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Doctor Bergin, of Wellington, New Zealand, gave this address several years ago at the 1980 Dublin Ethics Meeting arranged by the International Federation of Doctors Who Respect Human Life.

Dr. John Collins, a young physician in training at the Wellington Hospital, gave an address on "The Christian in Medicine" in which he said: "The ill person is very vulnerable. He needs to accept treatment or suffer further. He needs to trust the physician with his body and, at times, his mind. This trust is an essential element in the doctor-patient relationship and the doctor must reciprocate with his active concern for the whole person—body, mind and soul. This concern is embodied in all the accepted codes of medical ethics. Because of his commitment to this principle, the doctor must bring to the relationship his own values, not for the religious conversion of the patient, but to guide his diagnostic and therapeutic approach. He must, of course, also bring all the fruits of his study and past experience to the service of the patient."

This statement illustrates the relevance of a doctor's moral stance and points to the need for an ethic. Let the definitions be simple. Let morals be the types of personal and social action carried out and accepted by a community of men. Let ethics be the appropriateness of those actions for personal and social welfare, not excluding eternal welfare. Let morals be the study of what men do, and ethics the study of what they should do. Every man then needs an ethic, for whatever he knows of his own origin and destiny, he must choose the means to his goal. He will require a morality of means, if not of end. If he sees himself created and dependent with knowledge, albeit obscure, of his Creator, he also sees himself obligated to live to seek human perfection for himself and for others. Even if he sees no Creator, but bases his ethic on the wisdom of experience and the search for natural causes, he will judge motives, and will claim a right to life. The theist always, and the humanist sometimes, will see his right to life as the most basic of all his rights; for education, employment, speech, mar-

riage and family and the fulfilled life are meaningless without life. Since man relates to other men on his journey, he understands their right to live, and to fulfill themselves. Both he and other men, however, are subject to the ills of the human condition and are likely to call on the doctor and ask for assistance or advice.

The doctor knows his task as restoration, repair and enhancement of well-being, and is privileged to help as he can. If he is wise, he knows that his powers are limited, that eventually death will win but that with science, art and compassion, he may help until death comes. He knows that, beyond his family, his first neighbor is his patient, and that more will be required of him in care and compassion for incurable neighbors than in science or surgery for spectacular recoveries. The relationship of doctor and patient to the Maker they share is the real basis for medical ethics and medical care, for it is this which places the dignity of the human person and the unassailable right to life and the corresponding duty of the doctor to respect both. Professional medicine must begin with the right of every patient, no matter how old or how small, how healthy or how frail, to live out his time, and the doctor not totally committed to the preservation of that life is himself a danger to his patients.

Relationship Between Creator and Ethics

Are you nervous that I place a relationship between Creator and ethics, making it a religious relationship? Do I not know that neither all doctors nor all patients are Christian, or even theist? Yes, I *do* know, but I believe that the logical base for a firm ethic governing man's response to man in the power-laden intimate relationship that exists between doctor and patient is common spiritual allegiance to a power higher than themselves. Christians of any denomination can subscribe to it. Non-Christians who acknowledge a supreme being can readily accept it. And of our numerous colleagues who can only acknowledge man striving through his own agency to achieve limited perfection confined to this planet, many see a certain transcendence in man and intuitively acknowledge his right to life, or they do so on a basis of self-defense. I believe, nevertheless, that it is more difficult for the humanist to make the right to life absolute, or to hold value in suffering when there is no recovery in sight, but there are defectors among creed holders, too.

Men must choose and doctors must choose, and they will do so according to the strength of their convictions and the pressures upon them. For the very reason that some men have failed, and others are liable to fail, influential teachers, like Hippocrates, have codified what they deemed desirable, and have sought submission from their followers. When doctors later saw a special need to re-examine their

conduct and strengthen their guidelines, the World Medical Association formulated the Declaration of Geneva which has been placed so prominently for our consideration by the organizers of this conference. Once again we are examining adherence to this code, because in certain areas many have let it pass them by. The very purpose of such a code is to prevent arbitrary preference and pragmatism from taking precedence over objective truth and principle in determining right action, and the effect of abandoning or ignoring the code, especially in its most crucial requirement — respect for human life from conception — has been disastrous. The departure of a certain number of our profession from Hippocratic or Genevan ideals, the abandonment of traditional ethics, the diminution of standards in successive declarations of the World Medical Association and the draining of courage in the profession are all too obvious and I could exemplify this from my own country as easily as yours.

We have been subjected to and succumbed via the media to the same pressures: first, about healthy women who became ill and died from inattention in back streets; then about ill women who would not survive pregnancy; then about emotionally traumatized victims of rape and incest, both of which were made to sound epidemic; then about women who were younger or older than those who normally had infants; then about those who were poor and neglected, or who were rich and committed, and finally about the great majority who had convenience or personal liberty as their needs.

As a result of all this, we have, in the course of a decade, been through the sudden appearance of an abortion clinic testing the law and eventually winning; of media pressure; of marching in the streets; of Royal Commission and new legislation; of certifying consultants and supervisory committees. We are left with an annual induced abortion rate of more than 5,000 in a country which found fewer than 100 therapeutic abortions necessary in the same period as recently as 12 years ago. Therein lies the first paradox. A country known in the past for a high standard of infant care and low infantile mortality, not poor, not overpopulated, with a good welfare service, a well-trained medical profession and well-equipped hospitals, has found it necessary to abort 40 times as many unborn children a decade after the pressure was seriously applied, which significantly was soon after the 1967 Act succeeded in England.

Throughout the country the principal indication for abortion under the new dispensation has been mental ill health, and until recently the only diagnosis needed was a tick on the form against the word mental health. Paradox it is that doctors objected when a new regulation required them to give more detail about the mental sickness that made the abortion necessary; and paradox again that so little is heard of the mental state of the patients after the procedure, or that psychiatrists

generally have been so quiet about this new mental affliction of young, single women.

In the week that a new abortion clinic was being readied for action in our city, the morning newspaper published a front page photograph of a young woman who had been in chronic renal failure and had, soon after receiving a kidney from her brother, completed a normal pregnancy. In that same week, the hospital was visited by a distinguished surgeon from Paris to deliver a special scientific lecture on the performance of hepatic transplant. During his visit, he mentioned a hepatic transplant operation which he would attempt upon return to his own hospital on a very small child suffering from biliary atresia. Paradox it was that these surgical marvels, one for a mother, one for a child, should be brought to our attention at the same time as our new abortion facility became ready and waiting in renovated premises.

Paradox in Resuscitation/Abortion

Even without going to the length of hepatic transplant in infants, there is paradox enough in the work of neonatal resuscitaton in any hospital alongside that of the abortion team in the same hospital, if not in the same department. Equal paradox is the concern about perinatal mortality which is studied with such anxiety but with the abortion data excluded. There is paradox, too, in the fact that if one wishes to bring about mid-trimester abortion with prostaglandin F2, and one first reads the pamphlet that goes with the ampoule, one is warned that in some cases the child will arrive alive. Hence we have the supreme inversion of reality — live birth a complication of abortion. The Upjohn pamphlet does not make any recommendation about what should be done in the event of live birth, but we recall the legal outcome of the trials of two doctors (Edelin, Waddill) in the United States, charged with completing the dispatch of infants born in similar circumstances.

In late 1979, when a seminar was held under the combined auspices of the National Commission of the International Year of the Child and the New Zealand Human Rights Commission, it was found necessary to exclude a paper entitled "When Do Human Rights Begin?" This was because the paper dealt in part with the subject of abortion whereas the policy decision of those responsible for the International Year of the Child had defined a child as a living being living between birth and the age of 15 years. It may be in order for the United States Supreme Court, the definition committee of the International Year of the Child, and sequentially the New Zealand Human Rights Commission to say or act as if there is no such thing as an unborn child, or that if there is, no one knows when it is, but can a practicing doctor maintain that stance and still hold up his head? We can understand women with

false ideas about what liberates them, social engineers with false premises for their planning, clergymen with limited scientific contact. and media men who may be colossally ignorant about basic life issues; but doctors study embryology, fetology and obstetrics, and it is surprising to find the profession so adaptable to abortion whether by participation, promotion or silent acquiescence. Its members appear unaware of the anomaly of the disappearance of the medical situations previously regarded as indications for abortion accompanied by a wild increase in the same lethal procedures, unaware of the anomaly that exists when their decisions are social rather than medical, unaware of the even greater anomaly that exists when the patient dictates the surgical treatment, and oblivious to the enormous change in their own ethic which enables them to do professionally what they previously would have been forbidden to practice.

Granted that doctors are, in general, a reflection of the community from which they come (and this will show in their ethical standards), it still cannot be wrong to expect some resistance from them to the manipulations which would use them not primarily as surgeons or physicians, but as agents of social change in the way they have been used in sterilization. This has been done under the umbrella of high-sounding population programs and in the widespread provision of contraceptives for premaritals, nonmaritals and the promiscuous, and, most unhappily, in abortion. It appears that many doctors have never examined the thesis that contraception promotes, rather than prevents, abortion.

Strangely enough, the increased abortion rate around the world, or in a particular part of it, seems not to have earned doctors the opprobrium the phenomenon merits. It seems to me that this is to be attributed in part to the strong belief among the public and the politicians that there *are* abortions which are medically necessary, or that there are many more of them than an average conservative doctor, who is not totally opposed to abortion, would admit. While a high abortion rate is a factor of women prepared to have, as well as doctors prepared to do, abortions, the figure is compounded by the fact that doctors generally have not disabused the public, the press and the politicians of the idea that so many abortions are medically necessary. This is a distortion, a deception, on the part of doctors, and it equates with the deception fostered among people that the unborn child in its early stages is unformed as well as unborn — gubbins, jelly, or a "cupful of mush," as one notable New Zealand abortion protagonist termed it — instead of the beautifully designed, all-systems-go man in miniature that Leujeune called "a veritable Tom Thumb." As for growth, the expansion from zygote to man or woman, is surely paralleled only by the expansions the universe itself has undergone from the central point of infinitely condensed matter. It is a paradox that this renewal of creation is so well known, but in the field of abortion is so

little honored. Surely to hand this information to each patient along with an indication of possible disadvantages to the person and a clear presentation of available alternatives would make informed consent both more meaningful and less frequent.

Perhaps the most dangerous area for the profession and the community in which doctors have deflected from fundamental duty of repair or care is that of prenatal diagnosis and abortion for fetal defect, or what is worse, for possible defect. It must be admitted, sadly, that this is done with the general approval of the public and the majority of the profession. Be that as it may, it is difficult to imagine any medical or social action less in keeping with the expected approach of a doctor to the victim of illness, especially when the victim is small, inarticulate, and totally dependent.

Leaving aside temporarily the possible errors in diagnosis, procedural complications and those cases in which the abortion is carried out simply on the grounds of risk related to sex, we have the paradoxical situation wherein the person damaged after birth — head injured and paraplegic, for instance — will receive lengthy care and heavy expenditure, but a child with a lesser disability on a congenital basis is denied its share of help. More anomalous still is the fact that if the exercise is a cost-benefit one, which it largely is, the beneficial balance has not yet been demonstrated, and there is little recognition of the fact that the morally defective do more harm to and make more expense for the community than a child with spina bifida ever would.

What Doctors Should Not Forget

What doctors should not be allowed to forget is that the fetus, even when shown by science and technology to be defective, is still a patient in need of restoration and repair, and the problem is not really solved by removing the patient. That this is advised from a sense of compassion is understood, but it is not the real compassion that goes on looking after the patient when continuing care is necessary. Nor is the challenge to science accepted which would search for a remedy, rather than destruction. Finally, all should be anxious about the many things which occur as flow-on if this line of treatment is used. Infanticide and adult euthanasia are undoubted sequelae, but they are topics which will be dealt with by others and which, therefore, I do not wish to develop further here.

If this were not a gathering whose purpose is to emphasize the right of every individual to possess his own life, you might be tempted to join those doctors who try to escape the problem by declaring that they are "sick of abortion." At a recent panel discussion on ethical questions, the chairperson, a well-known television personality, asked one of the panelists how he would deal with a conflict of rights to life

in a situation where treatment would be available for only one of a pair of patients. He prefaced the inquiry with the comment, "I don't want to get into the abortion issue — we're all sick to death of that." The comment ignored the fact that the only party literally sick to death in the complex was the unborn child. When I hear such a remark I feel like responding that "I'm sick to death of abortion, too" — sick of the deception, the violence and the ignorance. I have already dealt with some of the fiction, most notably that vast numbers of abortions are being carried out on account of maternal ill health, next, that what is being aborted is some form of nothing and thirdly, that somehow an abortion can be done without killing a small child and can masquerade as treatment and carry the term therapeutic.

To the unborn child, the act of abortion is at the one time an act of violence and of non-love, and eventually the perpetrators will come to dislike themselves for what they have done. Nathanson's remarkable awakening, although not complete, is surely one of the most informative we have yet had. If abortion on the background of the fetal development with which we are now all familiar does not do violence to the conscience of those who apply it, it certainly does violence to the fetus who is treated by the abortionist as rudely as any passenger in a hijacked aircraft, or anyone having a grenade come unexpectedly through the door of his or her home or car window. Even where disaster is accidental, like the flying of an aircraft into Mount Erebus, there is paradox in the genuine concern which the community feels and expresses compared with the lack of concern for the greater number of fetal passengers put to death by doctors each month. There is inconsistency, too, in the tremendous and often dangerous effort that the community makes through massive search to find children lost in our seas or hills or caves, compared with the respectful inertia of most of the nation while doctors daily terminate the lives of other children whose whereabouts are only too well known before the operation begins.

Surely abortion can only be undertaken enthusiastically by someone who does not know the facts or denies their significance on the basis of smallness, weakness or incomplete development of the human fetus. Abortion is, of course, largely based on the deception to which I have already referred — that the fetus is represented as jelly gubbins or mush rather than as a marvelous manifestation of individual human life in the process of development, a fetal person growing to a child and then an adult person.

There is deception also in the view that it is a lesser thing to remove a fetus at an early rather than a later stage of pregnancy. Physically, of course, it is a lesser procedure, and I have heard it described as more aesthetic, but a farmer loses the same crop whether the seed is washed out of the ground after sowing, whether the birds pluck the green shoots, or whether a storm batters it when the grain is ripe. We lose

the same person at whatever stage of the pregnancy he or she is eliminated.

A further deception is that it seems to be considered a lesser thing to deprive an embryonic or fetal man of his life than to do the same to a child or an adult. But is it not a fact that if you attack a grown man, say one 35 years of age, you deprive him of only half his allotted span, and you take the life of someone who has a chance of stopping you either by counsel or law or physical resistance? When you attack an unborn child you are removing the whole of his future, whatever person he would have been, whatever life he would have lived, and you are doing it to a defenseless infant.

Ethics Concerns More Than Abortion

I have spoken about abortion to the extent that a casual listener might wonder whether medical ethics concerns only abortion. This is far from the case, for there are problem areas in the care and treatment of the defective newborn; in care and treatment of the worn-out and elderly; in resuscitation; in the unconscious respired patient awaiting the turn of the switch and the release of organs for transplant; in the premortal treatment of such a patient to render his kidneys more suitable for the recipient; in fertilization of the human ovum outside the womb, and the false starts that accompany it; in the allocation of scarce resources for the sophisticated and expensive in the face of massive need for the cheap and simple; in communication and confidentiality; in informed consent for treatment or research; in torture; in the maintenance of one's skills; in cooperation in prescription or procedure unacceptable to the conscience of one whose colleagues or government deem them obligatory; and in respect for the rights and duties of parents as well as the rights of their child. These all require discussion on a basis of principle to be applied, but none is as fundamental as induced abortion which places every victim beyond life or remedy.

If I offer principles which may assist in determining the issues, they are principles which may or may not be spelled out in standard textbooks. They have come to me in researching, discussing or sharing problems over a number of years. I list some of them. Start with the truth. Offer it with kindness and hope. Good medicine and good morals are inseparable — and it is not possible to find a right way of doing a wrong thing. It is the task of the doctor to cure or care, never to kill. Appropriate therapeutic procedures repair, replace, enhance function, never destroy. Doctors and nurses work for life, for individual lives, but neither in terms of economic nor of physical suffering do they seek life at any cost — extraordinary, disproportionate or irrational means to save life are not required. Dying is neither to be

hastened nor prolonged. There is a morality of means as well as of ends — some things should never be done. The rights of parents should not be ignored. Some actions which have both good and bad effects may be done for the good they achieve, but it is not right to do evil that good may result. A doctor's obligation to a patient is not greater than the patient's obligation to seek and accept his assistance, and that will vary with the hazard and effectiveness of what is offered and the family responsibilities the patient may have. A doctor informed in moral matters is in a better position to decide a course of action than a moral guide uninformed about medicine, and one might add that although it is not possible to legislate morality — not possible to pass a law that makes one love his or her neighbor — it is possible in the interests of all members of the community to legislate limits to the therapeutic and research actions of doctors.

How, then, do we have colleagues and students consider these principles and their significance in relation to the nature of man so that they can be applied for the benefit of man?

I believe it would be correct to say that apart from a certain indoctrination in medical etiquette and the provision of necessary data about legal responsibilities, medical schools have for many years eschewed the subject of medical ethics in much the same way as polite people have avoided religion and politics at the dinner table, or have offered behavioral science as a substitute. It is true that the same year that the Abortion Law dislodged the avalanche, Great Britain's General Medical Council recommended additional attention to ethical bases in the medical curriculum, and there is evidence now of renewed interest in the form of seminars, societies, books and journals in which difficult problems are dissected. Beyond medical schools there have been research or information centers established although the ethical exposure through these different channels would still be in a minority.

In our own city and clinical school in the past three years we have had a set of panel presentations about issues in medicine which is developing into a scheme for more comprehensive coverage by qualified personnel of difficult areas, not excluding the controversial. To these the student will hopefully add reading and the teacher, witness. The doctor, insofar as he sees his work as part science, will, if he pursues the scientific method, pursue truth; and if he builds on truth, will be sound in his philosophy and ethic. If it is too much to think of philosophy as a formal inclusion in the curriculum, it is not beyond hope that students and young doctors will be encouraged in their *informal* study to examine the total nature of man, of family and of society. With a firm view of what the patient is and what the doctor is, and what one ought to do for the other, the doctor will develop an ethic that is at least as logical as that of a man of science should be. If this were to be so, he would see abortion as a human rights issue before it is moral, religious or medical, and acknowledge the justifica-

tion for a stronger civil law against it. Nevertheless, without a more basic ethic than civil law, doctors are victims to the normative value of that law, although in the matter of abortion there are many who wish to be above even the civil law. Every doctor who subscribes to the view that abortion should be a matter between a woman and her doctor wishes to be above the law, wishes to be a tyrant with the unborn child as his slave. And if he has not been able to prevail with the view that there should be no law, he objects that he cannot work under the law which exists because it is unintelligible. In America, judges struck down laws because they were unconstitutionally vague. In New Zealand, doctors strike them down because they are too precise, and the law having been changed, many doctors, nurses and parents cease to see harm in abortion in particular circumstances, and soon cease to see harm in it in any circumstances. Numbers escalate, hearts harden, minds deaden and the plague spreads. It has happened everywhere the law has been changed. The law teaches. What was unacceptable becomes acceptable. It is because of this normative and formative factor in law that the Society for Protection of the Unborn Child, the principal body in New Zealand working against abortion in the political field, has in the face of many setbacks, maintained a campaign for restriction in the law even though its members know that the final answer to the problem does not lie in the law.

I have mentioned the modicum of ethical injection into our own medical curriculum and, if time permitted, would like to mention the very real contribution made in the same area by the Guild of St. Luke and Sts. Cosmas and Damian. I have referred to the Society for Protection of the Unborn Child, which in our own country and, I am sure, in others, has an educational as well as a political task. Before concluding I wish to refer to the other body with which I am personally associated, whose task is largely ethical education — this Federation of Doctors Who Respect Human Life. Paradoxical as that name is, it has been forced upon us, and we have assembled here for a task which is supremely educational. First, we increase our own learning from one another; then we take the message to our colleagues to make them aware in every milieu we enter of the enormity that is abortion. Experience has shown that this is not an easy task for we are combatting not only the aggressive doctor determined to kill the child if he thinks it necessary (or in many cases simply if the child's mother does), but we are also contending with many doctors not actively involved in abortion who yet refrain, for reasons of distaste for publicity or controversy, from positive statements on the issue, and others who, although they wish to have no part in abortion feel that their belief in freedom of conscience prevents them from taking any stance against those who do believe it proper, even on social indications. One of our most difficult tasks is to mobilize this silent opinion and direct it against further participation in abortion by doctors. In the areas

where abortion thrives, medical skills and facilities are already high; the change required is an ethical one. Peguy said: "The revolution will be moral or it will not happen." We are skirting the issues if we do not face the fact that they are basically moral, and are not going to be solved at a professional level until enough doctors have had their change of heart. It is my sincere wish that the events of this meeting will lead many colleagues to abandon their neutrality and adopt the cause of the Doctors Who Respect Human Life.

What I have been saying is that man, because he is possessed of knowledge and choice, must work by an ethic. Whatever his calling, he will have a standard, good or bad, by which he measures his contribution. Medical men, dealing intimately and powerfully with the lives of other men need, and many pride themselves on having, a high ethical standard governed by the good of the patients they serve. At the same time, the mores of doctors will reflect those of the community from which they come. When these are based on science and economics alone, doctors may come to make decisions in terms of cost/benefit and quality of life assessed in a rather restricted way. Standards may even change so much that doctors will surrender professional judgment to patient or group pressure, or succumb to financial inducement to carry out for payment by the state, procedures like abortion for which they would once have been forbidden to practice. Changes of this nature lead us to see the re-establishment of ethical principles based on absolute truth and absolute values as a great need facing the profession today. It is with the nature of the patient as man and the doctor as man that the ethic of the profession must begin. This may mean adding metaphysics, even theology, to the curriculum, but requires at least that doctors be logically aware of the origin and destiny of man, his importance as an individual and in the community, and along with these a recognition of morality of means as well as of ends.

Total Dignity, Right to Life Basic

Professional medicine begins with the right of every patient, no matter how old or how small, how healthy or how frail, to live out his time. Total dignity of the human person and an unassailable right to life are basic to the relationship. Experience has shown that departure from these leads to the varying degrees of deception and violence which we have seen reflected in some aspects of modern medicine, especially in relation to abortion.

It is the real task of every doctor to use what art and compassion he has to restore, repair or enhance the function of the sick man, to assist the operation of the design inherent in his structure and nature. He uses science to this end, but the advance of physical science cannot be

the end for man as patient, nor is an experiment or procedure to be done simply because it can be done. Science has brought much that is diagnostic and therapeutic, but there is anomaly — paradox — in the selectivity with which knowledge can be applied sometimes for life, sometimes against life.

The work of some doctors for the individual patient is complemented by the work of others for communities and populations. In these areas, the lives of individuals are also sacrosanct, and no doctor is carrying out true professional work who attacks individual lives allegedly for the social good. The community behaves paradoxically when it makes demands on doctors to dispose of some members in the interest of other members. Especially is this so when the same community uses its other resources in a fickle, erratic or harmful manner.

While there are undoubtedly men of ill will who would influence or compel the profession to participate in sterilization, abortion and euthanasia programs, there are many doctors of good will who are not aware of the dangers to the profession or the community in the activities cited. It is the task of doctors who respect human life (how paradoxical that doctors should establish a group with that name) to work principally within the profession to maintain their own standards of clinical and technical excellence and ethical rectitude; to convince their colleagues of the disaster course that many have adopted in error; to teach students and nurses by precept and example, also the general public and agents of the media, that medicine has little meaning or enduring value without an ethic. Such an ethic must be based on the truth about men which comes from philosophy as well as from science, for basic to any problem is the nature of patient and doctor along with obligations and the rights of both.
