnerable through illness or disability deserve special care and protection. Adherence to this principle provides a fundamental test as to what constitutes a civilised society.

5. The whole of humankind is the recipient of God's gift of life. It is to be received with gratitude and used responsibly. Human beings each have their own distinct identities but these are formed by and take their place within complex networks of relationships. All decisions about individual lives bear upon others with whom we live in community.

6. For this reason, the law relating to euthanasia is not simply concerned either with private morality or with utilitarian approaches. On this issue there can be no moral or ethical pluralism. A positive choice has to be made by society in favour of protecting the interests of its vulnerable members even if this means limiting the freedom of others to determine their end.

**The sanctity of life and the right to personal autonomy**

7. Attention is often drawn to the apparent conflict between the importance placed by Christians on the special character of human life as God-given and thus deserving of special protection, and the insistence by some on their right to determine when their lives

should end.

8. This contrast can be falsely presented. Neither of our Churches insists that a dying or seriously ill person should be kept alive by all possible means for as long as possible. On the other hand we do not believe that the right to personal autonomy is absolute. It is valid only when it recognises other moral values, especially the respect due to human life as such, whether someone else's or one's own.

9. We do not accept that the right to personal autonomy requires any change in the law in order to allow euthanasia.

10. The exercise of personal autonomy necessarily has to be limited in order that human beings may live together in reasonable harmony. Such limitation may have to be defined by law. While at present people may exercise their right to refuse treatment (although this may be overridden in special but strictly limited circumstances), the law forbids a right to die at a time of their own choosing. The consequences which could flow from a change in the law on voluntary euthanasia would outweigh the benefits to be gained from more rigid adherence to the notion of personal autonomy. But in any case we believe (para 6) that respect for the life of a vulnerable person is the overriding principle.

11. The right of personal autonomy cannot demand action on the part of another. Patients cannot and should not be able to demand that doctors collaborate in bringing about their deaths, which is intrinsically illegal or wrong.

12. It would be difficult to be sure that requests for euthanasia were truly voluntary and settled, even if safeguards were built into the legislation, and not the result either of depression or of undue pressure from other people. Circumstances may be envisaged in which a doctor managing scarce resources might, perhaps unwittingly, bring undue pressure to bear on a patient to request voluntary euthanasia. Similarly families anxious to relinquish the burden of caring (or to achieve financial gain) might exert influence. Experience suggests that legislative change can lead to significant changes in social attitudes, and that such changes can quickly extend into supporting actions which were not envisaged by the legislature.

**The distinction between killing and letting die**

13. Because human life is a gift from God to be preserved and cherished, the deliberate taking of human life is prohibited except in self-defence or the legitimate defence of others. Therefore, both Churches are resolutely opposed to the legalisation of euthanasia even though it may be put forward as a means of relieving suffering, shortening the anguish of families or friends, or saving scarce resources.

14. There is a distinction between deliberate killing and the shortening of life through the administration of painkilling drugs. There is a proper and fundamental ethical distinction which cannot be ignored between that which is intended and that which is foreseen but unintended. For example, the administration of morphine is intended to relieve pain. The consequent shortening of life is foreseen but unintended. If safer drugs were available, they would be used: pain would be controlled and life would not be shortened.

15. Doctors do not have an overriding obligation to prolong life by all available means. The **Declaration on Euthanasia** in 1980 by the Sacred Congregation for the Doctrine of the Faith proposes the notion that treatment for a dying patient should be 'proportionate' to the therapeutic effect to be expected, and should not be disproportionately painful, intrusive, risky, or costly, in the circumstances. Treatment may therefore be withheld or withdrawn. This is an area requiring fine judgement. Such decisions should be made

collaboratively and by more than one medically qualified person. They should be guided by the principle that a pattern of care should never be adopted with the intention, purpose or aim of terminating the life or bringing about the death of a patient. Death, if it ensues, will have resulted from the underlying condition which required medical intervention, not as a direct consequence of the decision to withhold or withdraw treatment. It is possible however to envisage cases where withholding or withdrawing treatment might be morally equivalent to murder.

16. The recent judgement in the House of Lords to permit the withdrawal or artificial nutrition and hydration from the PVS patient, Tony Bland, must not be used as an argument for the existing law to be changed. As with the general question of proportionate means, the complexity of the issue of artificial nutrition and hydration and the associated medical regimes means that there can be no blanket permission as regards PVS patients or those in a similar situation. At the very least, every person's needs and rights must be dealt with on a case to case basis.

**The extent of the doctor's duty of care**

17. The preceding paragraphs have touched on limits to treatment. The value attaching to human life implies that the primary duties of doctors are to ensure that patients are as free from pain as possible, that they are given such information as they and their carers request and require to make choices about their future lives, and that they are supported through the personal challenges which face them. We believe that to accede to requests for voluntary euthanasia would result in a breakdown of trust between doctors and their patients. Medical treatment might come to be regarded by the vulnerable person as potentially life-threatening rather than something which confers benefit.

**The treatment of patients who cannot express their own wishes**

18. Where formerly competent people have expressed their wishes about the way they would like to be treated, these should form an important consideration for doctors in determining how to proceed. Such wishes can only act as guidelines since medical conditions may exist for which they are inappropriate. If such wishes are unknown or inappropriate, or if a person has never been competent to express such wishes, then decisions about treatment should be worked out between doctors, families, carers and other health service personnel such as social workers or hospital chaplains.

**Advance Directives**

19. Advance directives may be useful as a means of enabling discussion between doctors and patients about future treatment. Where they exist, they can only be advisory. They should not contain requests for action which is outside the law, nor ask for the cessation of artificial nutrition and hydration. Care should be taken to establish that any advance directive was not made under duress. We would resist the legal enforcement of such directives since the medical conditions envisaged might be susceptible to new treatment, and medical judgements would have to be made about whether a person's condition was such as to require their advance directive to take effect.

**Care of terminally ill people**

20. The hospice movement developed from the concern of Christians that people should be helped to die with dignity. This work has enriched not only the lives of terminally ill people but also their carers, volunteers, and health professionals, who have found that caring for

those who are dying can be a great source of blessing.

21. We are concerned that the lessons learned in hospices about pain control, and emotional and spiritual support should be applied throughout the health service to all dying people. This requires that medical personnel remain aware of how advice on pain control may be obtained, and that adequate resources are made available for the care of sick and elderly people.

22. We believe that deliberately to kill a dying person would be to reject them. Our duty is to be with them, to offer appropriate physical, emotional and spiritual help in their anxiety and depression, and to communicate through our presence and care that they are supported by their fellow human beings and the divine presence.

**SUICIDE**

Traditionally the Christian Churches were very severe on suicides and attempted suicides, refusing the former burial in consecrated ground, since it was argued that the person who committed suicide was expressing his or her total lack of faith in God.

Nowadays, Christians generally recognise that suicide is not so much a deliberate rejection of life as an expression of dissatisfaction with the particular life the person is leading, and in many cases is a cry for help. To take your life is obviously a muddled and unsatisfactory way of responding to an unsatisfactory personal state of affairs, but seeing things in this way has led Christians to treat suicides and potential suicides as they would treat people who were depressed or sick in other ways, ie by seeking to help them where possible, and certainly not to engage in moral condemnation of them. This shift in attitude led this Board to produce ***Ought Suicide to be a Crime?*** And to press the Government to change the law so that suicide should no longer be treated as a crime. This change came about in 1961.

Further information and resources:

The local branch of ***The Samaritans***, the organisation which offers a confidential service to people who are suicidal and despairing, should be listed in the local telephone directory.