MEDICINE IN CONTEMPORARY SOCIETY

Edited by Peter Byrne

King's College Studies 1986-7

ing Edward's Hospital Fund for London

MEDICINE IN CONTEMPORARY SOCIETY

This, the second volume of King's College Studies in medical law and ethics, explores a wide range of contemporary ethical and legal issues in medical practice. Opening chapters cover problems in medical research (particularly in relation to new legislation on the use of animals), legal issues concerning confidentiality and minors, public ways of determining the competence of doctors and the future implications of malpractice litigation. Matters connected with malpractice are discussed from another angle by the director of Action for the Victims of Medical Accidents. The first volume's concern with IVF and associated matters is pursued further. A distinguished philosopher writes on the moral status of the conceptus and a leading practitioner reviews IVF, its procedures and prospects. Lord Scarman contributes a chapter on the implications of the Sidaway and Gillick judgments for medicine's relation to the law. A further chapter offers a review of the nature of child abuse and the role of medical practitioners who deal with abused children. The collection ends with a trenchant statement by Wendy Savage on the position of women in medicine.

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CONTENTS

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PREFACE

This second volume of King's College studies in medical law and ethics has been compiled in the same way as the first – from public lectures given at King's in the Spring of 1986 and from specially commissioned papers.

The content of the volume displays the continued importance and vitality of some of the issues discussed in its predecessor. The Gillick and Sidaway judgments and the evolution of the doctor–patient relationship are commented on again – we hope in interesting ways which will bring out the changing role of the law in relation to medical practice and the growth of public expectations of doctors. Assisted reproduction and the status of embryonic life still occupy professional and public attention. A lucid account of the issues of practice by a leading IVF specialist is offered here, complemented by the equally clear presentation of the fundamental ethical problems surrounding the status of the conceptus from Anthony Kenny. We hope these chapters will help the debate to attain greater standards of clarity and relevance.

New issues have also come to the forefront within the past year. Medical research, particularly in relation to animal subjects is one such and a lengthy treatment of this topic has accordingly been included. The problem of child abuse (and its management by social workers and health care professionals) has been continually in the news. Eileen Vizard's chapter is intended to offer a summary of the various approaches to the nature of child abuse, approaches which in turn suggest different ways of tackling this problem. Much discussion in medical ethics during 1986 centred on the case of Wendy Savage and her appearance before a public tribunal to answer allegations of incompetence. In public debate the narrower issues of Mrs Savage's case became connected with much wider ones:

the nature of child birth in the United Kingdom, 'high-tech' versus 'low-tech' medicine and so on. Ian Kennedy covers some of the problems arising out of the Savage tribunal in his chapter, while Mrs Savage herself contributes a challenging essay on one of the important underlying issues: the role of women in medicine.

The Directors of the Centre of Medical Law and Ethics hope that this volume will play its part in informing and stimulating public debate on all these important issues. I must emphasise that views expressed by the contributors are their own and are not to be attributed to the Centre as such.

Peter Byrne

REVIEW OF THE YEAR
1. ISSUES IN THE ETHICS OF MEDICAL RESEARCH

Peter Byrne

My review of the year focuses on issues in medical ethics. My colleague, Ian Kennedy, has been allotted the task of reviewing issues in medical law. I have chosen to comment on a range of issues which reflect public concern on the treatment of the subjects of medical research. The passage through Parliament of the Animals (Scientific Procedures) Act crystallised debate on the use of animals in medical research. The well-publicised activities of animal liberationists have also ensured that this topic is continually in the news. These activities, and the sentiments that lie behind them, present the picture of a hitherto accepted part of medical science as positively evil. This should and does give us cause for concern and reflection.

The use of child subjects in medical research has also been the subject of debate in medical ethics. This is largely due to the publication of the Institute of Medical Ethics's (IME) report *Medical Research with Children: Ethics, Law and Practice*.[1] The issues raised by that report will be considered first, for it seems best to approach the moral questions involved in the use of animals in medical research after first considering the principles which must govern the use of human subjects in research.

The ethics of medical research on children and animals raise quite peculiar problems because of the lack of any clear applicability of the enabling condition of consent by the subject of research in either case. Since the ethics of using child subjects in medical research are extensively covered in the IME report already referred to, I shall give greater space here to discussing the ethics of the use of animals, and in particular to exploring how far the recommendations of the new legislation can be ethically justified.

The IME report is surely correct in suggesting that the definition of 'research', and thus the demarcation of research from therapy, must be dependent on the intention that informs acts of medical research. An act of research is one which is not intended to directly benefit its subject by way of cure, treatment or compensation, but is intended to add to the stock of knowledge in medical science. An act of therapy is designed to benefit its subject through cure and so on. The IME working group is also correct in drawing from the link with intentions the lesson that many medical procedures may be both acts of research and therapy. Once we accept the obvious fact that acts may be informed by intentions of both sorts we must recognise that acts of research and therapy form overlapping classes. Many acts of research can be justified by their therapeutic intent. A procedure can be justified through its therapeutic intent if it is performed in the reasonable expectation that it will be of overall benefit to the subject of the procedure. There is a simple and direct utilitarian justification of the risks, pains and distress such acts may bring.

Even procedures which provide a direct, overall benefit to the subject must also be buttressed by the consent of that subject. Acts which are correctly judged to benefit a person's health will bring with them a countervailing dimension of harm if they violate that person's existence as an autonomous being. The relationship between these elements in the justification of the risks and discomforts therapeutic medical procedures may bring is a complex one. They may always be jointly sufficient to make an act of medical treatment licit, but they are not always jointly necessary for licit medical treatment. In cases of accident or emergency, explicit consent may properly be foregone. With doubtful or experimental cures no sure expectation of overall benefit may be present and consent may be judged enough to proceed. In general, where the research intent predominates in a medical procedure, or where it exists as the only intent behind the action, voluntary consent will have to operate as the sole justifying condition as far as the subject of research is concerned. But it will not always be sufficient of itself. There are some things which are wrong for a patient or research subject to consent to and wrong for a doctor or researcher to do even with the patient's or subject's consent. Thus most will agree that it is wrong for a healthy volunteer to give away a vital organ or limb and consent will be a slim justification for a doctor if he killed or maimed a subject in this way.

Direct utilitarian justification for the expected good of the subject does not happen in non-therapeutic research, for where there is no therapeutic intent towards the subject in a research procedure no good to the subject is intended. In licit medical research on human subjects 'a good to others' proportional to the risk or discomfort suffered by the subject will be intended. This good may be found in the development of a treatment or cure for an illness suffered by others, or in the significant advance of the stock of biological knowledge on which the general progress of medical science depends. Non-therapeutic research involves using one person as a means to benefit others. This may only be done through the will of the subject. To harm, or even risk harm, to one person for the sake of others cannot be licit without the consent of that person. To think or act otherwise is to risk using one person merely as a means to the ends of another.

This takes us back to a much favoured and repeated injunction in normative moral philosophy which is derived from the writings of Kant: always treat humanity, whether in one's own person or in another, as an end in itself.[2] Philosophers puzzle over the meaning and correctness of these claims about not treating others as means. For we do of course use others as the means to gaining our ends. We rely on the work, and even the willingness to risk life and health, of other people as part of the background to our own pursuit of happiness. Kant does not deny that we rely on others' services and make use of their work in our own lives; his underlying contention is that this is only proper if we do not deny their autonomy in so doing. To see others as autonomous beings is to see them as creatures who have plans of life, goals and schemes of happiness of their own. It is to see them as beings with interests of their own. (This is a richer sense of 'interests' than that perhaps used by animal rights theorists – as we shall see below.) 'Using others' or 'treating someone merely as a means to our ends' can then be equated with relying on their services or work in a way which hinders their capacity to reflect on and pursue their own interests. In this way, treating a person as an end takes us back to the need to proceed via his consent.

It is arguable, therefore, that the full force of the contrast between treating someone as an end and using him merely as a means only exists where the person is, or is destined to be, an autonomous being. In that case we can act in a way which respects or which violates that person's capacity to pursue his own interests. Reference to consent and to the distinction between treating another merely as a means and as an end seems to bring in a quite different ground for the appraisal of the licitness of medical or research procedures from that of utility. It is appropriate to call this apparently separate dimension of appraisal that of 'justice', for respecting another as an end in himself is connected with rendering what is owing and due to that person as the unique individual he is (through the link of respecting him as a centre of autonomous will with interests of his own). It is therefore tempting to conclude that this extra dimension of the justice of what we do is only in place where we are considering how to treat persons (that is, beings who have or are capable of autonomy).[3]

If what has been written so far about the ethical basis of non-therapeutic research is correct then it becomes easy to see the attractiveness of a conclusion about non-therapeutic research on children made famous by Paul Ramsey's classic discussion in *The Patient as Person*[4], namely that such research is never morally licit. In the case of one too young to give a proper, reasoned consent to undergo risks, pains and distress for the sake of others, the only route through which using one person for the service of another can be validated – the person's own consent – is lacking. Anyone influenced by this line of reasoning will be alarmed by two aspects of *Medical Research with Children*. The IME report makes it plain that non-therapeutic research on children does go on and endorses such research as licit, in certain circumstances. The report's endorsement of a parent's or guardian's ability to agree to let his child be used for non-therapeutic research is carefully limited to those research procedures which are not against the interests of the child.[5] This means that proxy consent may be given on behalf of the child only if the procedure poses no more than a minimal risk to the child's health or life. Part of the report's general aim is to promote a greater precision in the weighing of risks and benefits in research, and to this end it offers numerical equivalents of its three basic categories of risk to experimental subjects (minimal, minor increase over minimal, and greater than minor increase over minimal). The numerical expression of minimal risk given is as follows:

risk of death less than one per million;
risk of major complication less than ten per million;
risk of minor complication less than one per thousand.[6]

The implication of the report's recommendations is that, though by definition subjecting a minor to a non-therapeutic research procedure will not directly benefit him, risks of mortality and morbidity of this order are so low that undergoing the procedure will not constitute harm to the child. The risks may, therefore, be outweighed by the good they could bring to others.

It is surely right to pause and question both the practice implicitly revealed in the IME report and its endorsement of it. Even the minimal risks of such research procedures are unnecessary from the point of view of the child subjects undergoing those risks. This must be the case if the procedures cannot be justified by any therapeutic intent towards the child. But how could a parent rightly subject his child to any degree of unnecessary risk? To do this might appear to be making the child undergo avoidable harm. If there is an answer to these doubts it must lie in the general account to be given of the ethical basis of a parent giving proxy consent on behalf of his children. Here the report appears to create difficulties for itself, for in its account of the legal background to proxy consent to medical treatment it rejects any notion that a parent has rights over the child in the manner in which he might have rights over an item of property. It suggests a reading of the law which gives a parent rights to control a child's life insofar as these rights are necessary to oversee the child's own welfare. Its favoured image is that of the parent as the 'trustee' of the child's interests. His trusteeship is compatible with the child's future as an autonomous being, because it should properly be exercised so as to bring that autonomy into fruition.[7] This way of viewing the matter makes it plain that the parent has the right to grant proxy consent to acts justified by a therapeutic intent towards his child. The child's health is a precondition of its growth into an autonomous being, so it is in the interests of his autonomy that illness be combated. Moreover, autonomous human beings can reasonably be presumed to have certain generic interests in common, the satisfaction of which is normally a precondition of the exercise of autonomy in adult life. A generic interest in the full possession of the bodily organs and limbs could be mentioned in this regard. The child's mature wishes as an autonomous agent may again be reasonably anticipated if such interests are threatened in childhood.

This brief analysis is enough to show how the condition of consent to medical treatment can be satisfied in a real sense in the case of children deemed to be too immature to give a valid consent to treatment in their own person, but it throws into greater relief the question of how a parent could properly give proxy consent to his child to undergo a non-therapeutic research procedure even if it involves only minimal risk to the child. According to the analysis of proxy consent proposed, consent in such a case could be licit only if one of two conditions were satisfied: undergoing the procedure was necessary for the child's development into an adult, autonomous being; or submitting to the procedure could be seen to satisfy one of the generic interests of autonomous human agents. The first condition will not be met if the procedure offers no therapeutic benefit to the child subject. The second condition appears equally incapable of being satisfied, for it is implausible to suggest that adult human beings commonly have an interest in volunteering to undergo unnecessary risks (and/or discomfort) for the sake of benefitting medical research.

There appears to be a gap in the arguments of the IME report which must be filled if one aspect of current practice in medical research is to be justified. Considerations to meet this need can be offered if the obligations arising out of the relation between parent and child are construed in a certain way. We have seen that the IME report uses the notion of trusteeship to sum up the pattern of mutual obligations and rights that arise out of the parent–child relationship and, in part, help to define it. It is an important fact about these reciprocal obligations that they cannot be exercised and enjoyed without a supporting social context. Without the supporting institutions and aids of society this relationship of trusteeship could not be adequately maintained. It is not a relationship which isolates its parties from the community, but which ties them to it. From within the relationship there spring obligations to the society which supports it. The means of combating illness and disease offered by medical science are among the most important of the aids to the satisfactory fulfilling of the trustee relationship between parent and child provided by society. It can be argued, therefore, that from within the parent–child relationship there emerges an obligation to assist medical science in its continued efforts to improve this care and help to the relationship, which is after all the beneficiary of past acts of medical research. This obligation to help in the progress of medicine is not overriding in all cases and should certainly not be acted upon if to do so is incompatible with fulfilling the obligations that arise out of the trustee relation itself (which it surely would be if to assist research was to make the child undergo more than minimal risk of substantive harm). But the obligation can be strong enough for a parent to justifiably submit the child to minimal risk for the sake of it.

The analysis of the nature of proxy consent in *Medical Research with Children*, and my short expansion of it, reveal the importance of this notion in the proper conduct of research on children. Since what may be at stake in submitting the child to a research procedure is his interests as a future being capable of autonomous thought and action, some consideration needs to be given to those interests before research is consented to. And this consideration obviously needs to be provided by someone who is specifically charged with care of those interests and who is independent of those who wish to conduct the research. With this in mind two facts about the conduct of medical research in England and Wales using child subjects are bound to appear disturbing. The IME report reveals that not all ethics research committees *insist* on parental consent before research is undertaken on children and that not all those conducting or proposing research on children seek informed consent from parents.[8]

The discussion of the ethics of medical experiments offered so far indicates under what circumstances they can proceed without incurring the charge of using one being merely as the means to the good of others. This charge can be avoided where consent or something that may properly substitute for it is an essential part of the practice of medical research on human subjects. This way of escaping the charge has no way of being met in the case of the use of animals in medical research, or none that is at all obvious. Leaving aside claims that may be made on behalf of higher primates, animals are not autonomous beings nor are they destined to become autonomous. As sentient creatures, the thing of clearest moral relevance affected by their use as research subjects is their capacity to feel pleasure and pain. Some moralists argue that this is sufficient to conclude that animals have interests which can be respected or violated in humanity's treatment of them, a point that will be examined below. If this is accepted it might appear to enable something analogous to proxy consent to be exercised on behalf of an animal used in research, as when it is decided that it is proper to subject an animal to a procedure that involves minimal discomfort or risk of bodily harm and thus is not against the animal's interests. But even granted the assumption about interests, this would not really be analogous to proxy consent, for it would not be a matter of fostering the future development of autonomous existence or of furthering the generic interests autonomous beings can be presumed to have. It is also plain that many medical experiments on animals are against the 'interests' of their animal subjects. The suggested analogy to the consent requirement is thus likely to leave many experimental procedures deemed vital to the progress of medical science as illicit.

If we think the notion of animal interests has the same sense as that of human interests, and that the interests of animals have the same weight as the interests of human beings, then we would reach a radical and condemnatory conclusion on much medical research using animal subjects. This conclusion is happily drawn by increasingly vocal, and occasionally violent, groups who speak of 'animal liberation' and 'animal rights' in much the same way as radical defenders of abused ethnic minorities in human communities have spoken. What is important for our purposes is that this way of approaching the ethics of medical research on animals receives apparent support from recent philosophical accounts of the status of animals in relation to man. A number of things are distinctive in these philosophical accounts and the radical critique of the use of animals in research they engender. One is the extension of the notion of rights to animals, illustrated in this quotation from James Rachels: 'The right not to be tortured, then, is shared by all animals that suffer pain; it is not a distinctively human right at all'.[9] Another is the coinage of the term 'speciesism' to denote something analogous to racism: the irrational prejudice which falsely makes mere membership of a certain kind a reason for treating some better than others, even though there are no morally relevant differences between those who belong to the favoured kind and those who do not. With the use of 'speciesism' naturally comes an extension of the idea of equality to animals, as these remarks of Peter Singer show:

> All animals are equal ... No matter what the nature of the being, the principle of equality requires that its suffering be counted equally with the like suffering ... of any other being.[10]

A final distinctive feature of the philosophical case for 'animal liberation' is the manner in which its various components are grounded in recent writings upon some form of philosophical utilitarianism. This is important because it promises to remove radical concern about man's treatment of animals from dependence on philosophical or religious outlooks that are held by few and difficult to recommend and prove to all who count themselves as morally concerned. At its simplest, utilitarianism is the idea that an act is right if it achieves the maximum balance of pleasure over pain (or the maximum satisfaction of preferences) amongst those affected by it. It can plausibly be represented as the minimal basis of any form of moral reasoning, since to think morally is to leave egoistic considerations behind and to reflect on the consequences of our conduct for the interests of other people. This is how Singer represents it in his *Practical Ethics*.[11] He maintains that, if we think about the consequences of our conduct for the interests of others, we must take into account its effect on all sentient creatures, since as sentient they have pleasures and pains which can be affected by what we do. So we reach the conclusion that the minimal basis of morality rules out stopping at the boundaries of our own species (that is, 'speciesism') and demands the principle of the equal treatment of all animals (human and non-human) that Singer endorses.

Utilitarianism, which dominates much English-speaking moral philosophy, combined with the equally strong stress on rights in contemporary ethical theory have served to give radical concern for animal welfare a new basis, and have appeared to some to show the wrongness of using animals in medical research once and for all. I shall offer some comments on the new attack on 'speciesism' in relation to contemporary practice in the use of animals in medical research. Two preliminary points need to be made before I begin this task. It would be wrong, in the first place, to imply that the only contemporary philosophical defences of a radical approach to animal welfare are utilitarian.[12] I can only consider some of the arguments offered on these issues. It would also be wrong to suggest that someone like Singer, who has done much to popularise such coinages as 'animal liberation' and 'speciesism', does not see the limitations of utilitarianism in defending the notion of animal rights. Despite the fact that Singer's work is used by animal liberationists to justify their campaigns, Singer himself says that there are no 'absolute rights' which forbid the use of animals in medical research. Some experimental procedures on animals for the sake of human good may be justified in his view.[13]

For the foreseeable future the practice of using animals in medical research will be defined by the Animals (Scientific Procedures) Act 1986 which received royal assent on 20 May 1986, replacing legislation that was in place for 110 years. The Act covers laboratory experiments with animals for purposes other than for medical research but I shall concentrate on its implications for the ethics and conduct of medical research. One of the major differences between the old legislation and the new lies in the dual system of licensing that the 1986 Act establishes. This requires not merely that the researcher has a general licence to conduct experiments using animal subjects, but also a licence for any specific project he wishes to undertake. It is a condition of gaining this second licence that the researcher establishes the necessity of using live animals for the research he intends. The methods he is to use must be approved and the pain, if any, involved must be justified by the value of the experiment. The Act contains other conditions about the inspection of premises in which research with animals takes place and is supplemented by a non-statutory code of guidance issued by the Home Office. This contains the important provision that beyond certain bands of pain an animal must be humanely killed.

The new legislation has met with broad approval from what we might call 'middle ground' organisations concerned with animal welfare. For example, the Fund for the Replacement of Animals in Medical Experiments welcomed it as an important step forward in reducing the number of animals used in research and replacing animals wherever possible. (It should be noted, however, that the RSPCA was critical of some aspects of the legislation in draft, wishing specifically to see some of the humane provisions in the code of guidance included in the Act itself.) But the 1986 Act has not moved those who wish to see the total abolition of the use of animals in medical research. It is not designed to bring about total abolition. It does not answer to the view of the status of animals favoured by radical animal liberationists and such people have promised that the harassment of those individuals and institutions using animals as research subjects will continue. It is important, then, to see if the radical critique of the use of animals in research for human ends can be justified.

There is a coherent view of the moral status of animals in relation to man behind the new legislation and much contemporary practice in the use of animals in research. It is well summed up by Keith Thomas in his description of the attitude which underlay much of the writing that led to the humanitarian legislation on animals of the nineteenth and twentieth centuries:

> Man, it was said, was fully entitled to domesticate animals and to kill them for food and clothing. But he was not to tyrannise or to cause unnecessary suffering. Domestic animals should be allowed food and rest and their deaths should be as painless as possible. Wild animals could be killed if they were needed for food or thought to be harmful. But, although game could be shot and vermin hunted, it was wrong to kill for mere pleasure.[14]

One of Thomas's theological sources encapsulates this attitude in terms of the notion that, while man is the viceroy of creation, his rule is not absolute or tyrannical. Such a view is 'speciesist', insofar as it regards the concerns of human beings as by their nature superior to those of animals, but it does not regard animals as mere means to the attainment of human goals. The welfare of animals has independent weight. It must be taken into account in the pursuit of human satisfactions. It can mitigate or moderate some ways humans would like to treat animals for their own benefit, and exclude yet other ways if the human purposes concerned are too trivial to justify suffering in animals. This attitude deserves to be regarded as the consensus one in our society: it informs legislation in many areas, underlies public approval and support for important voluntary bodies and shapes the personal sentiments of many individuals. It is easy to see how the controlled use of animals for medical research could fit in with it. This consensus view can be contrasted with two positions at opposite ends of the range of opinion on this subject. One would regard the claims of animals as having no moral weight at all. There is philosophical opinion (notably that of Descartes) which denies the significance of animal pain and some scientists seem to side with this in practice. Mary Midgley quotes American researchers as affirming that animals do not count at all and that there are no moral issues in experimenting on animals. At the other end of the spectrum are the radical animal liberationists who, as we have seen, increasingly use philosophical arguments for extending the notion of natural rights and the idea of equality to animals. They then assimilate the suffering caused to animals in medical research procedures to the oppression of disadvantaged or weak human beings. From this assimilation the violent side of animal liberation gets a ready justification.

I take it that, in considering the ethics of the new Act and the current practices in medical research it seeks to regulate, we can dismiss that extreme view ruling out the pain of animals as being of no concern at all. Legislation and current practice need to be tested against two important questions. How well do they conform to what I have called the consensus attitude? Is the radical liberationist's critique of the consensus view and the current standards of society really to be preferred on cogent philosophical grounds? I want to deal with the first of these questions very briefly. It is essentially enquiring after the depth and genuineness of the humanitarian attitude displayed in the new legislation and in research practice. About the new Act we may note that much will depend on the political will of those Home Office ministers who oversee its working. It will be they who will decide upon the constitution of the key committees which will establish acceptable levels of pain and weigh the value of intended research against any distress caused. It is naturally too early to judge this matter, but it can be said that the Act embodies the framework for an enhanced humanitarian concern with animal welfare, not least because the idea of the project licence allows, in principle, the suffering of an animal subject to have independent weight against the purposes of the researcher. As for the practice of medical research, it is up to those who engage in it to show that it can proceed within the spirit of the legislation and actively embody a concern for animal welfare while at the same time advancing the state of medical science.

No full answer to the second of my two key questions can be offered here, but I shall attempt a brief survey of some of the more important philosophical points on which the radical view depends. We have seen that the radical critique of the use of animals in medical research functions essentially by transferring the terms used to condemn the use of non-voluntary human subjects in painful or mortal experiments to animals. It regards this transfer as possible on the basis of commonly used moral notions, those depending on a popular appeal to utilitarian considerations or to rights. It is common ground between the radical animal welfarists and the defenders of man's use of animals in medical experiments that these creatures are sentient and that their treatment as experimental subjects frequently inflicts discomfort, pain and even death upon them. The question at issue is what kind of side constraints these facts impose on our interest in prosecuting such research. The liberationist needs to establish the following kind of links from the fact that laboratory experiments can cause pain and death to animal subjects: inflicting pain or death on sentient creatures violates their interests; violating their interests in this way is also violating their moral rights; to violate their rights is to commit an injustice on fellow creatures for the sake of our own good; and so to act is morally indefensible. Let us now raise doubts about the cogency of this line of thought.

We may begin by examining the sense in which animals can have interests, granted that they are sentient creatures and capable of feeling pain. The fact of sentience will certainly not be sufficient to apply 'interests' to animals in the rich sense used earlier in this paper in describing humans as autonomous beings. That sense was related to the fact that human beings typically pursue interests, that is they have long-term plans and goals and their own conceptions of how their lives ought to be led. The fact that a being has interests in this rich sense is not, of course, a ground for concluding that he has rights to the things which accord with his interests. But the general capability of having interests of this sort may be an indirect reason for saying that a being is the kind of thing which enjoys rights as well, for one who could have interests in this rich sense would also be capable of the kinds of thought, reflection and action which would make him a moral agent. The differences to be marked between animals and human beings in this context have been used by R G Frey in his *Interests and Rights: The Case Against Animals.*[15] Frey's case is that the possession of concepts and powers of thought is necessary if we are to ascribe desires and emotions to a creature. Because animals do not use language, in the accepted sense, there is no ground for crediting that they have thought and conception. If they do not have desires and emotions then they cannot have interests in any morally decisive sense of that notion.

Animals certainly do have things which are in their interests even though it appears to be wrong to suppose that they are capable of pursuing or taking an interest in something. It is right to speak of animals having a wellbeing which can be promoted or hindered. This is sufficient to enable us to judge that things are for or against their interests and thus that they have interests. Yet this hardly seems to be a morally decisive sense of 'interests' for, just to give one example, trees can have interests in this sense and no sensible person would think this a sufficient basis for granting rights to trees.

This brief allusion to a complex philosophical debate over the meaning and moral importance of the notion of interests suggests some tentative conclusions for our discussion. 1. The word 'interests' has a wide usage and its precise connotation is not the same in all contexts. 2. In some contexts of use establishing that a being has interests is neither directly nor indirectly a ground for concluding, by itself, that it has rights. 3. It is not clear in talking about animals as having interests what is added to the recognition that they have a wellbeing which may be fostered or hindered or that they are sentient creatures capable of suffering. 4. There is strong reason to doubt that any decisive move to granting animals moral rights has been made through speaking of their having interests.

In the most extensive and best recent survey of the precise import of the notion of a right A R White concludes that it is a fallacy to argue that because a certain class of things, such as animals, is capable or actually has something in its interest, therefore it is capable of having a right.[16] According to White, we can only judge which beings are capable of having rights by reminding ourselves of the implications of speaking the language of rights, which he summarises in the following way:

> A right is something which can be said to be exercised, earned, enjoyed, or given, which can be claimed, demanded, asserted, insisted on, secured, waived, or surrendered; there can be a right to do so and so or have such and such done for one, to be in a certain state, to have a certain feeling or adopt a certain attitude. A right is related to and contrasted with a duty, an obligation, a privilege, a power, a liability. A possible possessor of a right is, therefore, whatever can properly be spoken of in such language; that is, whatever can intelligibly ... be said to exercise, earn, etc a right, to have a right to such logically varied things, to have duties, privileges etc.[17]

White is able to conclude that in the full sense of 'right' only a person can logically have rights, because only to persons can the key terms in the language of rights be applied. White defends himself from the charge that this restriction of rights to persons constitutes 'speciesism'. In saying that only persons can logically have rights, it is not being affirmed that other creatures can be ill-treated or that there are no moral constraints on the way in which persons can treat them.[18] What is being denied is that a peculiar kind of moral constraint applies to our relation with animals.

The idea that the notion of rights deals in a particular moral constraint is increasingly hard to make clear, so widespread has the tendency become to think that if it is wrong to treat a being in a certain way this must be because that thing's rights are being violated. If there were an equivalence in meaning between 'it is wrong to do A to X' and 'to do A to X is to violate X's rights', then we would have a simple argument for ascribing at least some rights to animals, since we could all think of at least some things which it would be wrong to do to animals in some contexts. This widespread tendency to expand the meaning of 'a right' can only succeed in emptying the notion of any precise sense it may once have had. It is not a tendency which the radical animal welfarist should endorse, for he needs the implication of a distinctive moral constraint which comes from the 'discovery' that animals have rights. The consensus view of the use of animals for human ends, such as research, acknowledges some important constraints on the use of animals, but they are not constraints which decisively bar the use of a particular animal for these ends, provided that the general practice in question gives an overall balance of good and that there is proportion and limitation in the use of this particular creature. The specific meaning of 'a right' makes the term refer to those moral permissions or constraints which derive from individuals and what they are entitled to by their nature and circumstances.[19] Rights are ways of signifying entitlements that derive from moral agents and their circumstances. Rights are, therefore, one important way in which we check and limit the means employed to gain ends which may be worthwhile in themselves. Because of the individualism of much modern theoretical and practical thought, two things are noticable in the use of the vocabulary of rights. One is the tendency to give appeal to rights an overwhelming rhetorical force, so that it becomes unthinkable to suppose that rights may be set aside or taken away. The second is the previously noted tendency to borrow the rhetorical force of the language of rights with the result that all moral claims we feel strongly about are rephrased in its terms. The second consequence of individualism needs no further comment. The first must be committed to an element of delusion. For rights are not in general inviolable; they can and do sometimes give way to claims based on other grounds.

The wide appeal of ideas of natural or human rights, and the conviction that these are absolute and imprescriptible, testifies to popular conviction that some of the moral constraints that derive from the entitlements of individuals offer unbreakable limits on the ways in which we seek to pursue our goals. In this respect the force of the appeal to the rights of those likely to be affected by our conduct is similar to the force of the reference to justice as a moral constraint. Ignoring for simplicity's sake certain contemporary ways of thinking about social justice, we think of justice of having a reference to the moral individual, to what is owing and due to him. Justice is not an aggregate good or end, and frequently restrains us in the pursuit of general good. Part of the thrust of the extension of the language of rights to animals is to associate what is considered to be the ill-treatment of animals with the violations of justice involved in setting aside someone's natural rights. If the use of animals in research involved committing injustices towards them, it would be correspondingly difficult to argue that this use could be justified by any general good it secured. Bringing in the notion of equality to appraise our treatment of animals will have a similar effect, since the notion is connected, along with related ones such as fairness, to the requirements of justice. The problem, however, in linking the extension of rights, equality and justice to animals with a utilitarian basis for morals is that utilitarianism is hard pressed to provide a backing for the idea of justice and for the moral importance of what is owing and due to particular individuals. Utilitarianism's fundamental thrust is to make quantifying, aggregating notions supreme in moral reflection, in particular the notions of the maximal balance of pleasure over pain or the maximal satisfaction of preferences. It can appear in some lights to be the last moral outlook of all to choose for grounding the extension of rights to animals, since it faces powerful problems in justifying placing decisive blocks on using some for the sake of others' ends.[20]

As noted above, Singer recognises the difficulties facing attempts to derive moral constraints on the use of animals for beneficient ends. This can be seen if his treatment of the wrongness of killing is examined. Singer describes how, on a simple utilitarian basis, sentient beings are replaceable.[21] At its most naive, a utilitarian outlook regards sentient creatures as vehicles for the existence of pleasurable states. They are not intrinsically valuable; the pleasurable experiences they enjoy are. Killing a sentient creature then becomes wrong insofar as it diminishes the number of such experiences by eliminating a bearer of them. The wrongness of killing could then be avoided simply through replacing the being killed with one which had an equal or better capacity to have these valuable experiences (provided, of course, that the process of killing were painless). The wrongness of killing appears to consist in the fact that it usually leads to the decrease of populations of sentient creatures; remove this consequence by a policy of replenishment and the wrong disappears. The simple utilitarian view is unable to capture the peculiar evil that we feel attaches to the act of murdering a human being, an evil that is present even if the murder is painless and does not diminish the human population. This evil is that of a fundamental act of injustice – a wrong done to the one who is killed. Among the ways in which we might articulate this apprehension of a fundamental injustice is through the notion of autonomy. Murder is the direst attack there can be on the autonomy of our fellow human beings. It is the complete negation of their capacity to value their own lives, to pursue their own interests and to act for themselves. Singer acknowledges that we need to supplement simple utilitarianism with this kind of reflection on the significance of the destruction of self-conscious, rational, autonomous existence to bring out all the evil that killing can entail.[22] But now it may be argued that the killing of animals, even though they are sentient creatures, cannot partake of this degree of evil, since in their case only the simple utilitarian argument is in place. Indeed, the evil of killing animals can be avoided all together if it is painless and if the sentient beings thus eliminated are replaced by new ones. The total amount of pleasure has not been decreased and the total amount of pain has not been increased. In a practice like the use of animals for medical research, where the animals used are part of populations specially bred for the purpose, the requirement of replaceability can be met and killing need not involve the reduction of the total amount of valuable experiences.

Parallel points can be made about the ethics of inflicting pain or distress. In simple utilitarianism the infliction of pain on a sentient creature is an evil because it adversely affects a total or aggregate – the net balance of pleasure and pain (or the net balance of satisfied to unsatisfied preferences). The pains of one sentient creature can in principle be balanced by the pleasures of another and the evil of inflicting pain on one being can thus be removed if compensating good to another results as a consequence. But while this may exhaust the ethics of inflicting pain in the case of animals, it cannot do so for human beings. Involuntary suffering at the hands of another is an instance of injustice where human beings are in question. Pain is the invasion of an individual's being as well as an experience evil in itself. Once again, reference to the notion of autonomy provides one means of explaining where the injustice in question lies. Inflicting pain on another human being is a way in which their capacity to pursue their own interests is reduced. It is a means whereby their existence is taken over by another. It is a denial of their autonomy. It is a wrong done to the individual, which we would not normally think could be compensated by the valuable experiences of another.

Two consequences of our examination of the use of utilitarianism in analysing the moral status of animals immediately suggest themselves. One is that it has not yet yielded the kinds of constraint on the treatment of animals that those who speak of animal rights are seeking. In fact, our examination appears to reveal the very differences in moral status that the castigation of 'speciesism' was supposed to eliminate. The second consequence of the examination of utilitarianism is that there could be a good utilitarian case for the use of animals in medical research. This case would be at its strongest if the current United Kingdom practice of using specially bred animal populations is considered. None of these animals would exist as vehicles for intrinsically valuable experiences without the existence of the institution of medical research.[23] No diminution in the total number of intrinsically valuable experiences need result from the institution if animals killed in it are replaced by new subjects and if, among this total population of well fed, well looked after animals, the pleasurable experiences of animals used in minor, not very painful trials and observations outweigh the pains of others. To this equation can be added the amount of human suffering, disability and death avoided by the use of animals within medical research. Moreover, we have seen that greater significance must be accorded to any human pain avoided when the balance-sheet is drawn up. The suffering involved in human pain can be seen to be greater than in parallel cases in animals because of the wider ramifications of human pain (for example, the damage done to autonomous existence and the richer emotional significance of pain).[24]

It is tempting even after so brief an examination of the relevant arguments to conclude that far from utilitarianism providing a basis for the radical critique of the use of animals in medical research, it leads to an endorsement of the perspective enshrined in the new legislation. There are good utilitarian arguments for the general practice of using animals for the ends of medicine; good arguments for limits on the amount of pain that may be inflicted in particular experiments; and good arguments for seeking to judge likely pain for animal subjects against the worth of the research aim. It would be wrong, however, to leave the impression that matters are so simple. A taste of the additional complexities that must be considered in any final assessment of the use of utilitarianism can be given by looking at two of the grounds Singer offers for thinking that his approach to the moral status of animals should lead to very major inroads into the use of animals for medical research.

Let us call those beings who have the basis for autonomous existence (namely, self-consciousness, rationality and the ability to use concepts) 'persons'. It would obviously be mere prejudice to maintain that no other creatures than human beings could be persons. The abilities behind autonomous existence could be manifested in other biological forms and, in fact, Singer maintains that they are manifested in the biology and behaviour of other creatures on Earth besides members of *homo sapiens*.[25] He mentions other primates and some of the higher mammals, such as whales and dolphins, in this respect. Even cats and dogs are worthy of the benefit of the doubt as to whether they are persons. If Singer is right, then the moral considerations on killing and the infliction of pain that supplement simple utilitarianism apply to these animals, and these considerations would forbid their deaths or pain being used as means to others' good.

The conceptual and empirical issues behind Singer's striking claim are complex. The conceptual issues concern what behavioural criteria need to be satisfied for these abilities to be present, and the empirical issues concern whether they are in fact satisfied by any favoured non-human species. A point of particular importance is whether the possession of linguistic abilities is a necessary condition for the key ones that underlie autonomy. We have already seen that the marking out of human beings by appealing to language use is a bone of contention in the debate about the moral status of animals. It is a key part of R G Frey's case for saying that animals do not have interests. While this and other issues surrounding Singer's claim cannot be settled here[26], one point of substance that tends to favour the general direction of his concern to protect primates and higher mammals must be made. The fact that personhood in human beings is embodied in a particular biological form must be given its due weight. Part of doing that is seeing as significant any close links in biology between human beings and other animals. Affinities and approximations in biological form should lead us to see affinities and approximations in moral status. Taking the biological embodiment of our personhood seriously should then lead us, for example, to seek at least a greater justification and to observe more severe restraints in the use of a chimpanzee in a medical experiment than a mouse. Taking our embodiment seriously will mean that the greater the biological affinity between a creature and us, the greater will be the affinity in what pain means to it and ourselves. These simple reflections inevitably create a dilemma for the scientific researcher, for the biological similarities which should severely limit his use of apes in research procedures may be the very things which make the employment of this type of animal important for scientific purposes. In cases of such dilemma, the humanitarian concerns of medical research will not be worthy of credit unless researchers are prepared to forego knowledge if the cost of gaining it is the infliction of great suffering on animals of this sort. We have in regard to animals having a biological affinity to man, or a degree of biological development close to man's, a matter where the actual workings of the new legislation will enable a clear concern for animal welfare to be demonstrated, if there is sufficient will. This concern could be shown, for example, in the assessment of project licences.

Singer is right in dismissing the notion that being a human is a necessary condition for enjoying personhood. The second major limitation he argues for in medical research using animals arises out of a different, though related, point about personhood. Singer contends that being a human is not a sufficient condition for being a person. In his view there are many human beings who are not persons and to whom the extra-utilitarian constraints on killing and inflicting pain do not apply. Into this category come young infants, the irreversably comatose and certain of the mentally retarded and handicapped. They are human non-persons because they do not actually possess the abilities that lie behind personal, autonomous existence. Singer thinks that the consideration these types of human beings at present enjoy should lead us to extend our concern to many animal non-persons.

In Singer's argument for the extension of restraints on the use of animals his refusal to grant infants the status of persons is not important. Though he, wrongly in my opinion, discounts the potentialities of human infants in this decision, he contends that there are powerful extraneous reasons flowing from the emotional attachments of human adults to their children which provide good utilitarian grounds for not treating infants in the same way we might treat animal non-persons. Singer makes his case instead by fastening on the '... many brain-damaged humans barely surviving in hospital wards and other institutions'.[27] Taking the example of such unfortunates who are orphaned as well, to avoid the complications of hurting other people's feelings, Singer asks why we would bar them from being used in fatal experiments when we would use animal non-persons of similar or greater endowments in such experiments. If we extend our sympathy to the human non-persons we should do so to the animal non-persons. Unless we were moved by the most naked 'speciesism', the result of this appeal to consistency would be a reduction in animal experiments. There is no morally relevant difference, Singer says, between these classes of non-person, and only a morally inadmissable bias in favour of his own kind enables the experimenter to distinguish human non-persons as a special case.

R G Frey has advanced a similar argument about human non-persons, but it is noticeable that he draws an opposite conclusion from it.[28] He suggests that it gives strong grounds, which may be defensible, for extending the range of fatal or painful or disabling medical experiments to human subjects who are mentally handicapped or brain damaged. Frey's use of the argument appears to be more logical than Singer's, for if one is thinking of ways of increasing the net balance of satisfactions (as someone who regards utilitarianism as the fundamental basis of morality will) one will be seeking opportunities to trade present ills for greater, probable goods. The realisation that only species-prejudice has prevented us from doing this in the case of the mentally impaired or damaged should lead such a thinker to revise his treatment of these humans and not his treatment of animals who show a similar low level of self-conscious, rational existence. This may serve to illustrate one of the possible consequences of radical animal welfarism: it can lead to a lowering of the standards by which we treat human beings as much as to a raising of the standards by which we treat animals.

A more direct attack on Singer's argument could question his assumption that only the present possession of the abilities lying behind personhood qualifies a being for that status. Deep metaphysical waters surround that assumption. I shall not explore them here. It is simpler to question the premise that belonging to a kind whose members are characteristically persons, in the philosopher's sense of that term, is not of itself a good reason to treat all humans as if they were persons. Can the fact that all members of the human race belong to the same species really be that morally insignificant to us? We may note in the first place how Singer's argument reveals that 'speciesism' refers to more than one kind of interest in the affinity of all human beings as members of the same group. If we treated membership of *homo sapiens* as a necessary condition for having the status of a person, our thinking *would* imply moral corruption because it would signal a readiness to dismiss the endowments of personhood that another kind of creature might display on the grounds that this being was not of our sort. Morally relevant characteristics of non-human persons, if there are any such beings, would be hidden or covered by us behind membership of a kind. This would be analogous to the moral evil in racism, for there the morally relevant characteristics of human beings which make them all fit for citizenship and the rights it entails are covered and dismissed by the fact of belonging to different ethnic groups. In both cases we have bad reasons for denying the existence of morally relevant endowments. But if we adopt, as we do, the mere fact of someone being a human as a sufficient reason for treating him at least as if he were a person, we are not thereby using difference of group membership as a cloak to hide any other kind's endowments. We are not denying a status to other groups of creatures that their actual capacities deserve. If this is 'speciesism' it is of a different sort, for it is a different use in moral thought of the fact that creatures fall into species. It is a use designed to extend moral concern to beings who would not be thought worthy of it if we did not think species membership as sometimes morally relevant. It is not a use of the species idea that restricts our moral concern to something less extensive than if it had not been introduced at all.

There are other areas of the moral life where membership of a kind is properly allowed to give someone a special concern for a class of people, provided it does not lead to the denial of obligations owed to others. Someone might correctly recognise special obligations to members of his family through the mere fact of common relationship. The fact of family relationship is not a good ground for denying rights demanded by those outside the relationship. It serves to extend the obligations owed by someone after he has acknowledged those owed to those outside the family. It is not a form of discrimination in the pejorative sense of that term. It shows how membership of the same kind can be morally important without leading to a denial of the morally relevant endowments of those outside the group. With membership come relationships which bring with them special obligations. Talk of 'speciesism' now reveals itself to contain a trap. It runs together and dismisses with equal venom two morally different attitudes. To criticise the attitude of using species membership to hide the endowments of non-humans and deny the obligations we owe to them should enhance our treatment of animals. To what extent it does so will depend on the view we take of the extent and meaning of those endowments. To criticise the attitude which takes species membership to be a ground for recognising fundamental obligations to all human beings, a recognition which need not mask whatever obligations we owe to other creatures, will tend to lower our treatment of the fellow members of our kind.

The significance of the facts of relationship between human beings made possible by their common membership of a species has been well documented by Leslie Pickering Francis and Richard Norman in their article 'Some Animals are More Equal than Others'.[29] I shall not repeat their arguments here. Suffice it to say that we should not wish to be persuaded out of the idea that there is no force in the plea 'but he is a human being' when faced with the obligations those whom Singer calls human non-persons impose on us in the way of care and protection. It is in my opinion wholly incorrect to suppose that taking away the force of that plea would in any way lead to a more compassionate treatment of animals. The example of such unfortunates should not be used to cloud the ethics of the use of animals in medical research.

Part of the force of the contentions of radical animal welfarism depends on its appeal to notions of natural right and equality in the discussion of the moral status of animals. This appeal is linked to, and reinforces, the argument we have just considered which claims that the minimal foundation of morality in the form of utilitarianism provides a basis for a radical change in our use of animals for human ends. The notions of natural right and equality are of particular importance in the presentation of the radicals' campaign as a 'liberation movement' and of their analogy between 'speciesism' and racism. Where a powerless group in society is unjustly oppressed by the powerful, appeal to natural right and equality is an important means of advancing its cause and demonstrating the wrongness in its lack of civil rights and economic opportunities. These notions offer ways of extending the area of moral concern to all those worthy of it. This extension is something that radical animal welfarists will present as the essence of moral growth. Mary Midgely describes these notions as '... tools for widening concern' and as necessary for anyone who wants reform.[30] Some brief comments on this aspect of the liberationists case must be offered, for if ideas of natural right and equality did apply to animals in any precise sense then we would be conceding again that the medical researcher stood in a similar relation to his animal subjects as to his human ones.

A preliminary doubt about the transfer of the notion of natural right must arise from our earlier discussion of the scope of the language of rights. We saw then that there was a real point in using this language only about persons. Denying that this language applied to animals was not synonymous with saying that we had no obligations to animals or that they lacked any moral status. Reform of our treatment of animals is no doubt due in certain areas, but it need not be based on applying the notion of natural rights to animals. This is likely to destroy whatever meaning that notion has. Similar preliminary strictures can be made about the appeal to equality in our treatment of animals. From our discussion of Singer's arguments it should be clear that his claim for the recognition of the equality of the interests of those likely to be affected by our acts is really a version of a utilitarian principle: 'one unit of pleasure or pain produced by an act must be counted as equal to any other of similar duration and intensity'. Even if utilitarianism can be presented as the minimal foundation of morality, this principle will not yield a conclusion demanding equality for animals. For we have seen that it does not entail that animals may never be sacrificed for the sake of the good of others. If we wish to justify our concern for the good of a particular creature we have to appeal to non-utilitarian considerations, such as those derived from what is owing to persons, but these turn out to discriminate between many animals and the mass of human beings.[31]

The notions of natural right and equality are vague enough when applied within human life. They have to be given a sense despite the obvious relation between legal rights and divergent customs and traditions throughout the world and the clear differences in endowments among human beings. If any sense can be given to these notions, it will be through reference to the idea of a community. Political equality is a valid idea if it involves the recognition of the basic fitness of all adult human beings for citizenship in a political and economic community. Racism is a denial of this shared fitness on the perverse ground of ethnic origin, coupled with the unfairness of demanding some of the obligations of citizenship without its key benefits. We might give some sense to the idea of natural right by reflecting on the need in any such community to recognise the minimum treatment that citizenship demands, or the minimum obligations that ruler owes to ruled in return for the observance of the duties of citizenship. No doubt a much better job can be made of explaining these vague but powerful ideas, but I question whether any valid, worthwhile attempt can proceed without reference to the explanatory idea of common membership of a community. If so, then the notions of natural right and equality cannot apply to animals in any clear sense at all. They have an essentially human reference because they denote the moral requirements which should structure life within a human community. A consequence of these moral requirements is that the objects of racism be liberated from the restraints of custom and law that prevent them from exercising the full opportunities and respect that membership of such a community should bring. The same could not be said about animals for, although unnecessary and undue cruelty to them is wrong, to act against it is not to liberate animals in at all the same way.[32]

There will always be differences over the moral status of animals and hence over the licitness of research on animals. These differences will arise out of divergent philosophical and religious views of the nature of animal and human existence.

There is no ready means of establishing which of these divergent outlooks is correct and so perhaps the limits of man's use of animals should be something over which reasonable individuals can agree to differ.

There are many ways in which those who have strong personal opinions on the status of animals can express them. They can be properly reflected in an individual's lifestyle, in what he chooses to eat and wear and in how he chooses to earn his living; they can be shown in reasonable attempts to influence public opinion and to engage in shaping future social policy. Strong private views will not licence obstruction and abuse of those who think and act differently. Still less will it justify violence towards them. The social policy of this country, as reflected in legislation and supported by an established moral consensus, allows the use of animals as subjects in medical research for human benefit, provided due bounds and limits are followed in its practice. The moral consensus behind present social policy is something that is represented as sheer prejudice by some writers on animal welfare. In this essay some of the arguments employed to justify this accusation have been considered. Their aim is to show that it is not merely the religious or philosophical outlooks of a few that are in conflict with social policy towards animals in research, but the very foundations of morality and some of the key ideas of liberal, humanist thought that many now take for granted. These arguments seek to show that the consensus behind social policy in the past and in the present is exactly the same as the consensus in earlier states of society that women or ethnic minorities did not deserve full civic rights.

In offering critical comment on the arguments meant to overturn current received opinion I have endeavoured to defend the liberty of those who wish to pursue research using animal subjects within the law. The position my arguments support is analogous in some respects to that outlined with regard to experiments on human embryos in the introduction to the first volume of King's College Studies. Many are moved by strongly held opinions to view embryos as if they were persons and to view embryo research as illicit. But they can claim no justification for thrusting these opinions on the rest of society through the form of law or the direction of research monies whilst social policy, backed by established moral consensus, is against them or at least not clearly in their favour.[33]

Social policy is based on the recognition of an important ethical imperative behind the pursuit of medical research. It is also informed by a concern for the welfare of animals. The legislator is faced with the task of balancing the obviously conflicting values involved here. The conditions laid down for granting project licences in the new Act suggest a resolution which allows independent weight to be given to the animal pain likely in a proposed piece of research and which puts greater emphasis than has hitherto been the case on seeking alternatives to using live animal subjects. Only the operation of the Act by the Home Office and its appointed committees will demonstrate if this desirable resolution to a tension within our values has in fact been achieved.

Notes and references

1 R H Nicholson (ed). Medical research with children: ethics, law and practice. Oxford, Oxford University Press, 1986. (Mention should also be made of the important report of the Royal College of Physicians, Research on healthy volunteers. Journal of the Royal College of Physicians, vol 20, no 4, October 1986, pages 243–257. This appeared too late to be commented on here.)

2 See Foundations of the metaphysics of morals. [Immanuel Kant] translated by L W Beck. Indianapolis, Bobbs-Merril, 1959, pages 46–47.

3 It should be noted that not all defenders of utilitarianism accept that there is a real contrast between justice and utility.

4 Paul Ramsey. The patient as person. New Haven, Yale University Press, 1979, page 14.

5 See 1 above, page 135.

6 See 1 above, page 119.

7 See 1 above, pages 131–133.

8 See 1 above, pages 183–184.

9 Quoted in: Mary Midgely. Animals and why they matter. Athens, Ga, University of Georgia Press, 1983, page 149.

10 Peter Singer. Animal liberation. London, Jonathan Cape, 1976, page 9.

11 Peter Singer. Practical ethics. Cambridge, Cambridge University Press, 1980, pages 12–13.

12 See, for example, S R L Clark. The moral status of animals. Oxford, Oxford University Press, 1977.

13 See 11 above, pages 58–59.

14 Keith Thomas. Man and the natural world. London, Allen Lane, 1983, page 153.

15 R G Frey. Interests and rights: the case against animals. Oxford, Oxford University Press, 1980.

16 A R White. Rights. Oxford, Oxford University Press, 1984, page 80.

17 See 16 above, page 90.

18 See 16 above, page 92.

19 See 16 above, page 174ff.

20 This does not prevent some writers from basing rights upon utilitarianism, L W Sumner being a case in point in his Abortion and moral theory. Princeton, Princeton University Press, 1981.

21 See 11 above, page 100.

22 See 11 above, pages 101–102.

23 This practice is reinforced by the 1986 Act. It lays down that, apart from strictly controlled exceptions, all animals used for research purposes must come from a registered breeding or supplying establishment.

24 See P Devine. The moral basis of vegetarianism. Philosophy, vol 53, no 206, 1978, page 486.

25 See 11 above, pages 92–99.

26 For a full discussion see J Bennett. Rationality. London, Routledge and Kegan Paul, 1964.

27 See 11 above, page 59.

28 See R G Frey. Rights, killing and suffering. Oxford, Blackwell, 1983, pages 115–116.

29 Leslie Pickering Francis and Richard Norman. Some animals are

more equal than others. Philosophy, vol 53, no 206, 1978, pages 507–528.

30 See 9 above, page 66.

31 Equality can have another important sense in these debates – when it refers to the demand to judge all relevant cases alike and to justify discriminating judgments against moral agents or subjects by pointing to relevant differences. It is then equivalent to a normative demand of rationality for consistency in reasoning. I have tried to show how this demand could be fulfilled by those who say that the treatment of human and animal subjects in medical research should be different.

32 See 29 above, page 527.

33 Peter Byrne. A survey of the year: 2. The limits of medical advance. In: Peter Byrne (ed). Rights and wrongs in medicine: King's College studies 1985–6. London, King Edward's Hospital Fund for London, 1986, pages 32–33.

REVIEW OF THE YEAR
2. CONFIDENTIALITY, COMPETENCE AND MALPRACTICE

Ian Kennedy

Gillick and confidentiality

It often seems that one of the last great unanalysed dogmas in medicine is the principle that the confidences of patients must be respected. To listen to some, particularly some doctors, you may think that confidentiality is the most important issue in medical ethics. Some doctors would have you think that it is an absolute principle with no exception, even if at the same time they may also seek to justify their discussing a patient's condition with his family without his knowledge or consent.

In his chapter Lord Scarman makes a brief passing reference to confidentiality. Before the issues he raises are buried again, there may be some value in devoting some time to them here. One of the many consequences of the decision of the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority*[1] is that it allows for such an opportunity. Although it is barely touched upon by the House of Lords, the issue of confidence has attracted more attention than any other since the case was decided. The issue can be stated shortly. Under what circumstances is a doctor bound in law or ethically by the obligation of confidence to a young girl who comes to see him. I use the term obligation of confidence, since this is the form of words traditionally used in the law. Its advantage is that it makes it clear that it is an obligation which is cast upon the doctor. It is, however, more accurately perceived as a duty, since it vests in another a right to claim that it be observed. Given the facts of *Gillick*, I shall confine my analysis to the situation in which the patient is a young girl. I cannot here attempt a more general analysis of confidentiality, though it may be warranted. There may be, of course, a number of points which are of general application.

1. Ethics

There is in the General Medical Council's (GMC) blue pamphlet entitled *Professional Conduct and Discipline*, a section headed 'Professional Confidence'. It was in this section that one of the issues which arose in the *Gillick* case had traditionally been dealt with, namely the circumstances under which a doctor may treat in confidence a young person without the knowledge of her parents. The central issues of the *Gillick* case – capacity, consent and the rights of parents and children – had previously been perceived to be legal issues on which the GMC's 'Blue Book' was best advised to keep quiet. Clearly, such a view is unfounded and ought to be remedied, but we are talking of what was the case.

Traditionally, the GMC's guidance had been that doctors in treating young girls were to observe the rule of professional confidentiality, without offering any detailed analysis of what this may mean. When the Court of Appeal handed down its judgment in *Gillick*[2], the GMC, conscious that ordinarily it ought not to give advice which might be unlawful, revised its guidance. It issued interim guidance advising doctors that they may not give contraceptive advice or treatment to girls below the age of 16 without parental permission. The issue of confidence as between the girl and the doctor could not, therefore, arise.

Once the House of Lord's decision was known, the GMC issued a further revision of its guidance. It advised, so far as is relevant here, that 'if the doctor is satisfied of the child's maturity and ability to understand', and the child refuses to allow a parent or such other person to be told, the doctor must decide, in the patient's best medical interest, whether or not to offer advice or treatment. He should, however, respect the rules of professional confidentiality.

If the doctor is not so satisfied, he may decide to disclose the

> information learned from the consultation; but if he does so he should inform the patient accordingly and his judgment concerning disclosure must always reflect both the patient's best medical interest and the trust the patient places in the doctor.[3]

It is that part of the advice which referred to the incompetent girl which has attracted criticism, most noticeably from the British Medical Association (BMA), whose Secretary, Dr John Havard, condemned it in *The Times* (26 February 1986) and in the *British Medical Journal* (22 February 1986). The adjectives 'confused', 'muddled' and 'woolly' were just some of those used. The view advanced by Dr Havard was, and remains, that even in the case of the incompetent girl, the fact that she had consulted the doctor and, presumably, what he had learned in the process of assessing her competence must be kept secret from others, including her parents, if she so wishes.

If this is intended to be a rule of general application, and it appears to be so, it only has to be stated to be seen to be untenable. If it were valid, it would mean that a girl however young and immature can bind her doctor to secrecy and, thereafter, the doctor must observe this secrecy, on pain of being judged otherwise to have behaved unethically. Imagine that a nine-year-old girl, for example, finds her way to the family doctor's surgery and tells her doctor not to inform her parents but that she would like some of the contraceptive pills which her older girlfriends have, as she is going to play 'husbands and wives' with them that evening. Anyone who seriously argues that the doctor not only *may* not but *must* not tell a soul about this visit is living in fairyland. Of course he may tell others, particularly, in most cases, her parents, whether he thinks she is in danger or just needs a good talking to. Indeed, many would argue that the doctor must tell the parents in such circumstances. The licence or, to some, the duty to tell others arises from the moral obligation of the doctor to put those who are responsible for the girl in a position in which they can properly exercise that responsibility.

Once this argument is conceded, it is clear that there must be some point at which the doctor will ordinarily owe an obligation of confidence to a young girl, but until that point is reached he will not. That point must be whether the girl is competent or not, competent to know her own mind and to reach a decision, for example, to ask the doctor not to tell her parents about the consultation. Indeed, Dr Havard himself seems to have conceded as much in an earlier article on the *Gillick* saga, written after Woolf J's judgment in the first instance. He wrote that 'the experience of other countries suggests that the medical profession may have a hard struggle on its hands to preserve *the right of competent minors* to confidentiality and privacy in medical treatment in the face of parental counter-claim' (emphasis added).[4]

This commonsense result can also be reached by a more formal analysis if the question is asked: what gives rise to the obligation in the doctor to respect a girl's confidence? As Dr Gillon, the Editor of the *Journal of Medical Ethics*, points out 'medical confidentiality cannot readily be seen as a moral end in itself, but ... as a means to some morally desirable end, whether this is the general welfare, respect for autonomy, or respect for privacy'.[5] For my part, I regard the end as being respect for autonomy. And, once it is understood that the obligation is a contingent one, it becomes clear that it needs a relationship of autonomous persons to come into existence. It follows that no obligation of confidence can be owed to a girl who is incompetent, since she is, by that token, not capable of exercising autonomy. Indeed, to insist that what she says *must* be kept secret, while admitting her incompetence, may be said to violate the principle of respect for autonomy, in that it may result in preventing her from coming to autonomy free from harm. Dr Gillon makes this very point – 'with children the question must always arise: is this patient sufficiently autonomous for the principle of respect for autonomy [the end served by confidentiality] to apply?'[6]

Thus, in my submission, the guidance given by the GMC is entirely in keeping with good medical ethics. Those who criticise it are confused in their understanding both of the nature and meaning of the obligation of confidence. Furthermore, many critics have simply misunderstood what the guidance says. It does not say that a doctor *must* tell her parents when an incompetent girl has been to see him. It merely advises him that he *may* do so, but that he must be prepared to justify doing so, since he must always be conscious of the need not to undermine the trust which patients, including young patients, put in their doctors.

Before leaving the GMC's guidance and the criticism it attracted, it is fair to say that the real basis of the criticism may not rest on ethical analysis but on what some fear may be the consequence of the guidance. Some, especially those involved in family planning services, argue that the effect of the guidance will be that girls who need advice and help will be deterred from seeking it, out of fear that a doctor may judge them to be incompetent and then tell their parents of their visit. I have no doubt that this fear is very real and deeply felt. But, however real it is, it does not serve as a reason for giving any other guidance than that given by the GMC. For, if the girl is incompetent and the doctor judges it proper to tell her parents or others, this, we have seen, is not only proper but desirable. If, however, the girl is not incompetent but the doctor behaves improperly and labels her as such for some idiosyncratic reason of his own, it is not the guidance which is bad. Instead, it is the doctor. Thus, to those who argue that the guidance should be framed to take account of what may, quite improperly, be done the answer must be that it is no part of the GMC's role to write codes of conduct to accommodate bad doctors. Its task is to write good medical ethics. It is the task of all of us to expose those doctors who abuse them.

2. *Law*

Although there may be some doubt as to the formal legal basis of the obligation of confidence owed by a doctor to his patient, there can be little doubt that such an obligation exists.[7] The general law on confidentiality talks variously in terms of binding someone to the obligation, or entrusting someone with secret information.[8] On the specific nature of the obligation owed by a doctor to his patient, the law as yet offers no guidance. What follows, therefore, is necessarily an analysis from first principles. I will seek to take the analysis step by step, as a series of propositions.

a. Since there will not usually be a contract between a young girl and a doctor, it is probable that the obligation of confidence arises, if it arises at all, in equity, through her entrusting him with information about herself, on terms that he will keep it secret. For the girl to be able in law to put the doctor in a position of trust, it must be, therefore, that she has the legal capacity to entrust. Equally, to bind the doctor in law requires the legal capacity to bind. It is submitted, therefore, that for an obligation of confidence to be owed in law by a doctor to his patient, the patient must have the necessary legal capacity to bind the doctor to such an obligation, which in turn must mean the capacity to understand what a relationship of confidentiality entails.

b. The obligation of confidence entails that one party has the right to control the dissemination of whatever information she makes available and that the other party to the obligation has no right to disseminate any information, subject to some major reason of public policy. Thus, the key to confidentiality is the right to control access to information as against third parties.

In the case of a competent young girl, her parents are third parties and she may legally exercise control over the information she gives to the doctor by binding him to secrecy. In the case of an incompetent young girl, her parents can exercise control over information which the doctor learns from her, in that they, on her behalf, can prevent him from disseminating it to third parties, for example, the press. This right to control arises from the more general right which parents have so as to be able to carry out the duties they owe to their children. In this case, the duty is to protect the child's privacy and welfare.

But this is not the important issue here. The question we are concerned with is, as between the incompetent young girl and the doctor, is the parent a third party? Can the incompetent girl purport to exercise a right of control over information given to the doctor so as to bind him not to disclose it to her parents? In my submission, the answer is that she cannot.

c. There are several ways to justify the conclusion just arrived at. The first that it is in the public interest that matters of importance to the welfare of a young child be disclosed to those responsible for the welfare of that child, so as to allow them to carry out their obligations to the child. These, ordinarily, are the parents. The girl is incompetent to exercise any right to control any information. The doctor has no such right, save as regards trivial information which he judges unimportant for the welfare of the child. His exercise of such judgment is, of course, subject to review, whether by an action in negligence at the suit of the child (or parents on her behalf) or by a complaint of unethical conduct, should the welfare of the child be harmed as a consequence of an improper exercise of judgment.

This would, I submit, be the mode of analysis which a court would follow if an incompetent young girl sought through a friend to enjoin a doctor from telling her parents certain information. An alternative legal analysis may be that while it is the young girl who is the patient, it is the parent also who enters into the legal relationship with the doctor, and it is only the parent through whom duties owed to the child can be fulfilled. It is the parents who in law may consent to or refuse treatment, who give relevant information for the purposes of taking a history, are legally entitled to information for the purposes of giving consent and to receive instruction for subsequent care of the child. Their entitlement to all of this is a necessary concomitant of their duty to safeguard the welfare of the child. It follows that information imparted to or learned by a doctor, out of the presence of the parent, must be passed on to them if, in the judgment of the doctor, it touches on the welfare of the child and is not trivial.

d. A parent has, however, no claim *in his own right as a parent* to be told information which the doctor has acquired. The right is contingent on his parental duty and is, therefore, exercisable only for such purposes. Thus, if a parent sought an injunction requiring a doctor to disclose certain information on, for example, whether he had treated a young daughter, the court would apply s1 of the Guardianship of Minors Act 1971, which requires the court to make the welfare of the child the paramount consideration when the court has before it a question as to the care and upbringing of a child.

Thus, a *prima facie* right to control information is vested by operation of law and good sense in the doctor, a right he must exercise for the welfare of his young patient and one which means that he will pass on all but trivial information to the parents. This does not mean that the young girl is binding the doctor. It is public policy which is regulating him. And, it follows, that it is equally public policy that a doctor treating an incompetent young girl may in law and ethics (and, at least in ethics, *must* sometimes) disclose information to parents. If he does, he will not be exposed to any action for breach of confidence at the suit of the girl since he owes no legal obligation of confidence to her. If he fails to do so in circumstances in which it is judged that he should, he may be exposed to liability at the suit of the girl if she suffers harm as a consequence of his failure.

In his chapter, Lord Scarman briefly mentions the issue of confidentiality. When the doctor has judged a girl incompetent, 'Is he', Lord Scarman asks, 'under an obligation to tell the parents that the girl has been to see him?'[9] He takes the view that the doctor owes the girl the duty of respecting her confidence such that 'the law would not . . . require the doctor to break confidence'.[10]

In such a brief comment, Lord Scarman obviously did not intend to review the law *in extenso*. As far as the more straightforward question goes, it will be seen that the view I reach entirely accords with that of Lord Scarman. There is no question of the doctor being *required* to tell others, apart from established public policy exceptions, and the law will not oblige him to do so. This is the view both of ethics and of law which I adopt. Lord Scarman does not, however, consider the more difficult question of whether the doctor *may* tell others. I submit that there is nothing in what he says which invalidates the view I have expressed. His use of the words 'duty of respecting confidence' does, however, warrant comment. I have sought to argue that such a duty does not, and should not, arise as between the doctor and the incompetent patient and, with respect, continue to hold this view.

If the analysis proposed is not accepted, there is another way to approach the questions posed which, in fact, leads to the same conclusion. Some may argue that the doctor owes an obligation of confidence by virtue solely of being a doctor and being consulted as such. The obligation arises, the argument goes, from the status of being a doctor. Another way of stating this is to say that, as a matter of good medical ethics and law, a trust is imposed on the doctor to guard the confidences of his patient. The trust arises in law as a matter of public policy. In ethics it arises out of the doctor's duty to respect the patient's autonomy and otherwise to act beneficently. In both cases it arises without the need for any action by the patient. The competent patient can, of course, vary its terms. The incompetent patient cannot and thus the obligation is owed to him automatically on his becoming a patient.

But, whether arising in law or ethics, the obligation is not without limits. In law, it is subject to other public policies which may have greater weight in a particular case. In ethics, it is subject to a determination of the proper limits of respect for autonomy. And these limits are of great significance in the case of the incompetent child. As a matter of law, there must be circumstances in which a doctor owes a duty to those who must care for the welfare of a child to inform them of the child's visit or request for assistance so as to enable them to carry out the duty imposed on them by society. To fail to inform them, whether parents or guardians, in such a case would expose the doctor to possible liability if harm should come to the child.

As a matter of ethics, the doctor must seek to safeguard the interests of the incompetent child, if the specific circumstances of incompetence are such as to expose the child to danger. Such may be the case if the incompetent child were seeking contraception or even advice about it. In such a case, the child's interests may well be protected only if her parent or guardian were informed. Incompetent to act autonomously herself, the doctor must ensure that her capacity ultimately to come to autonomy free from avoidable harm is protected to the greatest extent possible. The doctor must judge whether such protection is best achieved by informing the child's parents. If, in good faith, he judges this to be so, he would not on this analysis be behaving unethically.

This, then, is an alternative argument, put somewhat briefly. I prefer the argument advanced earlier, but am satisfied that whichever approach is adopted, it provides a valid justification for the view that a doctor may, if he judges it to be warranted, inform a parent or guardian that a young and incompetent child has been to see him.

The Savage Inquiry

Of course, *Gillick* was not the only event of medico-legal significance in the year, although it and its aftermath certainly caused the loudest noise. The inquiry set up to investigate the competence of Dr Wendy Savage became another *cause célèbre*. It was alleged that Dr Savage, a consultant in obstetrics and gynaecology at the London Hospital, in her management of five cases had fallen so far below the standard of proper professional conduct as to warrant her dismissal for incompetence. She was suspended by her employer, the district health authority, and an inquiry was set up pursuant to the government circular regulating enquiries into competence, HM61(112). The inquiry was conducted in public before a tribunal consisting of a legally qualified chairman and two doctors who are specialists in obstetrics and gynaecology. The district health authority was represented by leading counsel, Dr Savage had her lawyers and there were also lawyers who held watching briefs for other interested parties. The inquiry began on 3 February 1986 and lasted for six weeks. The report of the inquiry appeared some four months later and exonerated Dr Savage of any charge of incompetence.

The importance of the Savage inquiry for the legal commentator lies not only in the particular allegations made.[11] Of equal or greater importance are the questions it raises about institutional mechanisms and their purpose and use. One issue which dogged the inquiry and which remains unresolved even after the report has been issued and Dr Savage exonerated, is whether resort to HM61(112) was in fact appropriate. There seemed, to the observer at least, four possible reasons which could have explained, together or separately, the circumstances leading up to the inquiry and the reason for its being set up. The first was a *prima facie* case that Dr Savage was incompetent. The second was the relative merits of what has come to be called high-technology medicine in obstetrics since, rightly or wrongly, Dr Savage was identified as favouring a less interventionist approach to childbirth than some of her colleagues.[12] The third was the role and rights of women whether as doctors or patients. The fourth was a clash of personalities between Dr Savage and her colleagues.

It will be obvious that proceedings under HM61(112) could only have been justified, if at all, for the first of the reasons stated above. The second and third possible reasons are not without importance and arguably it is entirely proper that they be aired before the public so that the public, particularly women, are not only informed but can make their views known in the future.[13] None the less, however important it may be that such a public debate take place, it must be unarguable that the procedure under HM61(112) was neither designed nor intended for this purpose and that a less successful way of conducting a debate than this procedure, with its air of a criminal trial and all that goes with it, would be hard to imagine. As for the fourth reason, clashes of personality which affect the proper functioning of any institution, in particular a public institution, are a matter for those who manage the institution. They are management problems. Obviously, they call for resolution. Equally obviously, they do not call for recourse to proceedings under HM61(112) since no question of professional competence is raised, save perhaps that of the managers.

Many, and I am one, remain convinced that what lay at the heart of the Savage case was in fact the proper management and organisation of a number of highly-trained people who clearly did not see eye to eye. That it was not resolved at a managerial level was in many ways a tragedy. It resulted in great personal hardship for Dr Savage, suspended for some fifteen months with her very competence as a doctor challenged. It meant that patients were denied not only her services but also those of the other doctors who had to spend large amounts of time waiting around and giving evidence. And it meant that a very large amount of money (estimated at more than £250,000) had to be spent on an enquiry at a time when the NHS, particularly in inner London, could least afford even £1 to be spent other than on the care of patients.

Of course, had there been for a moment any real doubt that Dr Savage was incompetent and that the health of patients was in fact being put at risk by her continued practice, such an exercise may have been warranted, although even then it would have been a clumsy and heavy-handed process. But, with all due respect to those who argued otherwise, the evidence relied upon to allege that Dr Savage was incompetent was thin to say the least. It consisted first of a case in which a complaint had been made against Dr Savage by a patient's husband following the death of a baby. Even if one case of mismanagement can in principle amount to incompetence, there was to the objective observer great doubt as to whether the particular case amounted to mismanagement. Indeed, the enquiry found that it did not. As for the other four cases, they were produced after an examination of all cases managed by Dr Savage in the preceding eight years and none of them came up to proof.

In short, the Savage case could be said to have been one in which the necessarily formal machinery established to examine competence, formal since the consequences of a finding adverse to the doctor can be dismissal, was probably put to a use for which it was not intended and for which it was entirely unsuited. That it was so used exposed at least two institutional flaws in the management of the NHS. The first is the fact that doctors may be suspended and prevented from practice by resort to HM61(112) in circumstances in which competence is not the real issue at stake. The second is that no satisfactory mechanism appears to exist to correct weaknesses in personnel management which the general public can readily instigate or operate, even though it is the interests of the public which suffer if such weaknesses are not dealt with.

The need for such a mechanism and the unsatisfactory nature of recourse to HM61(112) can readily be demonstrated by reference to what has happened since the publication of the report which exonerated Dr Savage. So far from clearing the air and settling the issue, the report seemed to change nothing, save to put the district health authority in the position of having to reinstate Dr Savage. Acrimony remained and personal relations between the various doctors appeared in no way to have been affected for the better. There can be no better evidence that the public is not well served when institutional mechanisms are used for purposes for which they were not intended.

Malpractice litigation: crisis? What crisis?

No comment, however brief, on the state of medical law in the mid-80s is complete without some reference to malpractice litigation. Few subjects provoke more florid calls to the barricades to face the horde of disgruntled and (it is hinted) ungrateful patients. Few subjects are debated in which such firm views are advanced on such limited evidence. For, as Simanowitz points out in his chapter, while there is almost daily talk of 'the malpractice crisis' in full swing in the United States of America and about to swamp us here, the evidence necessary to sustain such claims is at best hard to find.

Malpractice litigation is a large and complex subject. As Simanowitz indicates, it goes beyond a mere study of the existing state of the law. It ultimately calls for an analysis of the much wider issue of professional accountability in all its aspects, since suing doctors in court alleging negligence is merely one way of seeking to hold them accountable for their conduct. Any detailed analysis, however, calls for more space than I have here. I will content myself, therefore, with noticing and commenting upon some of the arguments and claims currently being pressed with particular vigour as evidence that a state of crisis is imminent if not already upon us.

1. The first claim is that awards of damages granted by the courts in actions in negligence against doctors are now much higher than in the recent past. This is undoubtedly true as regards the awards at the top of the scale where the patient has suffered catastrophic injury. The Annual Report of the Medical Defence Union for 1986 states that: 'In 1980 the largest claim met by the Union was less than £300,000; 5 years later the courts have awarded sums exceeding £600,000'.[14] Obviously such an increase is far greater than the rate of inflation over the same period. Furthermore, these awards attract considerable publicity. This may, in turn, have caused an increase in the amount of damages awarded in cases of less severity. Indeed, this seems to be the case since, although the information available is limited, it is clear that the rate of increase in money paid out in satisfaction of claims in recent years is considerably greater than the rate of increase in claims made.[15]

If, then, awards in particular types of case, and generally, have increased, the important question to ask is: what significance should be attached to this?

Those who talk the language of crisis appear to attach greatest importance to three factors. Two are interrelated. They are, first, that premiums paid in the past to cover liability have not produced enough revenue to pay for claims now being brought. This is because the premiums levied from doctors five to six years ago were based on what was appropriate to meet future claims on the assumption that any rise in the overall value of such claims would follow the historic pattern of gradual and, more or less, predictable increases. Instead, there was, in relative terms, an explosion in the value of the claims, an explosion which, it is said, could not have been predicted. Had it been predicted, premiums could have been set higher in anticipation. As they were not, the consequence is that the funds available are sorely stretched.

The second and interrelated factor is that, if awards are to continue to increase apace, premiums must be greatly increased. Since in insurance terms the tail wags the dog, the amount of the increase must be such as to provide a fund equal to meeting claims valued not at today's cost but at the inflated costs anticipated in five to six years' time (this being the sort of time it takes before awards in the more serious cases of negligence are made). For that reason the Medical Defence Union declared in 1986 that it was to increase the annual premiums paid by members by approximately 70 per cent from £336 to £576.

It is doubtful whether these two factors in isolation can really be said to amount to evidence of a crisis in malpractice litigation. Awards of damages are increasing generally. And a premium of £576 is not particularly high in the context of professional liability insurance. When, however, the increase in premium is seen in context it could be said to presage a crisis, though it is important to identify whom the crisis threatens. Unlike other professionals, the vast majority of doctors do not earn their income in the market-place. They are paid salaries or according to a capitation system which they cannot readily influence to any great extent. This has enormous significance for insurance. If premiums increase, other professionals can pass on all or a large part of the increase to clients by adjusting their fees. Doctors cannot do so within the NHS: they do not earn fees. For GPs this does not matter at least for the present, since premiums paid to defence societies are recoverable from the state as expenses. Hospital doctors, who are usually the doctors who are sued, must pay the premiums themselves. If awards of damages continue to increase, therefore, the proportion of income required to meet these premiums will also increase. The logic of such an analysis leads to an inevitable conclusion. A point will be reached and, I submit, it will be sooner rather than later, when hospital doctors will regard the level of premiums demanded as unacceptable. And if the premiums are not risk-related, GPs will be paying the same premiums, at which point the state may well be increasingly reluctant to meet the cost of them through expenses.

At that point the compensation system, if unreformed, will collapse, for the simple reason that the defence societies will run out of money. Who will be affected by this? Certainly individual doctors will have been affected by increases in premiums up to a point. But, if we assume this point is when doctors decide enough is enough, we must also assume that the harm they suffer will be relatively limited. Those really affected will be patients who suffer harm through negligence. They will have no redress for their legitimate claims, for the simple reason that there will be no – or insufficient – money to meet the claims.

The conclusion must be, therefore, that the real significance of the two factors so far identified is to signal a crisis, but it is a crisis for patients rather than for doctors and one which in the noise and fury of the medical profession's concern for itself, appears to have passed unnoticed. It provides, however, the strongest argument of all for abandoning the existing system of compensating patients, to the extent that it relies on legal actions for negligence. Simanowitz, however, seems not to accept this conclusion and prefers instead the existing system of claims based on negligence.

I mentioned earlier that there were three factors relied upon to support the language of crisis in the context of increased awards of damages. The first two may indeed provide support, but the crisis if it comes will, as has been seen, affect the citizen more than the profession. The third factor continues the argument by seeking to identify and attack those judged to be responsible for this increase in awards of damages. The crisis exists and is of someone else's making. Those responsible are lawyers. If lawyers were not so persistently seeking to expand the heads of damage under which a patient can bring a claim and to ensure that everything is claimed that can be, awards of damages would not have risen so sharply. Lawyers are being far too clever on behalf of patients is the theme.

While it may be understandable for some, and particularly those such as the Medical Defence Union who are charged with defending the interests of doctors, to look for somewhere to place responsibility and to prefer to place it outside medicine, it is both unreasonable and unfortunate that the target should be lawyers. This is not because lawyers need any special protection from criticism. It is simply because the criticism is wholly misplaced. And not only is it misplaced, it also fosters the somewhat bankrupt but increasingly popular (populist) view that lawyers exist to make doctors' lives miserable and that the world would be a better place without them. Such a view does not, of course, extend to the wholly worthy lawyers who represent and advise doctors. They are exempt as being, presumably, on the side of right.

There are two principal flaws in the argument. The first is that doctors do not have an exclusive claim to a concern for the interests and rights of patients. Lawyers *also* are concerned to uphold and defend patients' rights. In a particular case, a lawyer may differ from a doctor in how he perceives a patient's interests. It should not be presumed that the lawyer is thereby acting in bad faith. Indeed, such a view does no credit to those who hold it. But, more important, the argument is flawed simply because it is not lawyers who decide cases and make awards of damages. Lawyers only argue and advocate a particular approach. And there are lawyers on both sides. It is the court which decides. Thus, unless it is argued that lawyers should not advance arguments for their clients or that courts are party to some sustained campaign against the doctors and their pockets, this particular argument is exposed for the nonsense it is.

2. The second claim made is that the number of cases brought against doctors has risen dramatically in recent years. In the Medical Defence Union's Annual Report, the President talks

of 'a very marked rise in the frequency of claims'[16], while the Treasurer refers to a 'steep rise in the incidence of claims'.[17] The difficulty any commentator encounters is, what do these statements mean? It may appear sensible to ask whether the 'steep rise' amounts, for example, to a 50 per cent, a 150 per cent or a 500 per cent increase in claims. Any answer to this question would, however, be meaningless unless the time scale over which the calculation was made was known together with the number of claims made, against which the rise is being compared.

Unfortunately, there is a complete lack of information on which to base such calculations. For what they undoubtedly consider to be good reasons, the defence societies do not make known the number of claims made, nor the numbers which are settled and contested. If the suspicion of those who have tried to look carefully from outside is anywhere near the truth, the view is that there were around 1000 to 1100 legal claims brought against doctors annually at the beginning of the decade, that is, claims on which legal advice was sought.[18] This does not mean that all of those subsequently proceeded to trial. Indeed a very small proportion went so far, probably no more than 5 per cent.[19] Of those which went to trial, again there was only a small proportion in which the patient was successful, perhaps only as much as 20–25 per cent. And, of those which do not go to trial, it is not possible to know how many were settled and how many were dropped. While it is easy, therefore, to assert that this decade has seen a dramatic rise in the number of claims, the entirely speculative nature of the baseline from which to begin calculation makes such assertions meaningless.

Without perhaps knowing what it means, let us grant, however, that there has been an increase in claims. The significant question must be what explanation there may be for the increase. For those committed to the school of 'doctors under seige' only one reason offers itself. For the rest, there are several others. First, an increase in claims may merely signify that aggrieved patients did not sue in the past even though they had legitimate grounds for complaint. A more educated population exposed to the language of consumerism may simply be asserting itself. Secondly, lawyers may have come increasingly to recognise medical malpractice as a legitimate area of civil rights or human rights law. There are those who talk of lawyers as fostering this area of litigation out of self-interest. I have already suggested that those who make this claim ignore the fact that lawyers as well as doctors may be concerned to protect the interests and rights of patients. That it may set patient against doctor may be regrettable, but in a system which requires this as a necessary prerequisite to obtaining any remedy, the lawyer is forced to do this if all else fails.

A third reason may be that as medicine becomes more technically complicated, particularly in hospital (and, of course, the vast majority of actions concern treatment in hospital), there are more chances that something may go wrong and that it may go wrong through human error or failing. As the mishaps increase, so will the claims. A fourth reason may be a combination of the three already mentioned. What these, and there may be others, demonstrate is that to state that claims have gone up is not necessarily to identify something which is intrinsically a bad thing. Unless the reasons for the increase are known, no conclusion is justified, least of all that there is some sort of legal conspiracy against those who practise medicine.

3. A third claim made is that the medical profession is in the throes of an insurance crisis. As has been seen, subscriptions to the defence societies have increased considerably. But, as premiums for professional negligence go, they are still really quite low and they are not risk-related although this has been mooted (and rejected) in recent years. It may well be that subscriptions will increase further although, as has been suggested, there is a limit to the amount a doctor in the NHS or the state will be prepared to pay. Talk of an insurance crisis is, therefore, unwarranted and seems more like an exercise in hyperbole than any reasoned contribution to the debate.

Indeed, even in the USA where claims abound, awards of damages are sometimes very high and insurance premiums appear huge by comparison, it is unclear whether an insurance crisis exists or has ever existed. For a start, the size of the amount paid in premiums can only be understood if it is seen as a proportion of a doctor's income. And, where there is a market place for medical care, doctors in large part have simply been able to pass on the cost of insurance premiums in the price charged to the patient, such that the proportion of income represented by insurance may not in fact have increased greatly. Furthermore, there exists a quite respectable body of opinion that has it that the so-called malpractice crises of the mid-70s and early 80s were less to do with any increase in litigation or awards of damages than to mismanagement by insurance companies. Insurers plan to cover future claims by accumulating a fund through increasing premiums. Terry, in a fascinating article, explains how the so-called crises may have come about.

> . . . the answer lies in low interest rates. During the late 1970s interest rates were high. Therefore, the insurance industry was able to record very high investment returns on its premiums prior to paying out any claims. High profits generated increased interest in writing policies by insurers to acquire investment income, and hence increased competition between insurers. As has been noted [Report of the Tort Policy Working Group, Feb. 18, 1986], 'These underwriting losses appear to be largely a result of coverage written in the late 1970s and early 1980s which may have been underpriced due to the industry's desire to obtain premium income to invest at the then prevailing high interest rates.' As the market went 'soft', so panic-stricken insurers either pulled out of markets or looked for areas where they could recoup their previous discounts quickly. The result – insurers increased medical malpractice premiums and orchestrated a 'crisis' scenario designed to focus the public's, the health industry's and the legislature's anger upon the lawyers.[20]

4. The next claim, and one which is often repeated, is that an increase in claims is resulting in what is called 'defensive medicine'. This is a problematical notion. It can perhaps be best discussed by separating the legal conceptual issue from the sociological phenomenon.

As a theoretical notion 'defensive medicine' comes close to being nonsense. The argument is that because of the law, as laid down by the courts, doctors are caused to resort to procedures they regard as unnecessary out of fear that if they do not carry them out, they may subsequently be judged to have acted negligently. This, they claim, is both wasteful of resources and may even be harmful to patients. The simple question is whether this is a valid interpretation of the state of the law? The simple answer is that it is not. Negligence by a doctor requires that he should have breached the duty of care he owes by law to his patient. The duty of care is, put generally, to act as a reasonable doctor in the circumstances, that is, to exercise that degree of care and skill which a doctor doing the job in hand would ordinarily be expected to have. The relevant degree of care and skill in cases of medical negligence is *a matter of expert evidence*, that is, it is set by doctors in evidence to the court. A doctor does not act negligently in matters of technical competence if he can show that his conduct is judged reasonable according to a body of informed medical opinion. The legal regulation of doctors is unique in this respect. In all other professions and walks of life, the standard of care by reference to which a person is judged is a matter of law for the court to determine. Expert evidence is relevant but not determinative. In the case of medical care, however, expert evidence *is* determinative of the issue. Thus, the law only ever requires the doctor to act in a way *other reasonable and informed doctors* judge to be proper.

The proposition that the courts or lawyers are setting harmful or unrealistic standards for doctors is, therefore, patently untenable. Doctors set standards and that means legal standards for doctors. It may be, of course, that the standards set by some are hard for others to meet. The professor at the teaching hospital may have unrealistic expectations of the *locum* in the cottage hospital. But this is a matter for doctors to argue among themselves, and before a court if it is deemed relevant. From the point of view of the patient, it may merely reflect the uncontentious proposition that patients are entitled to good medical care and that a doctor should not escape liability if he fails to meet a standard of care which his colleagues say he could and should have met. Nowhere in this analysis is there any requirement that doctors should carry out unnecessary tests. Indeed, to do so is bad medical care. A test is called for in law only if a doctor of reasonable competence in the circumstances would judge it necessary in the patient's medical interests to carry it out.

The sociological phenomenon represented by 'defensive medicine' should not, however, be overlooked. This is that, whatever the theoretical arguments, doctors up and down the country have got it into their heads that the law is 'after them' and, as a consequence, it would be safer to do the unnecessary x–ray than face a possible lawsuit later. What we have on our hands, therefore, is a problem of education, not a malpractice crisis. Sadly, those to whom doctors naturally turn for advice and information, the British Medical Association and the defence societies, seem slow to carry this message. Indeed, it is they who are often in the van of those crying wolf. So busy are they in looking for someone to blame when doctors are held liable in negligence, that they take up the slogan of defensive medicine unembarrassed by its lack of validity. In so doing, of course, so far from serving their members, they do them and the public a major disservice. In particular, lawyers are singled out for blame or criticism, although they are only advocates, or it is 'the law', as some abstract entity, which is criticised. They do not, of course, criticise the judges who decide cases, since judges do not fit the conspiracy theory of hot-heads out for personal gain (lawyers). Nor do they criticise (how could they) their own colleagues who instruct the judges on what good medical practice is in any particular case.[21]

Somehow this unhappy state of affairs must be corrected, for the sake of doctors and patients alike. It will not be until the medical profession examines the evidence impartially. Their advisers have a heavy responsibility here and must discharge their duty to advise and explain with greater concern for the welfare of all than has sometimes been shown in the past. If progress could be made on this front the growing tension between courts and lawyers on the one hand and the medical profession on the other could be eased somewhat before real social damage is done. If to this were added a commitment to encourage doctors to adopt a more helpful attitude when asked to explain matters to patients when things appear to have gone wrong, even greater strides would be made in establishing good doctor–patient relations. No one wants doctors dragged into court or even threatened with legal action. But until doctors learn to explain, to admit errors when appropriate and to apologise, the spectre of increased litigation will edge closer to reality. One obstacle to doctors explaining or apologising is the distinct lack of encouragement to do so which they receive from those who advise them or claim to speak for them.

Conclusion

For the reasons advanced, therefore, claims of a 'malpractice crisis' need the most careful examination, as do some of the alleged consequences of an increase in litigation. Moreover, some at least of the solution lies, as it always has and as has been said so often, in more openness by the doctor in dealing with a patient with a complaint.

What should be done when all preventive measures have failed and a patient decides to take legal action is a separate question. Simanowitz suggests that the existing system of tort litigation is perhaps to be preferred, despite its weaknesses, to any alternative such as a 'no fault' system (by which I assume he means a 'no liability' system) based on the social security system. For my part, I do not agree and have put my views elsewhere.[22] Even if he is right in principle, there is little doubt in my mind that the days of the tort system are numbered for one reason above all others. The reason is money for, as I have argued, there will come a time sooner rather than later when awards of damages will overtake the available funds and doctors within the NHS will be unable (or unwilling) to pay any greater proportion of their salaries by way of premiums to meet the claims. If this is the case, would it not be wiser to be planning an alternative system now?

Notes and references

1 *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402.

2 [1985] 1 All ER 533.

3 General Medical Council. Annual report. March 1986, page 4.

4 John Havard. Medical confidence. Journal of Medical Ethics, vol 11, 1985, pages 8–11.

5 Editorial. Medical confidentiality. Journal of Medical Ethics, vol 10, 1984, pages 3–4.

6 See 5 above, page 4.

7 See *Hunter v Mann* [1974] QB 767.

8 See, generally, F Gurry. Breach of confidence, Oxford, Oxford University Press, 1984.

9 See Lord Scarman's chapter, Law and medical practice, page 138.

10 See Lord Scarman's chapter, Law and medical practice, page 138.

11 For a full discussion, see the Savage Inquiry. For contemporary commentary see, for example, The Times, 9 July 1986 and the Guardian, 9 July 1986. To avoid misunderstanding it should be made clear that counsel for the district health authority in the inquiry was my namesake, Ian Kennedy QC, now Ian Kennedy J.

12 It was sometimes asserted that Dr Savage was opposed to resort to Caesarian sections unless it was absolutely necessary. It is helpful to notice the comparative rate of use:

UK overall	10–11 per cent
Dr Savage	8 per cent
London Hospital generally	12 per cent

13 See, for example, The Times, 5 February 1986.

14 Medical Defence Union. Annual report 1986, page 52. The Times, 21 August 1986 reports an increase from £130,000 in 1977 to £680,000 in 1986.

15 See Report of the Treasurer in Annual report 1986 at 14 above, pages 52 et seq.

16 See 14 above, Annual report 1986, page 7.

17 See 15 above, page 52.

18 Ian Kennedy. England. In: European Science Foundation staff and others (compilers). Medical responsibility in Western Europe. New York, Springer-Verlag, 1985, page 127.

19 See 18 above, page 129.

20 Terry. The malpractice crisis in the United States: a dispatch from the trenches. Professional Negligence, September/October, 1986.

21 See, for example, the comments of Dr Halle, the Treasurer of the Medical Defence Union in his Report: 'Many doctors are already practising "defensive medicine"; the Caesarian section rate is rising and investigations are carried out which are not clinically necessary, but whose omission might be criticised' (see 15 above, page 52). Criticised by whom is the question, since medical evidence is needed before a case can be mounted let alone succeed. Further, it could be said that to carry out an investigation which was not 'clinically necessary' may itself be negligent if harm resulted from it.

22 See, for example, Ian Kennedy. The unmasking of medicine. London, Grafton, 1983, page 174 et seq.

IN VITRO FERTILISATION: PRACTICE, PROSPECTS AND PROBLEMS

Robert M L Winston

There is a responsibility and a challenge in accepting this invitation to discuss problems related to *in vitro* fertilisation (IVF). One cannot but observe that scientists and doctors should be more open and open-minded about areas involving their expertise. This is particularly true of the subject of human reproduction, especially as many aspects of the 'new technology' raise crucial questions and misgivings which concern all humanity.

I shall examine the most contentious issues last. In order to understand the implications of IVF, we need first to examine some technical aspects.

Table 1 shows the successive medical steps required for IVF success. In effect, it also shows the step towards IVF failure. The initial phase of the assessment and selection of suitable patients is perhaps the most critical. Curiously, it is also the most neglected. It is widely believed by the general population and, dare I say, by most of the medical profession too, that IVF is a treatment for infertility. This is false. It is simply a way of allowing somebody to have a baby by a 'one-shot' process. If treatment by IVF fails, patients are actually no further forward whatsoever. Indeed, they may be worse off because they will have been subjected to powerful drugs and surgical procedures but no part of their body has been medically 'improved'. Once the IVF treatment cycle is completed without a pregnancy, they are no longer being treated. This is a fundamental difficulty with this rather peculiar technology. It is therefore reprehensible that very few IVF centres pay much attention to

Table 1 Steps to success in *in vitro* fertilisation

1. Selection of suitable patients.
2. Preliminary medical and emotional preparation of the couple.
3. Superovulation to stimulate the ovaries.
4. Meticulous monitoring of events up to ovulation.
5. Collection and purification of the sperm.
6. Surgical collection of the eggs.
7. Insemination of the eggs in culture.
8. Incubation of fertilised eggs in culture.
9. Evaluation of the condition of any embryos.
10. Transfer of embryos into the uterus.
11. Assessment of any developing pregnancy.
12. Counselling the couples in whom the technique failed.

counselling the couples who fail to get pregnant at the conclusion of this lengthy and involved process. The 'advice' too often seems to be 'well, as soon as you can raise more funds, we would be most happy to see you back again'.

Preparatory treatment before an IVF attempt may be quite involved. It may involve surgery to free the ovaries and many other distressing tests such as hormone studies, with daily blood sampling and ultrasound. Another feature is that IVF requires a colossal amount of very careful biochemical monitoring before and during the treatment. The success of many IVF programmes, including our own at Hammersmith, depends largely on careful superovulation. This involves the biochemical stimulation of the ovaries to provide more than one egg simultaneously. Superovulation is a key event in the whole process; as we shall see, it is also a key event ethically.

A woman is born with about five million eggs in her ovaries. Each of these eggs is genetically unique. something like three or four may be 'used' if she gives birth to an average sized family. In her reproductive lifetime, between the onset of puberty and the menopause, she may expect to ovulate some three or four hundred of those eggs. This figure assumes, of course, that she has eleven or twelve menstrual periods each year. This means the rest of the reproductive part of the ovary is mostly redundant. It is quite an extraordinary feature. In IVF, the superovulatory strategy is to 'improve' on nature by bringing on some of those redundant eggs simultaneously in the same menstrual cycle.

Superovulation has a number of problems associated with it. One aspect still not fully understood and not widely appreciated, is that there is only a short period of time, a 'window', in each menstrual cycle when it is possible to collect eggs capable of being fertilised and which can grow into embryos. Remarkably, that window is only about three hours. Therefore, in a 28 day menstrual cycle, it is vital that we detect when eggs are about to be shed. We need to recover them just beforehand, fertilise them and then produce embryos. If that three hour window is missed, the whole process fails. Consequently, a great deal of work goes into the precise timing of egg collection. The best programmes arrange to collect eggs around the clock on a seven day a week basis. This requires huge resources, very sophisticated biochemistry and a staff prepared to get out of bed at four o'clock in the morning. If they are anything like the denizens of Hammersmith Hospital, the staff tend to be insanely obsessional.

Immediately before eggs are collected, the husband's sperm are prepared in the laboratory. Normally ejaculated, untreated semen cannot be used to fertilise eggs. The sperm have to undergo the same biological process they would experience inside the female genital tract. That involves their being washed in the laboratory in special fluids akin to female body fluids. Only after this, are sperm and egg mixed in glassware (*in vitro*). They then may form an embryo and, if possible, be subsequently transferred to the mother's uterus.

The process of embryo culture is one that doctors fondly believe that they have solved. In fact, this process is one of the most imperfect aspects of the whole technique and it may explain why so many apparently normal embryos do not implant after they have been transferred to the uterus. No matter how complex the culture media that are used, they cannot contain all the factors needed for perfect embryo growth because many of these factors are not yet synthesised nor even identified.

Embryo transfer, the process of putting the conceptus back into the womb after fertilisation, is commonly done in humans two days after fertilisation. The fertilised egg has

Figure 1

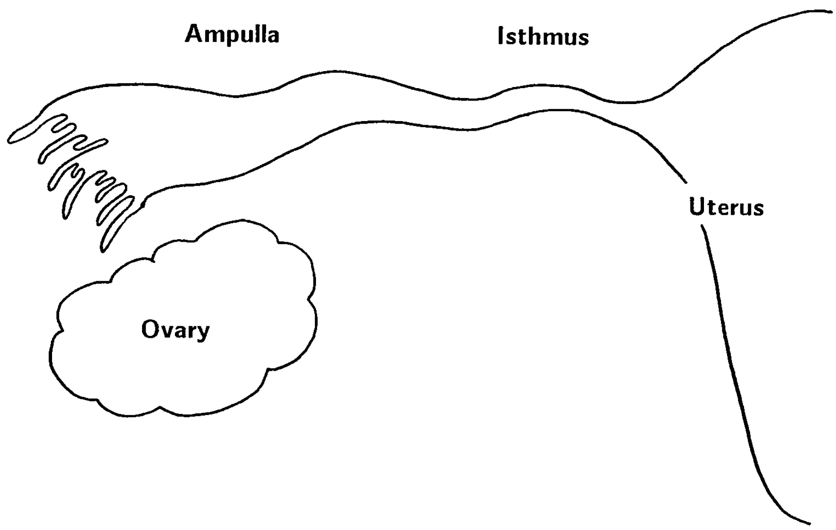

Diagram of one half of female genital tract to show the fallopian tube. The outer segment, near the ovary, is the ampulla. The isthmus is that part closest to the uterus. The inner diameter of isthmic portion is 0.5 mm. Both ends can easily be blocked as a result of infection.

usually divided by then into about two to eight cells. We rarely put IVF embryos into the uterus after the two day stage of development because they don't usually implant if things are left that late. This is one of the many fascinating biological problems of IVF. This failure of more advanced human embryos to implant does not occur in nature. Each of us was in our mother's fallopian tube for four days. We think of ourselves as being conceived in the womb but, in fact, we only arrive there four days after fertilisation. Transport into the uterus is very carefully controlled and the fallopian tube appears to be programmed in a very sophisticated way. The fertilised egg does not move down the tube into the uterus in a linear fashion. Rather, like a rhumba dancer, it zig-zags by taking two steps forward, then one back. We know of this somewhat faltering progress because if we take an embryo from the isthmus (see Figure 1) and put it into the ampulla, it immediately moves to the place from where it was taken and resumes its journey. Conversely, if an embryo is removed from the ampulla and placed in the isthmus, it returns to its proper position and resumes its slow dance. The reason for this apparently reluctant voyage seems to be to allow synchrony between the time the embryo arrives in the uterus and the growth of uterine lining. This may give the best chance of implantation in a natural menstrual cycle. With IVF we override that system; we transfer embryos into the uterus at an earlier stage than they would normally enter the uterus. The reason for this is opportunistic; our culture methods are inadequate to maintain the embryo in the best possible condition for longer.

As already mentioned, an important aspect of IVF is superovulation, the stimulation required to force the ovary to produce several mature eggs in one cycle. At the start of the normal, untreated, menstrual cycle, when levels of pituitary hormone from the brain are rising, one follicle may develop an egg which will subsequently ovulate. The policy in IVF is to augment this natural event by giving drugs which mimic the rise of pituitary hormone. This means that more than one follicle is usually forced to mature, so that in 12 days' time the woman will become rather like a rabbit, producing more than one egg simultaneously. Humans, of course, don't normally produce a litter. If they did, IVF teams would be very happy. *In vitro* fertilisation in humans involves trying to achieve pregnancy in what is actually the least fertile of all mammalian species. The unique human system certainly produces special problems.

Another important influence is the culture system. The culture system is so sensitive that the slightest impurities or changes in the number of molecules per millilitre or changes in acidity (to give but three examples) can make a fundamental difference to embryo growth. In my own institution, for example, application of non-toxic emulsion paint to walls of corridors 150 metres away from our IVF laboratory was enough to stop embryo growth totally. Minute traces of the volatile substances released by the paint, past two sets of doors, were sufficient to cause havoc for three weeks inside the laboratory until we traced the problem. This month we have an appalling problem; human fertilisation is less than it has been for four years because 300 yards away, two large cranes building a new block are belching out diesel smoke mixed with cement dust. Although these fumes are extremely diluted by the time they reach the laboratory, this is sufficient to have a significant effect on the culture system.

In order to reduce environmental contamination, we routinely place the embryos in sealed plastic tubes which in turn are put into hermetically sealed plastic modules. These modules are then shut inside the culture oven which has two separate doors. This gives four different barriers to provide some protection. Other physical factors may be equally important. Room lighting may be deleterious to human embryos, especially certain wavelengths. We never allow eggs to be exposed to fluorescent light, another example of the need for meticulous environmental control.

Egg collection is normally done using a laparoscope, a telescope inserted into the abdominal cavity. It can also be done by ultrasonic guidance, using a 'blind' approach. Sometimes, this is erroneously called non-surgical collection – erroneous because, of course, this jargon suggests in some way that 'non-surgical' egg retrieval does not carry surgical risks to the woman. The egg is miniscule, unidentifiable to the naked eye. Consequently, a scientist with a microscope needs to be in the operating theatre to examine the collected follicular fluid in a controlled and sterile environment. The fluid will be screened very rapidly within a few seconds to identify whether an egg is present; the surgeon can then go to the next point of the ovary to collect another egg. Frequently the ovary may be surrounded by adhesions, the result of inflammation, a situation which is common in cases where the tubes are totally blocked. This may make egg collection impossible or quite difficult and many special instruments may be inserted into the abdomen at laparoscopy to overcome this kind of problem. In spite of any adhesions, in a good superovulatory cycle we would expect to collect at least four to eight eggs and, occasionally, twelve.

Eggs collected directly from the ovary are not immediately mature and they are pre-incubated for usually approximately six hours. If they are mixed with sperm immediately after collection they will be killed. A slightly immature egg, even if the timing is nearly right, will still die in the presence of sperm unless its biochemical maturation is completed. Thus, for the first six hours after collection not very much is done to eggs beyond keeping them in a dark incubator under conditions resembling those in the human body. After that period, sperm will be added to the egg. Even though hundreds of sperm swarm around the egg – like drones around their queen – it is remarkable that, providing an egg is normal, only one sperm will be capable of entering it. There is a complex and interesting process which prevents multiple fertilisation of an egg – obviously if more than one sperm did enter the egg, the embryo would have the wrong complement of chromosomes. As the first sperm shoots through the zona pellucida, the kind of shell around the egg, the egg itself instantaneously sets up a barrier – the so-called granular layer. This barrier prevents penetration of that egg by a second sperm.

An interesting feature is the consideration of when life begins. I don't intend to get deep into that argument. Clearly the human egg is alive and clearly the sperm are alive too. Perhaps the question really is whether this egg – once it is penetrated by the sperm – is a unique individual in the accepted sense. Certainly Enoch Powell, for example, believes it to be an unborn child. I find that concept rather difficult because the actual process of fertilisation is not instantaneous. It takes place over a time continuum of several hours. Although the sperm penetration of the zona pellucida occurs almost instantaneously, the decondensation of the sperm head, the change in the chromosomal complement of the egg and the other stages of what is still part of the fertilisation process, take place over an extended period. To my mind it would be quite ludicrous to suggest that the moment of penetration of the egg is the moment of formation of a new human because at that stage it doesn't yet have any of the unique characteristics or genetic structure that it will require. One simply cannot define when a new being has undoubtedly developed.

One aspect of IVF is the care needed with all aspects of gamete (egg and sperm) handling. All of us have dropped eggs from time to time in the kitchen. Accidents can also happen in the laboratory. For example, with less than very delicate handling the zona pellucida can be ruptured and the cell contents can be extruded. So this is yet another of the problems with the technique; we need to keep very careful control of the damage that can occur and be aware that we have caused it.

Our problems are by no means over once fertilisation has occurred. A normally dividing embryo tends to have cells (or blastomeres) of equal size. During very early development these cells all divide more or less synchronously and are somewhat separated from each other. Remarkably, at the earlier stages of development each one of these undifferentiated blastomeres has equal potential and each, if separated from the others, can form a fetus. However, cleavage may be quite abnormal and this was a major problem in the early days of IVF. It is still common to see pre-embryos which show irregular cell division or fragmentation with blastomeres of obviously equal size and shape. Occasionally one may see parthenogenetic cleavage – that is division in the absence of sperm penetration at all. We believe that when the cells in fertilised embryos are irregular there is less likelihood of a fetus developing. However, even when an embryo has only one normal blastomere (with some abnormal blastomeres around it) there still is a chance of perfectly normal development from that one cell. Occasionally, the early pre-embryo shows such abnormal cell development that we feel it would be too risky to transfer it to the uterus.

The assessment of embryo development causes considerable problems. Obviously, it is not acceptable to put back an abnormal embryo into a patient. We may look at an embryo two days after fertilisation and decide to discard because it looks very deformed. Occasionally this judgment can be wrong. All workers in IVF can recall instances when apparently diseased embryos were not replaced, but when they were subsequently left in culture they developed into perfectly normal blastocysts – a stage at five or six days when although the embryo is still so small it cannot be seen with the naked eye it is impossible to return it to the womb. Pre-embryos at this stage simply disintegrate in our imperfect culture systems.

Checking the morphology of the human embryos we culture is only one way of controlling what we do. Many units also use animal embryos, cultured separately but in parallel with the human ones under identical conditions, to check the systems in use. We put animal embryos through the same fluids, the same culture media, gases and instruments which are used for humans. This gives a somewhat crude check that the system is adequate. Certainly it is better than nothing, though animal embryos are not as sensitive to toxic materials as are human ones. Regrettably, few IVF units use this approach. For one thing, it is expensive. It is also time-consuming. At Hammersmith, we feel however that it is essential to use some form of quality control and our system is tested every week with mouse embryos in parallel cultures.

This approach can be very useful. For example, when the embryos are transferred to the uterus a plastic catheter – a fine tube – is used. There are a variety of different catheters on the market. For a few moments it will contain the embryos whilst they are placed through the woman's vagina and into the womb. If the plastic is toxic, the short time the catheter is in contact with the embryos can be enough to damage them. In our quality control system, we have found batches of embryo catheters which killed every single animal embryo with which they came into contact. If we hadn't used a mouse embryo culture system to test these normally manufactured catheters, which are sold on the open market, we would not have known why none of our patients were getting pregnant. It is staggering to think that many units must be buying catheters which are toxic, but because no quality check is being made, repeated failure is occurring. This is one of the reasons why we feel strongly that any government legislation concerned with IVF should lay down guidelines to include proper standards of practice and technology. Bills, such as that introduced by Enoch Powell, completely ignore this vital issue.

Peter Brueghel the Elder must have been fond of this particular drawing (see Figure 2), an engraving of which is in the Albert Library in Brussels. He drew several versions in about 1558; it also exists as a woodcut and, in reverse, in pencil. It shows the alchemist supervising the work in his laboratory. This drawing could be taken as a parable for our crude attempts at *in vitro* fertilisation. Assistants are trying to get the fire going (the culture system) in an attempt to transfer base metals into gold, and the alchemist's wife (obviously this is a rather unsuccessful private practice) has an empty purse. The surroundings depict

Figure 2

The Alchemist. Pieter Brueghel the Elder, 1558. In The Bibliothèque Albert I, Brussels.

neglect and despair. The children are running amuck in the corner; one is wearing a coal scuttle on his head. The consequences of these experiments are seen in the inset (a common mediaeval device), through the window on the right. The whole family (minus the alchemist) is thrown onto public charity with admission to the hospital (or poor house) – the child still wearing the coal scuttle. In the picture the alchemist is reading from his big book. Across the top of the open page in Dutch is written ALGHEMIST. Although this pun can be translated as 'alchemist' it can mean loosely 'all has miscarried'. 'Mist' can also be translated in a rather more scatalogical way.

This parable should remind us that we are in danger of neglecting all other clinical considerations in search of a dream called IVF. The paradox is that huge resources are in danger of being squandered on IVF, while just a little more spent on the rest of infertility practice would actually be of far more benefit to our patients. Success rates in IVF are still really low, much lower than other forms of infertility treatment, and IVF is

Table 2 Hammersmith Hospital IVF programme: overall success rate, September 1983 to July 1986

	1983–4	*1984–5*	*1985–6*	*Total*	*% success*
Treatment cycles commenced	278	368	433	1079	11.5%
Egg collection reached	151	196	264	611	20.3%
≥1 egg collected	141	190	263	594	20.9%
≥1 egg fertilised	115	163	181	459	27.0%
Embryo transfer reached	115	162	176	453	27.3%
Clinical pregnancies	28	37	59	124	

Overall percentage success rate per stage of IVF depicted in right-hand column. Note the small but steady annual improvement in success rate so that in 1985–6 the success rate after embryo transfer is 59/176, that is, 33.5%. Furthermore, many patients underwent several treatment cycles so that the overall success rate per patient is rather higher than stated. However, of the 124 pregnancies reported, 13 ended with miscarriage which lowers the overall chance of producing a live baby from each treatment cycle commenced.

more emotionally demanding and more exhausting for our patients than other therapy.

What kind of success rate can be obtained in a very successful IVF system? Table 2 gives an idea of the Hammersmith results up to the middle of 1986. The pregnancy rate may be calculated either from the number of patients entering a treatment cycle, that is the commencement of treatment, or from the number of women having an attempt at egg collection, that is about half-way into treatment, or from the number of women actually getting as far as having embryos transferred to the uterus – which really is almost the last stage of the treatment. Obviously, if figures are only taken from embryo transfer, many early failures will have been excluded from results. Interestingly, whenever figures are quoted in the press nearly all units ensure that only their embryo transfer results are quoted. Moreover, the percentage of women who miscarry – usually higher than normal after IVF – is seldom quoted either. All this puts considerable gloss on the real expectancy of success.

The least publicised ethical aspect of IVF includes the problems of raised expectations of patients. There is a kind of macho appeal associated with *in vitro* fertilisation which is very distasteful. So often, when we go to an international meeting to talk about some aspect of infertility, the immediate question colleagues ask is how many IVF pregnancies have you got? If none, it is assumed you can't be much good at reproduction. We perhaps need to be reminded that there are many ways of reproducing without the need for glassware. I find it inappropriate that every single university department in the United Kingdom is toying with the idea of setting up an IVF service. Some of these departments haven't even got their routine obstetrics and gynaecology in proper order. The pressures that we, and the press, have generated are very detrimental to our subject.

Another, really crucial, factor in success is the number of embryos transferred simultaneously to the uterus. The more embryos put back, the higher the chance of at least one implanting and giving a pregnancy. Table 3 gives Hammersmith's results. Interestingly, the chance of pregnancy with a single embryo transferred is not so dissimilar to the situation with natural intercourse. When a woman has intercourse without contraception her chances of getting pregnant in that menstrual cycle are 12 per cent (Table 4). Presumably on most occasions fertilisation occurs but pregnancy does not develop. As you can see from the British data in

Table 3 Hammersmith Hospital IVF programme: effect of multiple embryo transfer on pregnancy rate, September 1983 to July 1986

Embryos transferred	*No of patients*	*No pregnant*	%
1	106	7	7%
2	103	26	25%
3	108	26	24%
4	126	61	48%
*5–6	10	4	40%

* Practice of transferring more than four embryos simultaneously now discontinued because of the risk of multiple births.

Table 4 The cumulative probability of conception in normal women

Months trying for baby	*British women*	*American women*
After 1 month	0.12	0.20
After 3 months	0.32	0.50
After 6 months	0.54	0.74
After 9 months	0.68	0.87
After 1 year	0.82	0.93
After 1½ years	0.90	0.98
After 2 years	0.95	0.99

Note that British couples have a 12 per cent chance of conception each cycle but that couples in the USA have approximately a 20 per cent chance. The reason for this difference is not clear. Various studies have confirmed that embryos are formed at least twice as often as a normal pregnancy actually occurs.

Sources: Data taken from Vessey and others (1978) for UK and from Cramer, Walker and Schiff (1979) for USA.

this table, it takes the average couple about five or six months to conceive successfully. A woman cannot be regarded as infertile until she has been having intercourse for about a year. Why American women are apparently more fertile is a mystery. Because we know that embryos are formed in far more cycles than pregnancy develops, it is clear from these figures that nature herself does not regard the embryo as an unborn child. In our IVF programme about seven per cent conceive when one embryo is replaced; this is not very different from the cumulative chances of natural pregnancy (Table 4). When two or three embryos are replaced, about 25 per cent will conceive; with four embryos, almost 50 per cent will conceive. The snag is that the more embryos transferred, the higher the risk of twins, triplets or even quadruplets. Multiples greater than twins or triplets carry considerable medical and social hazards so we need to avoid them if possible.

In vitro fertilisation is a disturbing and demanding treatment. It frequently causes immense distress to the couple undergoing it. It is also physically difficult and very time-consuming. Indeed, the woman usually has to give up work during treatment and, unless she is prepared to travel, may have to live temporarily in digs or a hotel during the treatment cycle so that she can be 'on call'. Moreover, the stress on the male partner is not to be belittled. He is required to give support and encouragement at all times and, most important, needs to produce semen at short notice in hospital premises in circumstances which are very dispiriting. Because of these immense pressures, it is not at all unknown for men in these circumstances to find it impossible to get an erection, let alone ejaculate.

Clearly then, because of these arduous circumstances, we need to maximise the chance of success. Single embryo transfer is really out of the question and is no longer practised. There is too much trauma for too little return. However, we also bear in mind the problems of producing quadruplet pregnancies. We have actually had three sets of quadruplets at Hammersmith Hospital. All have been born alive and done well with excellent obstetric care. Nevertheless, these really represented most serious medical and social consequences of our treatment. In each case, the woman had to spend weeks in hospital in order to get viable babies and delivery required Caesarean section for very premature infants. Inevitably, until there is more research done on human embryonic development and implantation, these risks remain.

Until we can prevent the risk of a multiple birth, or multiple miscarriage, or the risk of a genetic defect associated with multiple pregnancy, we obviously may not place more than three or four embryos into the uterus simultaneously. To transfer more seems to me to be quite unacceptable; but because of the need to maximise the chance of success it is unacceptable to transfer only one embryo. Here, then, is a considerable ethical dilemma. We are never able to forecast how many of a patient's eggs will fertilise – sometimes only one in every five does. Hence we need to collect as many eggs as is reasonably possible. Consequently, on a 'good' day when all a woman's eggs fertilise successfully we find ourselves holding six, eight or even twelve of her embryos.

The questions raised are very considerable. They include whether we should just collect single eggs, try to fertilise them and put them back. This would give at best a seven per cent success rate. Even this figure assumes that each egg we collected will fertilise and that each fertilised egg would grow into an embryo. In practice this would only give a four per cent chance of success – hardly a viable treatment. Alternatively, should we generate as many embryos as possible, transfer them all with the risks that would involve. Can spare or surplus embryos be given to another patient who is also infertile? An interesting concept, but it raises the serious ethical difficulty that the 'adopting' patient might get pregnant whilst the infertile donor does not. Can they be frozen? I personally think that the technique of embryo freezing is very imperfect. We still do not know whether replacement of thawed embryos is entirely safe and whether there may be a risk of genetic damage. Can we therefore use such 'spare' embryos for research rather than destroy them?

What of the benefits of embryo research? The utilitarian arguments in favour are considerable. There is no doubt that we would improve female infertility treatment, that we might alleviate much male infertility, that we would understand the genesis of spontaneous abortion rather better, that we could develop new contraceptive measures and that we could study the genesis of some birth defects.

Why is there such interest in infertility research? Infertility affects one in ten couples in the United Kingdom and only one-third of seriously damaged couples attending infertility clinics will end with successful treatment. Contrary to what is believed, most male disorders are largely untreatable. This is important because in 30 per cent of infertile couples the man has the problem. We need to appreciate the trauma of infertility. Infertile couples generally believe quite erroneously that their childlessness is their own fault. This causes huge guilt and erodes the self-esteem of both men and women. There is no doubt that infertility causes huge hardship as well as feelings of inadequacy and guilt. People who become infertile frequently stop making friends, they don't go out socially, they don't want to see other people's babies – even a sister with a child can be an embarrassment and a threat to them. They are frequently reluctant to enter a room where there are young children. There is also an important sexual connation. In our society there is confusion between sexuality and fertility. Infertile people frequently end up feeling sexually inadequate, with loss of orgasm, male impotence and a deterioration in the most private area of existence. Sexual problems result in recrimination and self-recrimination. Sometimes marital break-up and divorce can be a direct result of a fertility problem.

Although embryo research is certainly not the only way to improve knowledge about infertility, there is no question that this kind of approach is essential for the development of some treatments. Without embryo research, human test-tube babies would not have been possible. Most, if not all this work, can be accomplished by studying very early conceptuses. Professor Ann McClaren has suggested that the very early embryo be called a 'pre-embryo'. She makes what seems a totally justifiable distinction between the undifferentiated group of cells seen during the first fourteen days after fertilisation and the implanted embryo which develops primitive organs thereafter and which has far greater potential for becoming a fetus. Some have sneeringly described the term 'pre-embryo' as 'the first cuckoo'. This seems quite unreasonable, because morphologically, embryologically, functionally and potentially the fourteen-day-old embryo differs more from its immediate predecessor than does the pre-embryo from the egg.

Embryo research will also be of great help with diagnostic *in vitro* fertilisation. Many infertile couples are inexplicably infertile and can only be treated effectively if diagnostic tests are improved. To make a diagnosis, we may need to take sperms and eggs from a couple and fertilise them. We would have no intention of putting the embryos back because we would be checking to see whether there is something wrong with early development. A similar principle exists with regard to miscarriage. At least 100,000 women miscarry in the United Kingdom each year. In four-fifths of cases we have no real idea what has caused the problem. Miscarriage is a huge emotional shock to a couple, one that few get over very easily. The need to understand miscarriage and treat it more effectively is very great indeed. Take the potted history of just one of my patients. She has lost ten pregnancies at various advanced stages of development and nearly lost her life twice. Once she was brought into hospital *in extremis* with profuse blood loss; on another occasion she spent five months in hospital in an attempt to keep her baby inside her uterus. This attempt, like the other seven months she has spent in all in hospitals, was unsuccessful. A Powell-like Act of Parliament would prevent somebody like myself taking eggs from that woman, sperm from her husband and mixing them together to see if there is something wrong with the embryos that she is generating. That experimental approach seems to me (and to my patients) totally ethical.

Another area is contraceptive research, one of the world's biggest needs. Nearly all available methods have unacceptable side-effects. Contraceptive techniques also have a failure rate and we need to ensure that newly-developed methods do not damage embryos which 'get through' any method in use. Embryo research is also likely to provide major improvements, by identifying compounds which either modify fertilisation or embryo development. These are likely to have fewer toxic side-effects than existing contraceptives. Many compounds may need to be tested and at some stage we will have to confirm that they are effective with human embryos. It would be a disaster to find that a compound produced abnormal pregnancies in the event of method failure in a third world country.

One of the objections to this sort of research is that of the 'slippery slope'. This argument runs somewhat along the line that society will accept straightforward IVF, even if procreation occurs without sex and even when spare embryos are created. Research on embryos taken with permission from the couples affected is probably acceptable, providing that the research is to help those individuals specifically. IVF for unmarried couples creates a bit of difficulty. Embryo freezing is, frankly, really not terribly satisfactory. Generation of embryos specifically for research conjures up frightening prospects, while genetic engineering, cloning and animal hybrids lead to the popular Frankenstein libel and thence ever downward to the pit of hellfire and damnation. I don't believe in the slippery slope; indeed, it seems to me to be a very bad moral argument. Either an embryo is an unborn child and therefore sacrosanct in all situations, or it isn't. I believe that society can regulate these matters; it obviously does with other aspects of medicine. The moral fibre of our society has not seriously been threatened by organ transplants, even though very serious moral problems are raised by them.

If we are determined to protect the human pre-embryo, one logical necessity would be the need to change widely used existing methods of contraception. In this country alone, the coil (IUCD) is responsible for preventing approximately one million embryos from implanting every month. The low-dose contraceptive pill and particularly the progesterone-only pill by no means guarantee that fertilisation cannot occur; these drugs work in part by preventing implantation. There is certain evidence of this from the comparatively high incidence of ectopic pregnancy that occurs with progesterone contraception. If we really believe that each embryo is truly an unborn child (as Mr Powell claims) we would have no alternative but to replace every IVF embryo, even when we have strong evidence that an embryo was defective in some way. The responsibility for deliberately bringing defective infants into the world is one that certainly most clinicians would shun. Indeed most of us would regard this as highly unethical. One cannot help but observe that our society, in common with many others, has already taken a view about the status of the human embryo in its acceptance of the widespread use of legalised abortion. Abortion involves the destruction of embryonic tissue well after the period of differentiation – when all the adult organs have already developed to an advanced stage.

One of the deficiencies of Mr Powell's Bill (and the recent Bill introduced by Ken Hargreaves – which is basically a revamp of the Powell Bill) is the attitude to research. Powell rightly claimed that his Bill need not necessarily affect all research. Embryo research would actually be permitted, *providing that any embryos upon which experiments had been conducted were returned to the uterus at the conclusion of the experiment.* The monstrous consequences of such extraordinary legislation seem to have completely escaped him. If such research *was* done, the parents and any offspring produced would in effect be human guinea pigs.

His Bill (and similarly the Hargreaves Bill) would also prevent any validation of what is done to improve the environment of human embryos. Take, for example, the techniques of embryo freezing. Improvements could not be validated because all thawed embryos would be required to be returned to the uterus. We could no longer make certain that potential improvements in culture solutions, in cryoprotectant or in freezing technology had had no effect first on embryos which had been subsequently preserved for thorough study under the electron microscope. The status of surplus embryos was also left unclear in his Bill. While I have no doubt that some of Mr Powell's supporters believed that his Bill would prevent doctors generating surplus embryos in their programmes, his Bill completely ignored that difficult area. The Society for the Protection of the Unborn Child must have felt cheated when they learnt the content of the Bill.

Moreover, under this kind of legislation, the fate of the embryo once it had been inserted into the uterus would not be at all clear. That is interesting, because Powell provided that no person may hold in his possession 'an embryo that has been produced by *in vitro* fertilisation' before its insertion into the uterus. That raises certain interesting possibilities and difficulties. Sometimes patients have an ectopic pregnancy after IVF which threatens their life and requires immediate removal. Alternatively, they might need to have an abortion for very good medical reasons. Technically, a surgeon engaged in essential procedures of this kind would be repossessing an embryo illegally. In order to circumvent this ridiculous anomaly, Mr Powell subsequently added a clause to his Bill that no person may possess an embryo 'before it has been inserted into the uterus'. This ludicrous amendment meant that an unscrupulous scientist could legitimately have circumvented the law by inserting an embryo into the uterus and then flushing it out again! Perhaps the most ridiculous point of all is that Powell's proposed legislation provided no protection at all for embryos produced by *in vivo* fertilisation. We could have still produced naturally fertilised eggs for research perfectly legally and perhaps we will do so unless the government sits down with the experts and works out legislation which has a logical basis.

This kind of legislation ignores the issues which require attention in our society. Our most pressing need is protection against blemished treatment and inferior medicine. IVF is a difficult and complex treatment, often inadequately provided in less than satisfactory premises and circumstances. We must fight to establish good treatment where individuals are not at risk of exploitation and where the embryos produced are healthy. So far, projected Parliamentary legislation has ignored a central issue. A society which has totally deficient counselling for infertile couples and quite inadequate investigation allows the private sector to make huge profits, without ensuring any kind of control over the conduct of *in vitro* fertilisation. If this continues while all ethical research is totally prevented, techniques which could be of extraordinary benefit to society will surely end by being extremely harmful.

ABORTION AND THE TAKING OF HUMAN LIFE

Anthony Kenny

A year ago I published an autobiographical memoir entitled *A Path from Rome*. In it I described how, having become a Roman Catholic priest, I became too uncertain of Catholic doctrine to continue in that profession. One of the elements in my final disenchantment with Catholic institutions was the reluctance of bishops at that time – it was in the early 1960s – to condemn nuclear warfare. In an epilogue in which I described how I had become agnostic about many fundamental Catholic doctrines I wrote thus:

> There are points on which I identify much more closely with the Church I have left than with the liberal agnosticism of the world in which I live. Thus, I believe that the Church has been fundamentally right in opposing abortion no less firmly than I believe that it has been fundamentally wrong in opposing contraception. In so far as abortion is the termination of the life of an actual, identifiable, human individual it is wrong for the same kind of reasons as the killing of non-combatants in war is wrong. It is a pathological feature of the intellectual climate of our time that so few people are consistent in their attitude to the killing of the innocent. When I am with people who share my opposition to nuclear deterrence, I commonly find I am alone in disapproving of abortion; if I want to find company which opposes abortion it is easiest to do so among those who are hawks on the arms race. This is true not only of secular society but also of the Catholic Church: the strengthening of the opposition among bishops to nuclear warfare has gone hand in hand

> with a weakening among priests and nuns of their abhorrence of abortion (page 208).

Abortion is a difficult topic for the moral philosopher. The difficulty is not just that strong views are held on both sides of the debate about the rightness or wrongness of abortion. The problem is that the issue of abortion is interlocked with several of the most difficult general problems in moral philosophy (the debate between absolutism and consequentialism; the pros and cons of utilitarianism; the moral significance of the distinction between doing things and letting them happen) and with some of the most profound issues in metaphysics (the nature of life, the essence of human personality, the principle of individuation, the relationship between actuality and potentiality). To present a fully worked out moral theory of the ethics of abortion involves taking sides in a number of debates which have exercised philosophers for generations.

This is one reason why any judgment about abortion by a philosopher will be controversial. But the morality of abortion, though controversial, is not a borderline issue. There are a number of difficult and controversial issues – such as the morality of white lies, or certain forms of tax evasion, or the propriety of various kinds of social discrimination – where reasonable people may differ and arguments may be offered on both sides. But issues of this kind involve drawing moral boundaries which both sides may agree to be to a certain extent arbitrary; and nobody thinks particularly ill of someone for taking the opposite side in this kind of debate. But it is different in the case of abortion: here we have an action which, if it is wrong at all, is very wrong indeed. Abortion is not the only instance: nuclear strategy provides a similar case.

Considered moral judgment about abortion is made more difficult still when the issue is presented within the context of feminism. Abortion is sometimes treated as a moral issue within the exclusive competence of women: as the women's issue *par excellence*. It is absurd to suggest that only women are in a position to make moral judgments about abortion; there is no moral issue which falls within the exclusive domain of either sex, for men and women belong to the same human moral community, and if they did not the issue of fairness between men and women could never arise. But one does not have to be a feminist to accept that the issue of abortion is of quite special concern to women. If abortion is permissible, those who suffer from it will be divided roughly equally between members of either gender; if abortion is prohibited, the burdens resulting from the prohibition lie much more heavily upon the female sex than on the male.

Many opponents of abortion see the issue as essentially a simple one. Their argument can be summed up in a nutshell:

> Taking innocent human life is always wrong.
> Abortion is taking innocent human life.
> Therefore, abortion is always wrong.

I believe that this argument is essentially correct; but I do not think that it is at all as simple a matter as it appears. There are many ways in which the two premises of the argument can be attacked, and in order to show that the attacks fail, the premises need to be spelt out, explained, and to a certain extent qualified. This I shall now try to do; and while I hope that the explications which I will offer will bring out the essential soundness of the anti-abortionist position, I must expect that some of the qualifications I shall introduce may well be unwelcome to many of those who oppose abortion.

The first premise of the argument against abortion is the proposition that taking innocent human life is always wrong. This proposition is also the starting point of many of the arguments offered by those who oppose nuclear warfare and the mass-bombing of cities. Those who affirm the proposition do not normally wish to rule out any action whatsoever which may result in the death of the innocent. In the context of warfare, it will be allowed; it may be legitimate to attack military targets even though some civilian deaths may unintentionally result. Similarly, moralists and divines have long agreed that a pregnant woman in illness may be offered necessary medication even if it is foreseen that an abortion may ensue. What the proposition is meant to rule out is the intentional killing of the innocent: killing that is directly intentional in the sense that the death of the innocent human being is either an end of the agent or a means to one of his ends.

Many contemporary moral philosophers would reject the proposition that taking innocent human life is always wrong. It is uncommon to find moralists who believe that there are some actions which are always wrong, but killing the innocent is not one of these actions. What is widespread is the view that there are no actions which are always wrong; that there are no kinds of action which must be avoided, come what may, whatever the circumstances or consequences of avoiding them. Moralists of this school of thought are often called consequentialists, since they believe that the morality of an action should be judged by its consequences. Moralists who believe that there are some actions, such as taking innocent life, which should never be performed are called, by contrast, absolutists.

An absolutist, then, in this sense, is one who believes that there are some kinds of actions which should never be done, no matter what the consequences are of refraining from doing them. The consequentialist with whom he is contrasted believes that there is no category of act which may not, in special circumstances, be justified by its consequences.

The distinction between absolutist and consequentialist should not be confused with the distinction between absolutist and relativist. In this sense, an absolutist is a person who thinks that there are some moral principles which are valid for all human beings; a relativist thinks that moral principles hold only within particular societies, or at particular times.

Most absolutists are no doubt absolutists in both senses. But the two contrasts are quite distinct. Let us call an absolutist in contrast to a consequentialist a prohibitionist: he is an absolutist in that he believes some things are absolutely prohibited. Let us call an absolutist who is contrasted with a relativist a universalist: he is an absolutist because he thinks there are some principles which are absolutely universal, no matter what the time or place.

One can be a universalist whithout being a prohibitionist. Classical utilitarians like Bentham were consequentialists, but the principle of utility – the greatest happiness of the greatest number – was as valid in the twelth century as in the eighteenth, in Hanoi as in Hampstead. One can be a prohibitionist without being a universalist. One may subscribe to the principle in our society that nothing will ever justify infanticide, while thinking that in other societies it may be permissible. For purposes of practical debate about abortion, and abortion legislation, in countries such as the UK and the USA it is not conflict between universalism and relativism that matters, but the issue between prohibitionism and consequentialism.

Thoroughgoing consequentialism is probably more popular in theory than in practice: outside philosophy seminars, perhaps, not many people will agree that no kind of action, however outrageous, can be morally ruled out in advance, and that one should literally stop at nothing in the pursuit of desirable consequences. But there is, equally, a very widespread suspicion of prohibitionism. Two objections to prohibitionism are particularly common.

First, do not absolute prohibitions often lead to absurd, morally repungant conclusions? To take a fictional case much discussed by moral philosophers: suppose that a corpulent schoolmaster takes a group of 20 pupils potholing, and on the way back to the upper air gets stuck in the exit; he cannot be pushed one way or the other, and if he stays where he is the 20 pupils will die for lack of oxygen. Surely here it would be right to blow up the fat teacher to save the 20 trapped children? But to do so would be to violate the prohibition on killing the innocent.

Secondly, where do these absolute prohibitions come from? No doubt religious believers see them as coming from God; but how are they to convince unbelievers of this, and if they cannot how can they expect unbelievers to feel bound by them? Surely only someone who believes in God, and indeed in a specific divine revelation, can consistently uphold the notion that some acts are absolutely prohibited. Can there be a prohibition without a prohibiter? Does not someone who subscribes to absolute prohibitions merely express the prejudices of his upbringing?

In my view, these objections show a misunderstanding of what morality is. There appear to be three elements which are essential to morality: a moral community; a set of moral values; and a moral code. All three are necessary. First, it is as impossible to have a purely private morality as it is to have a purely private language, and for very similar reasons. Second, the moral life of the community consists of the shared pursuit of non-material values such as fairness, truth, comradeship, freedom: it is this which distinguishes between morality and economics. Third, this pursuit is carried out within a framework which excludes certain types of behaviour: it is this which marks the distinction between morality and aesthetics.

If this is correct, then prohibitionism is not simply one form of morality, not just a preferred form: it is something constitutive of morality as such. The answer to the question 'who does the prohibiting?' is that it is the members of the moral community who do it: membership of a common moral society involves subscription to a common code. Universalism, as defined above, can now be seen to be the belief that any member of any moral community belongs to the single community which is the human race: that is, that there are moral relationships, and shared values and codes, between any two human beings.

To give a less schematic answer to the question 'where do moral codes come from?' one must make distinctions. The question may be historical or epistemological. Historically, the answer is that each person acquires a moral code from the society in which he is brought up; he may, and commonly will, criticise and reject some part of it. Epistemologically, the answer is that moral codes are justified and criticised in terms of their effects on the moral values of the community. Indirectly, they are also criticised or justified in terms of material values, since moral values are often second-order values concerning the distribution of non-moral goods and evils, benefits and burdens.

There is no general principle from which moral principles can be derived, as theorems from an axiom; equally, there is no one source – for example, sense-data – from which all our non-moral knowledge is derived. The moral and non-moral values which provide the justification for moral codes are various and independent of each other.

Moreover, what is justified is not the individual act in accordance with the principles of the code. It is by reference to the effect of the principle – in general – on these values that its merit is assessed. It may well be that a particular act or omission, in accordance with a moral code, will not be deleterious to a particular value of the society. And yet it may be conducive to the society's values that this kind of act be prohibited.

It is thus that the absolutist (prohibitionist) answers the difficult cases brought against him by the consequentalist – such as the trapped potholer conundrum. Innocent life is more secure in a society in which the code forbids the killing of the innocent in general, even though in individual cases innocent lives may be lost as a result of the observance of the code.

Not all those who oppose abortion are prohibitionists. Similarly there are many who oppose nuclear deterrence on grounds which are utilitarian rather than absolutist. But so many of those who believe that abortion is wrong do so on the grounds that it is something that is absolutely prohibited, that it seemed worthwhile to spell out, and defend, the kind of absolutism involved.

Let us turn to the second premise of the anti-abortion argument: abortion is taking innocent human life. Defenders of abortion will dispute this, saying that a fetus is not yet a human being, even though it will become one. Until comparatively recent times theologians who condemned abortion agreed none the less with the proposition that a fetus was not yet a human being, at least in the early stages of pregnancy; they condemned abortion not as the destruction, but as the prevention, of the life of a human being. Their judgment on this matter was based on superannuated biology; but the question remains a live one, whether a fetus is a human being, and if so at what stage of its development it begins to be one.

The question is often posed in a confused form: 'when does life begin?'. If this means 'at what stage of the process between conception and birth are we dealing with living matter?' the answer is obvious: at every stage. At fertilisation egg and sperm unite to form a single cell: that is a living cell, just as the egg and the sperm were themselves alive before their fusion. But this is clearly not the question which is relevant to the moral issue of abortion: worms and rosebuds are equally indubitably alive, but no one seeks to give their lives the protection of the law. So perhaps we reformulate the question to 'when does human life begin?'. Here too the answer is obvious but inadequate: the newly formed conceptus is a *human* conceptus, not a canine or leonine one, so in that sense its life is a human life. But equally the sperm and ovum from which the conceptus originated were human sperm and human ovum; but no one wishes to describe them as human beings or unborn children. If asked 'when does life begin?' we must respond with another question, 'when does the life *of what* begin?'.

Sometimes the question is formulated not in terms of life, but in terms of animation or personhood. Thus, we ask 'when does the soul enter the body' or 'when does an embryo become a human person?'. Contemporary discussions of the morality of abortion and the status of the fetus often shy away from these questions. Thus, in the Commons debate on Mr Enoch Powell's Unborn Children (Protection) Bill, Mr St John Stevas said:

> We need not bother ourselves about recondite questions of when the soul, if there be a soul, enters the body. That is a theological question. It does not provide the opportunity for a final answer. Nor need we, in my opinion, discuss when a human personality is present in an embryo. Again, that is a metaphysical question.[1]

The Warnock committee, whose report on human fertilisation and embryology[2] was the occasion for Mr Powell's Bill, had similarly attempted to short circuit the question of personhood. Some people, the committee observe, think that if it could be decided when an embryo becomes a person, it could also be decided when it might, or might not, be permissible for scientific research to be undertaken upon embryos. The committee did not agree.

> Although the questions of when life or personhood begin appear to be questions of fact susceptible of straightforward answers, we hold that the answers to such questions in fact are complex amalgams of factual and moral judgements. Instead of trying to answer these questions directly we have therefore gone straight to the question of *how it is right to treat the human embryo.*

A philosopher writing on these matters cannot evade, as a politician or a committee may do, the question of personhood. It is indeed a metaphysical question when personhood begins: that does not mean that it is an unanswerable question, but that it is a question for the metaphysician to answer. The question about personhood is also the same as the question about life, rightly understood. For 'when does life begin?' must mean 'when does the life of the individual person begin?'.

The question is a philosophical one, but in order to answer it one does not need to introduce philosophical jargon, or appeal to quasi-theological concepts such as the soul. As so often in philosophical perplexity what is needed is not recondite information, or technical concepts, but reflection on truths which are obvious and for that reason easily overlooked.

If a mother looks at her daughter, six months off her twenty-first birthday, she can say to her with truth: 'If I had had an abortion twenty-one years ago today, I would have killed you'. Each of us, looking back to the date of our birthday, can say with truth: 'If my mother had had an abortion six months before that date, I would have been killed'. Truths of this kind are obvious, and can be formulated without any philosophical technicality, and involve no smuggled moral judgments.

Taking this as our starting point, however, it is easier to find our way through the moral maze. Those who defend abortion on the grounds that fetuses are not human beings or human persons are arguing, in effect, that they are not members of the same moral community as adult humans. But truths of the kind which we have just illustrated show that fetuses are identical with – are the same individuals as – the adult humans who are the prime examples of members of the moral community.

It is true that a fetus cannot yet engage in moral thinking or the rational judgment of action which enables adults to interrelate morally with each other. But neither can a young child or baby, and we do not think this temporary inability gives us the right to take the life of a child or baby. It is the long-term capacity for rationality which makes us accord to the child the same moral protection as the adult, and which should make us accord the like respect to whatever has the same long-term capacity, even before birth.

To be sure, there can be goodness or badness in human actions with regard to beings that are not members of the human moral community. Those who believe in God do not think of him as a member of our moral community, and yet regard humans as having a duty towards him of worship. Non-human animals are not part of our moral community, and yet it is wrong to be cruel to them. But the moral respect we accord to children and, if I am right, should accord to fetuses is something quite different to the circumspection proper in our relation with animals. For the individual who is now a fetus or a child, if all goes well, will take its place with us, as the animal never will, as an equal member of the moral community; as Kant might say, as a fellow-legislator in the kingdom of ends.

I have claimed it as an obvious truth that a fetus six months from term is the same individual as the human child and adult into which, in the natural course of events, it will grow after birth. This seems true in exactly the same sense as the child is the same individual as the adult into which it will grow, all being well, after adolescence. But if we trace the history of the individual backwards towards conception, then matters cease to be similarly obvious.

It may be thought that there is something odd about the whole procedure of trying to settle the moral status of a fetus and an embryo by working backwards from a consideration of the adult and infant. But, as the Warnock committee pointed out, this is the procedure the law finds natural.

> Under civil law in England and Wales the Congenital Disabilities (Civil Liability) Act 1976 allows, in limited circumstances, damages to be recovered where an embryo or fetus has been injured *in utero* through the negligence of some third person. It is thus accorded a kind of retrospective status where it is born deformed a damaged as a result of injury.

The retrospective procedure in such cases is only an extension before birth of the attitude we take towards children when we seek to protect them from disablements of all kinds including those which will only exhibit themselves in adult life.

But there are difficulties in tracing the history of an individual back from the fetal stage towards the moment of conception. Many opponents of abortion see no such difficulty. In the debate on the Powell Bill, Sir Gerald Vaughan, opposing experiments on embryos, had this to say:

> It is unarguable that at the point of fertilisation something occurs which is not present in the sperm or the unfertilised ovum. What occurs is the potential for human life – not for life in general, but life for a specific person. That fertilised

> ovum carries the structure of a specific human being – the height, the colour, the colour of his or her eyes, and all the other details of a specific person. I do not think that there can be any argument against that. The fact that the embryo at that stage does not bear a human form seems to me to beg the issue and to be quite irrelevant. It carries the potential, and, just as the child is to the adult human, so the embryo must be to the child.

Sir Gerald concluded, following the Royal College of Nursing, that human rights were applicable to an embryo from the first moment of conception.

Sir Gerald obviously chose his words with care, and what he says about the potential for human life is absolutely correct: in the conceptus there is the blueprint for 'the structure of a specific human being'. But if he is to establish his conclusion, he needs a different premise, which is that the conceptus contains the structure of an individual human being. But a specific human being is not an individual human being. This is an instance of a very general point about the difference between specification and individuation. The general point is that nothing is ever individuated merely by a specification of its properties, however detailed or complete. It is always at least logically possible that there should be two or more individuals answering to the same specification; any blueprint may be used more than once. Two peas in a pod may be as alike as you please: what makes them two individuals rather than one is that they are two different parcels of matter, not necessarily that they differ in description.

In the case of human beings the possibility of two individuals answering to the same specification is not just a logical possibility: it is a possibility which is realised in the case of identical twins. For this reason an embryo in the early days after fertilisation cannot be regarded as an individual human being. The single cell after fusion is totipotential, in the sense that from it develop all the different tissues and organs of the human body, as well as the tissues that become the placenta. In its early days a single embryo may turn into something which is not a human being at all, or something which is one human being, or something which is two people or more.

For this reason, if a mother points to her child and says: 'If the embryo in my fallopian tube nine months before your birth had been destroyed, you would have been destroyed' what she says is not an obvious truth parallel to those we illustrated earlier. We may, of course, say to one of our children, 'you were conceived while we were on that holiday in Venice', and this is not simply a metaphorical utterance similar to 'all those years ago you were only a twinkle in your father's eye'. But it does not have the same kind of meaning as 'you would have been killed if I had had an abortion six months before the date of your birthday'. For there is not the uninterrupted history of a single individual linking conception with the present, as there is linking fetal life with the present life of the child or adult.

There is, indeed, an uninterrupted history of development linking conception with the present life of the adult; but there is equally an uninterrupted history of development back from the present to the origination of each of the gametes which fused at conception. But this is not the uninterrupted history of an individual. For each of the gametes might, in different circumstances, have fused to form a different conceptus; and the conceptus might, in different circumstances, have turned into more or less than the single individual which it did in fact turn into. Of course all development, if it is to proceed, depends on factors in the environment: an adult may die if diseased and a child may die if not nourished, just as an ovum will die if not fertilised and a conceptus will die if not implanted. But though children and adults may die, they cannot become part of something else or turn into someone else. Fetus, child, and adult have a continuous *individual* development which gamete and embryo do not have.

At what point, or by what time, has an embryo become an individual human being? If we can answer that question, it seems that we can give a non-arbitrary date from which abortion becomes morally impermissible. The Warnock committee was not considering the morality of abortion, but (*inter alia*) the morality of experiments on embryos; but the deliberations of the committee are very relevant to the ethical issues surrounding abortion, though for political reasons many discussions of the Warnock report have played down this relevance. A minority of the Warnock committee thought experiments on embryos should be altogether prohibited; the majority were in favour of allowing it, but thought it should be impermissible after the fourteenth day. Their reasons for fixing this term were well summarised by the Minister of Health, Mr Kenneth Clarke, in his speech in the debate on Mr Powell's Bill:[3]

> A cell that will become a human being – an embryo or conceptus – will do so within 14 days. If it is not implanted within 14 days it will never have a birth. The majority of embryos do not implant. Nobody knows exactly how many ... The committee thought that experiments should be licensed as long as no embryo was kept alive for more than 14 days *in vitro*. The basis for the 14 day limit was that it related to the stage of implantation which I have just described, and to the stage at which it is still uncertain whether an embryo will divide into one or more individuals, and thus up to the stage before true individual development has begun. Up to 14 days that embryo could become a person, two people, or even more ... 14 days is the stage before which the rudiments of the nervous system have been laid down ... that means that as far as anyone can tell, pain does not enter into these experiments.

Many people seem to think that it is a decisive factor in assessing the morality of abortion whether or not the fetus feels pain in the process of abortion. The film *The Silent Scream* was made by opponents of abortion in the hope of convincing supporters of abortion that the fetus does indeed feel pain. But whether or not the fetus feels pain in an abortion, it is undoubtedly deprived of life in an abortion; and someone who thinks that it is permissible to kill a fetus but not to cause it pain must think of it as like a non-human animal which we have the right to kill provided we do so humanely without unnecessary suffering. But for someone who regards the fetus as a human being the issue of pain can be no more than marginal. Even with adult human beings, the wrongness of deliberately injuring them arises far more from the disablement caused by injury than from the pain involved in its infliction. And whereas death is not painful (even if dying is) death is total disablement: so there is an *a fortiori* argument from the wrongness of disablement to the wrongness of killing, where there is no *a fortiori* argument from the wrongness of causing pain to the wrongness of killing.

Mr Powell's Bill to prohibit experiments on embryos was supported, on a vote, by 238 MPs against 66. Critics of the Bill pointed out that it was inconsistent for the House of Commons to prohibit the destruction of embryos at an inchoate stage while permitting the abortion of well-developed fetuses. Supporters of the Warnock committee's proposals argued that it was inconsistent for critics to object to the destruction of embryos in experiments while permitting their destruction by intra-uterine contraception devices.

Both points seem to me well taken. The use of the intra-uterine device is not, as is sometimes said, a form of abortion because what is destroyed is not a human individual as a developed fetus is. On the other hand, all the reasons put forward by the Warnock committee for prohibiting experiments on embryos after the fourteenth day seem to be equally good reasons for prohibiting the destruction of embryos and the abortion of fetuses after that day also.

A fetus, while being a human individual, is of course also uniquely involved with the life of another human individual, namely the woman in whose womb it is implanted. Because the life of the two are so closely interwoven, the recognition of the general wrongness of abortion does not settle the question (a difficult one which I do not attempt to investigate here) of the correct moral decision in cases where the fetus presents a threat to the physical life of the mother in which it is developing. There are two extreme positions in this area: the feminist view that the fetus should be regarded simply as a part of the mother's body like any of her own organs; and the view common among Catholic theologians that the fetus should never be aborted even if the only alternative is the death of both mother and fetus. Both positions seem to me clearly wrong, but it is not easy to state exactly where the truth lies between these two extremes.

Before the debate on the Unborn Children Bill, Mr St John Stevas presented a petition, bearing two million signatures, which began:

> The Humble Petition of the residents of the United Kingdom of Great Britain and Northern Ireland showeth

> that we affirm that the newly-fertilised human embryo is a real, living individual human being.

There may be good reason for prohibiting experiments on embryos, as the petitioners prayed. But this affirmation, if the argument of this paper has been correct, is not justified. The newly-fertilised embryo is indeed real, living, and human: but it is not an *individual* human being.

No doubt, in arguing for the general wrongness of abortion, I would find company among many of the signatories to the St John Stevas petition. But if the moral objection to abortion is to be coherently stated, I believe, abortion must be carefully defined in the words quoted at the beginning of this paper:

> In so far as abortion is the termination of the life *of an actual, identifiable, human individual* it is wrong ...

Notes and references

1. Parliamentary debates, House of Commons. Hansard, vol 73, col 651, 15 February 1985.
2. Department of Health and Social Security. Report of the Committee of Inquiry into Human Fertilisation and Embryology. Cmnd 9314 (Chairman: Dame Mary Warnock) London, HMSO, 1984.
3. Parliamentary debates, House of Commons. Hansard, vol 73, col 686, 15 February 1985.

SOCIAL FACTORS AFFECTING THE MEDICAL MANAGEMENT OF CHILD ABUSE

Eileen Vizard

Introduction

Any consideration of the role of a doctor, in relation to the management of child abuse, needs to be put into a wider context, one that enables historical, sociological, political, and practice issues to be included. Those who see the role of the doctor in the management of child abuse as being limited to detection of non-accidental injury – bruises, fractures, and so on – may well be puzzled by such an extension of context. However, as this chapter will attempt to show, while the sequelae of child abuse may be of a medical nature, the underlying causes of child abuse are not simply medical, but multi-factorial. The complex, multi-factorial, and often chronic nature of child abuse, with the associated and seemingly inevitable difficulties in inter-professional communication and liaison, has been mentioned repeatedly in each of the major inquiries into child abuse deaths, starting with Maria Colwell in 1973[1], and highlighted again recently in Louis Blom-Cooper's report on the death of Jasmine Beckford in 1985.[2]

Historical perspective on child abuse

We might well ask 'why now'? In other words why, after centuries of neglect, abuse and deprivation involving children, should there have been such a tremendous interest in child abuse within the last 20 years or so?

It is true to say that following Henry Kempe's description of 'the battered child' in 1962[3], and the subsequent medicalisation of the problem, professional awareness of child abuse rose sharply, and this has in part accounted for a continuing interest in and awareness of this problem. However, the level of interest in child abuse and, recently in Britain, in child sexual abuse, has risen to such a degree, with almost daily reports in the press and the media about deaths from child abuse and sexual assault of children, that we must look further afield to find out 'why now'?

It has been suggested by Nigel Parton in his book, *The Politics of Child Abuse*[4], that the period between the end of the Second World War up until the death of Maria Colwell in early 1973 saw the discovery of the 'battered baby' problem and its subsequent medicalisation into a 'syndrome' backed up by an increasing volume of medical literature. During this period the Battered Child Research Unit was set up under the auspices of the NSPCC in 1968.[5] Its practice was derived directly from the work of Henry Kempe in Denver, and therefore was medically and psychodynamically based. However, Parton describes the social reaction to Maria Colwell's death[6] and the subsequent inquiry within a post-war context of a changing social order, increasing levels of violence, and a general sense of social unease.[7,8] The notion of 'moral panic' as a possible contribution to the public reaction towards the Maria Colwell inquiry points to an important historical issue. It is interesting to look at possible parallels between societal concern about violence as described in 'The Violent Society' in 1972–3[9], which corresponded with increased public awareness of physical child abuse on the one hand and, on the other hand, the current conflict about sexual mores at both ends of the political spectrum, and the present preoccupation with child sexual abuse.

In 1972 Keith Joseph as Conservative Minister of State for Social Services put forward the notion of the 'cycle of deprivation' as a model for understanding, and intervening in, cases of child abuse.[10] Parton describes this attitude, as leading to 'benign paternalistic social work intervention'. This model, in many ways, has been very influential in setting the tone for social work intervention in child abuse in the last 15 years. At the same time, running parallel with Sir Keith Joseph's notion of re-educating and retraining abused and abusing parents by a process of voluntary engagement and casework, there emerged an abrasive and hostile media reaction towards newspaper reports in the early 1970s describing child abuse deaths. This media reaction inevitably pilloried the social workers for their lack of care and skill; and at the same time social workers were often characterised by the media as being interfering busy bodies, in some ways undermining the rights of the private citizen.[11] Hence, just ten years after Kempe's description of the 'battered baby syndrome', a professional scapegoat had emerged in the form of the local authority social worker. There is no sign that this tendency towards professional 'battering' is diminishing, rather the reverse.

Ever since Ambrose Tardieu, in 1878 in Paris, wrote his treatise on the maltreatment of children and laid the blame fairly and squarely on their adult caretakers[12], professionals have been at pains to shift the burden of blame from the father to the child (as provocative agent, in Freudian terms)[13], to the mother (as colluder, in marital terms)[14], to the family unit (in family systemic terms)[15], and so on – rather like a game of pass the parcel.

In the context, therefore, of mounting criticism of social work management in relation to child abuse cases, the impeccably fair and impartial report of the Panel of Inquiry into the circumstances surrounding the death of Jasmine Beckford[2] came as a breath of fresh air. The implications of the Blom-Cooper inquiry report will be discussed later, but it is clear that this major inquiry has highlighted a number of issues in child care policy and practice at a crucial time in the history of awareness of this subject.

Another movement which has brought the needs of women and children very much into the public eye has been feminism. The feminist movement and particularly radical feminists take the view that abuse of children is merely an extension of power politics into the home, and on this basis feminists have seen the blame for child abuse to lie firmly with men.[16] This view, however, is a narrow one. It lacks a proper theoretical basis, does not take into account the role of the mother in chronic child abuse, nor the choice of boy victims as well as girls.

Similarly, in recent years, both children's rights and parents rights groups have sprung up in North America and in England.[17] These movements may be related in part to increasing statutory involvement in child care decision making, and the perfectly proper and desirable wish to protect the civil liberties and rights of both children and parents in these matters. Not surprisingly, there are conflicts of interest between the members of both groups, as well as a common thread of healthy cynicism about state intervention in family life.

As Henry Kempe observed[3], a society's awareness of child abuse develops in stages and involves the breaking down of inherent resistances towards perceiving the problem. It is interesting that physical and emotional abuse were well described and accepted before, for instance, child sexual abuse. In this connection it has been said that 'the recognition of child sexual abuse, is entirely dependent on the inherent willingness of the individual [professional] concerned, to entertain the possibility that the condition may exist'.[18] This perceptive statement by an American paediatrician can be applied just as easily to all cases of child abuse, not just sexual abuse, and it might be worth remembering that the intensity of our repression of awareness of child abuse is matched only by the intensity of our indignation and moral outrage when child abuse is disclosed. While the editors of certain tabloid newspapers do not need to worry, for instance, about moderating their attitudes towards 'child killers/sex beasts, and so on', it is the role of the professional to achieve a balanced view in child care cases.

Sociological issues

The balance between state intervention in the family life of child abusing families and the implications for society are discussed in depth by Dingwall, Eekelaar and Murray in *The Protection of Children*.[19a] Among the issues discussed are Parton's notion that child abuse and neglect must be formulated as social problems, because of the family's abrogation of its role as an agency for moral socialisation. In other words, since families cannot set their own standards, the state has been obliged to do so for them, and in so doing has decreed that child abuse and neglect are social problems. The background to this post-war sociological view of child abuse has already been discussed. One possible consequence of the state and its agencies taking a more active role in child abuse case management is the inevitable rise in the numbers of reported cases of child abuse and neglect, a situation which has been seen repeatedly in North America and in England following increased professional awareness of the subject. A rise in reported rates of child abuse can, therefore, give the impression that there is more of it going on at any one time and underlines the right of the state and its agencies to intervene in family life in order to protect children. Stuart Hall and others have argued that by listing a series of problems and linking them to a bigger underlying issue – 'the tip of the iceberg' argument – there is a net exaggeration of the process, a 'signification' spiral. Clearly the media can and does play a part in this postulated mechanism of exaggeration of child abuse.

The research of Dingwall and colleagues has led them to adopt a middle ground position in respect of state intervention where, however, the bottom line is still the need for child protection. In many ways, this is a traditional view linked to the argument put forward by Parton in which he describes medical writers such as Kempe and Franklin as 'paternalistic' because they are seen to advocate a paternal state, with unrestricted access into the family in pursuit of child protection.

However, the other side of this coin is the liberal state, and the dilemmas thrown up under such a regime by the wish for a radical non-intervention policy on the one hand, and the need for social regulation on the other.[19b] In this model, Eekelaar describes the first preferences as being for social regulation by individual initiative, any departure from this needing special justification, as in the case of state intervention. The point is made that most disputes are settled without lawyers, and most illness treated without doctors. In this model only two types of a regulatory response (to child abuse) are possible. First, the development of specialist agencies and, second, the socialisation of citizens with a voluntary acceptance of liberal ideas. These are the foundations, it is suggested, upon which the liberal state might combine to protect both the rights of children and their families.

However, it can be readily seen that both the paternalistic and liberal models are over simplistic and take no account of the special developmental needs of the child. Children cannot be perceived as miniature adults, able to engage in relationships on the basis of free will and informed consent. Furthermore, children have special needs from a developmental point of view and these need to be addressed in a positive way. This may mean intervention, as in primary prevention programmes in the community, but against such intervention must be set the right of children to be left to get on with their own lives for most of the time. Though integrating these needs of children probably requires an awareness of the various ideologies discussed, it depends more on the capacity to be flexible and free to respond to children's needs rather than being hidebound by ideologies.

In many ways the issue of inter-professional disputes and disagreements, highlighted in all child abuse inquiries as a major cause of mismanagement, can also be seen as a microcosm of political ideologies. For instance, the 'paternalistic' medical approach, favouring active intervention to protect the child, may be at odds with the 'rule of optimism' and the notion of 'natural love' prevalent in social work practice, which is again likely to be at odds with a legal ideology characterised by notions of guilt or innocence, and will certainly be at odds with either the parent's rights or the children's rights movements. Finally, all of these views will be at odds with the liberal ethos of radical non-intervention.

Practitioners, familiar with the case conference structure in child abuse, will be aware that it is very easy for a mixed group of professionals when under pressure, and perhaps sharing a common burden of guilt about previous mismanagement, to regress to their separate ideological bases and to blame each other, rather than being able to think together about the best interests of the child.

Political issues

The politics of child abuse are complex, and relate to the sociological issues discussed above, as well as to day-to-day practice.

Nigel Parton makes the point that the medical 'disease' model of child abuse, with its narrow focus on psychopathology, and its concentration on dangerous people, may miss the significance of dangerous conditions such as poverty and inequality. However, Newberger and Bourne have pointed out the initial usefulness of 'recasting' child abuse as a medical problem in order to stimulate national concern in the 1960s.[20]

It is argued that economic factors play a crucial role in child abuse, and policy and practice should address the social context of child abuse rather than providing individualised treatment for abusing parents. In a sense this political argument has something in common with the feminist view, which locates the responsibility for child abuse, in wider societal attitudes, towards women and children and the inequality of their opportunities compared with men in everyday life. Other writers, such as Pelton, have highlighted the 'myth of classlessness'[21], whereby child abuse is seen to be evenly distributed across all the social classes (and reported prevalence indicating higher rates among the lower social classes are seen to be artefacts of the higher attendance of working class people at state agencies). The perpetuation of the myth of classlessness, it is said, then feeds into existing medical and psychodynamic orientations towards the problem, whereby a universal, intrapsychic and pathological model can be put forward for child abuse, and wider political, social and economic factors can be legitimately ignored.

The ecological perspective, as described by Garbarino and Gilliam, proposes that child maltreatment is an indicator of the overall quality of family life and therefore is concentrated amongst the least socially advantaged groups.[22] This 'ecological' notion refers to the way in which the family as an organism interacts with its immediate environment, and vice versa. The ecological model complements, rather than discredits, the 'disease' model of child abuse, while being basically a sociological view. Other models of child abuse, which attempt to encompass political and sociological issues are the sociocultural approach, as described by Strauss, Gelles and Steinmetz[23]; the structuralist view, as described by David Gil[24], and other, more idiosyncratic views, such as are held by most non-academic professionals working in the field of child abuse.

My intention in reviewing some of these political and sociological models is to demonstrate that the detection and prevention of child abuse, and our capacity to perceive the facts of child abuse, is directly affected by our political stance on the subject, and this in turn affects our style of intervention (as has been discussed above) and certainly affects whether or not we offer help to such families and how we approach the problem of prevention.

One of the criticisms often made of a family systems approach to understanding child abuse is that it is nothing more than an elaboration of the medical 'disease' model which takes no account of wider issues. Although this criticism is probably justified in general terms, it must be balanced by one of the theoretical advantages of working within a multidisciplinary team, namely that wider perspectives on a particular family lifestyle may be brought to the discussion by colleagues from other disciplines, such as school, and social services. Again, this highlights the importance in terms of service delivery of adequate interprofessional liaison.

Finally, wider political issues have particular bearing on how we view the prevention of child abuse. It seems clear that whereas the liberal, radical, non-intervention model would favour voluntary education of the population in terms of parenting skills and child development, presumably with no sanctions applied for non-cooperation, the medical model might favour more active, possibly statutory, involvement of abused and abusing parents in re-education programmes coupled with, for instance, personal safety instruction for abused children. The legal view as recently expressed in the decision to increase the length of sentences for rape offences might be that harsher penalties will prevent the commission of these crimes. At present, therefore, it is very difficult to reconcile these different approaches to prevention.

Issues of practice

It might be possible to say that the issues for practice depend again upon the political persuasion of the individual professional. However, we live and work within a society where the law has determined that the 'best interests' of the child must always be put before consideration of an adult's needs and on this basis, and in the light of the many recent child abuse scandals, it is clear that there are major implications for practice which may be summarised under the following headings:

1. Training

In the report of the Panel of Inquiry into the death of Jasmine Beckford[2], out of a total of 68 recommendations made by the inquiry, no less than seven separate recommendations refer to the need for training magistrates, solicitors and social workers in aspects of child abuse if they are to be involved in child care decision making. However, it is clear enough from the comments made in relation to the low level of awareness of certain medical practitioners mentioned in the report that these recommendations should be taken as applying across all disciplines as a matter of urgency. Further training in the specific signs, symptoms and sequelae of child abuse does not, of course, ensure that all cases of child abuse will be detected and prevented. However, the Blom-Cooper report pointed out again and again that confusion and disagreement between professionals as to the meaning of signs, symptoms and behaviour led to major deficiencies in case management. Many of the remaining 61 recommendations of the report are directed towards issues of practice; in the case of social workers, for instance, the aims of case work are clearly delineated. The need to see the *child* at all times as the client, and to pursue the best interest of the child, is emphasised again and again throughout this report. A specific recommendation is made that the professional training of social workers should not be less than three years, and that a larger proportion of that training should be devoted to specialist areas of knowledge, including child abuse. This recommendation, which is very much in line with recent recommendations made by the British Association of Social Workers[25] is, however, at odds with the declared policies of certain London borough councils. These make it possible for untrained social workers to be appointed in child abuse cases for both ideological and practical (that is, manpower resources) reasons.

Louis Blom-Cooper QC, Chairman of the Committee of

Inquiry, summarised the spirit of the recommendation as follows:

> 'Put the child first, and if that means doing something that is disliked by the parents, that's what has got to be done.'

2. *Legal practice*

A major problem in child care cases which come to court is the issue of who can speak for the child and represent the child's interest in court. Paradoxically, in access cases there has been an assumption that one or other of the parents would be able to represent the child's interest in court. However, it has actually been laid down in legislation that separate representation for the child should be the *norm* unless the court feels it unnecessary to safeguard the interest of the child.[26] In other words, even in an unopposed application to recind a care order a conflict of interest between the adult's and the child's need is *assumed.*

In the case of contested child care cases recent legislation has made it clear that the appointment of a guardian *ad litem* is essential to safeguard the child's interest. In fact, it has been made clear that in all care related proceedings under the Children and Young Persons Act 1969, be they unopposed applications to discharge relevant orders or newly initiated proceedings, the first issue before the court is to decide whether a separate representation order should be made.[27] However, as mentioned previously, there is a possible escape for magistrates, for instance, who do not wish to grant separate representation. If they are satisfied that it is *not* necessary to make such an order because there will not be a conflict of interest then they can so direct. The point is made that the way in which courts exercise their discretion, in the absence of guidance from the rules, varies enormously and this means that children are not all being treated alike in the same sort of proceedings, and that some are being denied equally effective access to justice.

However, once a guardian has been appointed it should be possible for the guardian to take an overview of the child's best interest, select an appropriate solicitor and, if necessary, to ask for expert opinions on the child's needs, and to present all the relevant evidence to the court in due course. At present guardians can be appointed from panels set up under the Magistrates Courts (Children and Young Persons) Rules 1976[28] and, if this is not possible, a guardian can be appointed from a child care agency which was not a party to the proceedings. This should ensure that the guardian had the necessary independence but, in practice, much of the burden of guardian *ad litem* work has fallen on experienced and appropriately trained local social workers and this has thrown up difficulties in terms of such social workers finding adequate time to be released from their ordinary duties to perform the taxing work of a guardian *ad litem*.

Although recent legislation (the new re-revised Magistrates Courts (Children and Young Persons) Amendment Rules 1984[29]) have gone some way towards clarifying the extent to which magistrates may exercise discretion in the interpretation of child care legislation, in practice this does not seem to have percolated down to magistrates courts, with the result that sometimes idiosyncratic rulings are made in child care cases. In fact, in the Louis Blom-Cooper report on Jasmine Beckford's death, one of the recommendations specifically stated that magistrates must not make riders to care orders under any circumstances since this is outside their jurisdiction.

Much of this relates to difficulties in training with respect to magistrates, and this has been mentioned earlier. However, the need for training within the legal profession extends to solicitors as well, and the Law Society itself has recently proposed the establishment of a national panel of solicitors, specially qualified to represent children in care proceedings, in order to improve standards of practice.[27] The point has been made that solicitors are *not* trained to deal with children at all and they may well have little or no experience of contact with disturbed or abused children. This brings us back to the need for close cooperation between the guardian *ad litem* and the guardian's chosen solicitor, where it should be clear that the guardian is seen as the expert in child care and not the solicitor. However, the Blom-Cooper inquiry also recommends that the solicitor should strive under all circumstances to speak separately with the child in order to hear the child's view; and again the code of practice laid down by the Solicitors' Family

Law Association states that 'the solicitor should treat his work in relation to children as the most important of his duties'.[30] This recommendation has many parallels with the BASW directive in relation to social work practice that the child should be perceived as primary client.

Finally, there seems to be a fundamental issue relating both to the training of lawyers and to current thinking and practice in relation to child care cases. Both solicitors and barristers are still trained within an adversarial framework which allows testing of evidence. This has given rise to a long tradition of legal work conducted in both criminal and civil matters from a 'win or lose' standpoint. It is clear from clinical practice in work with child care cases that there can be no 'winning' or 'losing' from the child's point of view, but rather a process of making the best of a bad job, which has been described as 'the least detrimental alternative'. This has lead to a philosophy of child care decision making, described in the British Association of Adoption and Fostering (BAAF) literature based on concepts such as permanency planning for the child, the child's sense of time, the least detrimental alternative[31], and the best interests of the child (rather than the wishes of the parent) being put first.[32] However, resolution of conflict within such a framework of practice is hampered rather than helped by the present perfectly acceptable pugilistic approach enshrined in legal practice. The suggestion has been made, and endorsed by recent inquiries, that child care cases could be dealt with in a family court where evidence could be given on behalf of all parties represented, including the child. In this situation it is proposed that the model of 'testing' the evidence to provide proof of neglect, abuse, and so on (as in criminal cases) might change. In order that a forum is created where reports are presented to the court for discussion on the assumption that the final outcome can only represent the 'least detrimental alternative' for the child and parents. This model would be conciliatory and solution-seeking, rather than attempting to prove one party right and another party wrong.

However, it is clear that opinion remains divided on the merits of the family court notion[33], and a recent leader in *The Times* points out that 'The creation of a Family Court would be a structural change in the administration of the Law, not a reform of the Law itself'.[34] A practical argument against creating a family court is the enormous cost involved in setting it up. These and other issues are discussed in the consultation paper issued by the Lord Chancellor's department[35] and it seems unlikely that a consensus can be reached in the near future.

The role of the medical practitioner

I can do no better than to summarise the recommendations in the Blom-Cooper report (Appendix H: Non accidental injury to children, section 4–6) relating to GPs, hospital staff, clinic and school medical officers.

The role of these practitioners is, first, to *discuss* the issues with other professionals, such as health visitors, who may provide valuable background information.

Second, to *record* precise details of injuries and how they are said to have been caused; illustrate all injuries and clinical findings on charts; and to record events fully for medico-legal purposes.

Third, to *consult* a senior medical colleague – usually a consultant – immediately and directly.

Fourth, to *attend* subsequent case conferences.

It will be clear from this, and I hope from the preceeding discussion, that the role of the medical practitioner involves perceiving himself or herself as a member of a multidisciplinary team where the medical contribution may have vital significance in helping to decide on child protection and management. However, there is an overriding ethical responsibility, I would suggest, for the medical practitioner to follow through such cases of child abuse, or suspected child abuse, and to make sure that his or her specific concerns about the child are registered in case conference minutes, and are communicated clearly to other professionals in an intelligible and simple way during discussion. It was failure to 'translate' vital orthopaedic medical findings of abuse and trauma in the case of Jasmine Beckford into a statement of concern about child abuse which lead to a situation where the medical findings were shared in the case conference but their implications were not discussed or linked into child care issues being presented by the other professionals present.

It is often felt by all professionals concerned in cases of child abuse to be very difficult to ascertain the degree of emotional trauma suffered by an abused child, to determine whether, for instance, permanent separation of the child from his or her parents would be more or less detrimental to the child's best interests than rehabilitation with the natural parents. Recent experience has highlighted the usefulness of *extending* the role of the medical practitioner so that a child psychiatrist may be invited to assess the emotional needs of the child. More and more, child psychiatrists are being used in this helpful way to supplement the body of other professional opinion in such cases. Child psychiatrists work within a multidisciplinary framework and have considerable experience in dealing with liaison and communication between professionals of different disciplines about the needs of the child. The child psychiatrist can, therefore, be seen as an important member of the multidisciplinary team and one who is well qualified to give a professional view on the long-term best interests of such children. Child psychiatrists with a special interest in child abuse are now calling for the establishment of some sort of family court forum in order to achieve a more balanced and less confrontational approach to child care decision making.

Summary

It will be seen from the historical, sociological, political and practice issues discussed that the role of the medical practitioner in the detection and prevention of child abuse cannot be viewed as a separate issue in overall management. For instance, in case conferences it could not be suggested that doctors have any right to assume a position of primacy, nor do they always have the necessary training and qualifications to do so.

Although Henry Kempe as a paediatrician has led the way in the description of the plight of abused children, and although he has subsequently been followed by several eminent paediatricians in this field, doctors still have a long way to go in terms of improving their own awareness of child abuse, their standards of practice in this field and their skills in interprofessional communication.[36]

However, I do think that one important role for medical practitioners lies in teaching and training, so that other disciplines can become acquainted with the medical findings associated with child abuse and hence become more informed in their work of monitoring children at risk. A natural and positive spin-off from doctors undertaking child abuse teaching and training with other disciplines is the cross fertilisation of ideas achieved during such a process. Doctors may start to learn more from, for example, social worker colleagues about child care legislation and child protection issues.

Occasions for multidisciplinary training which include a teaching contribution from a paediatrician and a child psychiatrist, when built into the inservice training programmes of the professionals concerned, should improve standards of practice and will certainly help in the detection and prevention of child abuse.

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MEDICAL ACCIDENTS: THE PROBLEM AND THE CHALLENGE

Arnold Simanowitz

Since the official launch of Action for the Victims of Medical Accidents (AVMA) in August 1982, the plight of such victims has received massive publicity and the sleeping giant of public concern has become disturbed.

This is not surprising. It is highly unlikely that the British public, given the opportunity of peeping through the thicket which surrounds the casualties of medical care, and glimpsing some of the horror stories which lie within, should not first recoil in horror, and then start thinking about what can be done to change the situation. The story of a young mother, fit and healthy, a sportswoman and teacher, who goes into hospital for a minor operation and who ends up so incontinent that she has to give up her job and is only confident of being 'dry' when she lies flat on her back; of another young woman who has a baby and is so badly torn that her bowel movements pass through her vagina and she continues to suffer pain and discomfort six years later, so much so that she can no longer bear sexual intercourse; of a young man who has treatment for a minor case of colitis and is so badly burned by the drugs administered that he loses the sight of one eye and is left with the other in a dangerously weakened state; of the numerous cases of children suffering brain damage at birth: these stories cannot fail to move society to demand action.

But concern with this problem did not begin with the launch of AVMA. While the medical profession has tried for many years to play down the size of the problem, concern on the part of some people has inspired periodic inquiries into it. Thus, in

1973 the Davies report[1] dealt at length with the question of complaints against hospital authorities, while in 1978 the Pearson commission[2], which looked at the whole field of personal injury compensation, devoted a section to consideration of the compensation of victims of medical accidents. These are two different aspects of the same problem and should be taken as a starting point for an explanation of what the issues are.

When something goes wrong while a patient is receiving medical care, two questions should immediately be raised. First, why did it go wrong and what explanations should be given to the patient and/or his or her family? Second, what can be done to rectify the position and to compensate the patient? In any discussion of the present system or its improvement it is essential that both these aspects should attract the same attention. Any system of inquiry into the causes of the mishap *must* go hand in hand with an inquiry as to how to rectify the position and compensate the patient, and vice versa.

It never ceases to amaze people who come new to the problem of compensation for medical accident victims (usually as a result of their, or a member of their family, becoming a victim) that whatever catastrophe may befall them as a result of medical treatment, under British law compensation does not automatically follow but depends on the legal concept of negligence. If it can be shown that the mishap is, to quote one of the most often used phrases of the medical profession, 'just one of those things', then whatever the seriousness of the mishap (severing an artery in a hernia operation, for example) or the consequences (total paralysis, for example) no compensation whatever is payable. In order that compensation may be payable it is necessary to demonstrate that someone was at fault or, in legal terms, negligent – that is, they failed to come up to the accepted standard of medical care. The consequences of this requirement of proof of negligence are twofold. In the first place, it involves the need for claimants to employ a doctor's colleagues to analyse every detail of his/her work and endeavour to establish, often in public, that the doctor, who might be an eminent and competent consultant, on this occasion behaved in a way which was below the standard of medical care expected of someone in his/her position. Second, it means that whether a person is compensated or not is a lottery. Two people may have undergone the same operation and suffered the same complications, perhaps leaving them totally disabled for life. If in the one case the judge decides, on the balance of probabilities (perhaps in his own mind 51 per cent to 49 per cent) that the doctor has been negligent, the plaintiff may receive as much as £700,000; if in the other case the judge decides on balance (perhaps again in the same proportion, this time reversed) that the doctor has not been negligent, the plaintiff will get nothing at all.

The process of trying to obtain compensation is distressing for the victim and/or the family. It can be extremely costly and, therefore, prohibitive to those who either do not qualify for legal aid or have substantial means of their own. The process can also take an inordinate length of time; sometimes a case will not come to court for ten years and even compromise of a case can take as long.

The system of 'no fault' compensation seeks to overcome all these problems. The victim will not have to prove fault on the part of the health carers so their behaviour will not have to be scrutinised; all who have suffered an accident will receive compensation so that the lottery will disappear; and without the need for a detailed inquiry into fault, there will be greater compensation from the health carers and this, together with a simple procedure for dealing with compensation, will mean that it is paid relatively quickly.

The idea of a system of 'no fault' compensation is not a new one. In Britain it was first seriously canvassed by the Pearson commission in 1978, and two countries have actually introduced such a system for compensation of victims of accidents of all kinds – New Zealand in 1974 and Sweden in 1975. More recently in Britain the British Medical Association (BMA) set up a working party which in July 1986 called for a state-funded scheme to provide compensation on a 'no fault basis'[3] and the Association of Community Health Councils for England and Wales (ACHCEW) at its annual conference in the same month decided to set up a working group to look at how such a scheme could work in this country.

It is ironic that Action for Victims of Medical Accidents, the only grass roots organisation in Britain for such victims, is not able wholeheartedly to welcome such moves. Of course we are passionately in favour of a system which would compensate victims quickly and adequately. The problem is, that 'no fault' compensation represents only one approach to a problem, the ramifications of which go far wider than can be dealt with by simply throwing money at it. It is not surprising that the BMA has belatedly taken up the call for such a system. In 1978 in its evidence to the Pearson commission, it was against the need for a 'no fault' system.[2] What has changed since then? I do not believe that the number of accidents taking place, proportionate to the number of patients treated, has increased (although the truth of the matter is that there are no statistics available which could demonstrate this or the contrary). It is simply that, thanks in part to the activity of AVMA, the public has become more aware of its right to complain about inferior medical attention and to seek compensation for negligence from health carers in the same way as it does from any other body or person that is guilty of negligence. As a result, doctors, to quote Dr Maurice Burroughs, the Chairman of the BMA working party, 'are increasingly worried about the rising number of complaints and negligence claims against them' and we often hear how anxious they are about the steep rise in their insurance premiums which in 1986 were increased to £576 a year. In other words, to the cynic it may seem that the impetus for the scheme on the part of the BMA comes primarily not because of concern for the patient but because of concern for the position of their members. This is hardly the best basis for the introduction of 'no fault' compensation.

It is more surprising that the community health councils should have become involved in this aspect of the problem of medical accidents. They, as much as AVMA, will be aware that the vast majority of the victims of medical accidents do not initially seek financial compensation but want an explanation for what went wrong, sympathetic treatment and, if appropriate, an apology. They, as much as AVMA, will be aware how much the attitude of the health carers, when an accident takes place, is the cause of the distress to victims and their families; they as much as AVMA will be aware of the lack of accountability of doctors insofar as accidents are concerned. These major problems will not be solved by a 'no fault' compensation system. Indeed, the last mentioned will be exacerbated, not cured, by the introduction of such a system. It seems that they have made the same mistake as doctors, if for different reasons. They have assumed that the urgent problems which beset the issue of medical accidents can only be overcome by a 'no fault' system and without further investigation have decided to push for it.

There are, in my view, a number of major reasons why the BMA and patients' organisations such as ACHCEW are putting all their energies into pressing for a 'no fault' compensation scheme. One is the lack of information about the problem of medical accidents itself. It is quite extraordinary that two responsible bodies should be proposing a complex and expensive solution to a problem when they do not have the faintest idea what the size and nature of that problem is. Nobody knows how many medical accidents occur in Britain each year, what their distribution is, or what the nature of the accidents are. The DHSS refuses to keep statistics of medical accidents separately from ordinary accidents (see the reply from the Solicitor General to John Tilley MP, 7th May 1981: 'I regret that this information is not collected and could not be made available except at unacceptable expense'). There is no obligation on health authorities to keep or pool statistics. Even the doctors' defence organisations, the Medical Defence Union, the Medical and Dental Defence Union of Scotland and the Medical Protection Society, who do at least have statistics of doctors who consult them when they believe that they may have been involved in an accident, refuse to publish even that only partly helpful figure. The *British Medical Journal* in a recent editorial recognised that there is a need in Britain for a formal study of how many people are injured by medical treatment.[4]

We also do not know for what number of accidents a 'no fault' scheme would be really useful. Accidents can be divided for the purpose of this article into four different categories:

1. Those where negligence is clear.
2. Those where, for various reasons, the victims or their relatives would not wish to make a claim under any system.
3. Those where absence of negligence is clear.

4. Those where negligence is in dispute.

1. A 'no fault' compensation scheme is not required to deal with those cases in which negligence is clear. It is true at the present time it is not easy for a victim to obtain compensation even in cases of this kind. The medical defence organisations say that they settle the 'obvious' cases quickly. In AVMA's experience that is not always the case. In any event, the answer to this kind of case can be easily found without resorting to a system of 'no fault' compensation. If the medical profession were to change its attitude towards negligence claims, as I argue later in this chapter, it would be possible to settle all obvious cases within a very short time indeed.

2. There are a number of categories of injury where there should be no question of making a claim for money compensation. First there are those cases involving the death of a young child. The law very sensibly imposes a maximum figure of £3,500 as damages for the loss of a child. Most parents, when they learn this, are horrified and regard the figure as an insult. But what is the correct figure? Ten pounds? A million pounds? Twenty million pounds? Most people would agree that no money can compensate for the loss of a child, so that an arbitrary figure of £3,500 is as good or as bad as any other. But what parent would litigate, or indeed make a claim against a 'no fault' fund if other avenues were open to them to obtain satisfaction?

Similarly, in the case of old people, the law assesses the damages for pain and suffering on the basis of loss of amenities of life. If the actuarial life expectation of an old person is only a couple of years then the damages will be very low. Invariably no other damages such as loss of earnings are involved. Accordingly, the damages are usually not worth pursuing and, again, no old person or relative would think in terms of money compensation if they received other satisfaction. A 'no fault' scheme would not help in any way.

I think it is important that I define the word 'satisfaction' in the context of medical accidents because that is what all victims want when a medical accident has taken place. It does not mean money alone, and often does not mean money at all. It is what I have alluded to before: a full and honest explanation; an apology if it is appropriate; an assurance that every precaution will be taken in future to prevent someone else suffering in a similar way; the knowledge that the action of any person involved will be carefully considered and disciplinary steps taken if that is appropriate; and, finally, financial compensation. From AVMA's experience with more than 4,000 complainants, it is clear that the priority is almost invariably in that order, the exceptions being when the consequence of the accident is so serious that severe disability or death follows so that financial compensation is crucial to the continued well-being of the victim and/or the family. In those cases, the need for money can loom large.

Also in this category are many people who would in no circumstances whatsoever seek financial compensation. Some because they are sufficiently affluent not to bother; many because they find something distasteful about claiming money for an injury when they have suffered no pecuniary loss. Unfortunately, because of the dearth of statistics referred to before, there are no statistics which would reveal what percentage of victims would fall into this category, but it is abundantly clear that there is a large percentage of victims for whom 'no fault' would be no help at all.

3. and 4. The only categories of victims for whom there appear to be an overwhelming case for some system of compensation based on 'no fault' are those where there has clearly been no negligence, or where negligence is in dispute. The size of these categories remains unknown for the reasons stated above. What *is* known, however, is that in the two systems introduced in Sweden and New Zealand these categories have been substantially whittled down. In New Zealand in order to have a valid claim there must have been an accident. The disputes which have arisen on this issue have involved almost as much litigation as did the old concept of negligence. For example, if a person undergoes a heart operation but fails to recover it must still be proved whether the death arose from something done or omitted by the doctor (an accident whether negligent or otherwise) or whether it was an inevitable outcome of the original condition. In Sweden the scheme does not

compensate one of the categories of accident which is fast becoming a major one in this country, that of babies brain-damaged at birth. The reason given for this by Carl Oldertz, who is responsible for running the Swedish scheme, is that the damages in such cases are so large that to include them would make the Swedish scheme economically unviable.

What is therefore being proposed at the present time is a scheme to deal with a small minority of medical accidents, the cost of which is unknown but could be substantial, which will create an enormous upheaval and will, even in the most optimistic view, take a very long time to implement.

In a recent address to ACHCEW, Mr Oldertz said that in Sweden it had taken, from the time the decision had been made to introduce the scheme, two years to bring it into operation. In this country it will clearly be many years before even a decision is taken. The present Conservative government with its attitude to public spending is highly unlikely to be sympathetic to a scheme which will cost many millions of pounds. (It is significant that the BMA has opted for a state-funded scheme, rather than considering one where at least some financial input comes from its members.) While the Labour Party without any meaningful research is making noises about a commitment to a 'no fault' scheme, the fact is that no government of whatever colour is going to have the money in the near future to commit itself to a costly 'no fault' compensation scheme of unknown benefit.

And while the investigations and inquiries into the form and nature of the scheme are being pursued, what will happen in the mean time? Whenever the issue of medical accidents arises, the medical profession, and indeed the government of the day, will be able to say, 'We've committed ourselves to a scheme which will solve all the problems. We are looking into it, but in the mean time we can do nothing'. That is where one of the fundamental objections lies. It is not to a 'no fault' scheme as such, because in principle that must be the ideal way of dealing with money compensation for any accident, medical or otherwise. It is rather to the inadequate commitment the slogan of 'no fault compensation' represents. The slogan is being used by a medical profession anxious to get itself 'off the hook'. 'No fault compensation' is an easy slogan reminiscent of others equally as superficial which from time-to-time appear on the political scene.

I suggested at the beginning of this chapter two questions which should be raised when a medical accident takes place. A 'no fault' compensation scheme deals with only part of one of those questions – how the patient should be compensated. But the other question – what can be done for the patient in other than money terms and why the accident happened – is of even greater importance to the vast majority of victims. That is a fact that only an organisation such as AVMA, dealing day in and day out with sometimes as many as 20 complaints a day, can know.

The approach of the BMA to the problem can at best be described as myopic. Instead of approaching the whole problem of medical accidents, including that of negligence, and trying to discover the nature and cause of the problem and how best to deal with it, they have looked at one small part of the problem, admittedly the one which, if it does not in fact affect their members most, certainly causes the most vociferous reaction – that of financial claims. Of course if they looked only at that part of the problem it would be surprising if they did not come to the decision to press for a state-funded 'no fault' compensation scheme.

The key to the problem of medical accidents does lie with the medical profession, but not in its determination to bring in a new system for compensating victims. It lies in the attitudes towards victims of medical accidents. For this reason, the enquiry by the BMA into 'no fault' compensation and the result of that enquiry represents a lost opportunity for the medical profession. What was required was a fundamental reappraisal of doctors' attitudes towards victims.

At present what happens when an accident takes place, or even if there is a suspicion that an accident has taken place, is that the caring comes to a stop. Just at the very point when the patient is at his/her most vulnerable and in need of both greater medical care and intensive counselling the care ceases altogether and the counselling is not available. Not only that, but the patient, or relatives of the patient, receives no information about what has happened; the doctor certainly does not volunteer it, and even if asked, gives no reply, or an evasive one. Often, and this is a common complaint of victims, the doctor in charge does not even make an appearance to talk to the patient or relatives.

This attitude does not end with 'the doctor', consultant or otherwise. Stories are repeated time and again of the nurse whose attitude suddenly changes from being an 'angel' to being curt, uncommunicative and inaccessible. This is a direct consequence of the attitudes of the doctors at the top. Where they are saying nothing, how can lesser members of the team dare risk their displeasure by deliberately or inadvertently disclosing something which should not be disclosed? Far easier to discourage conversation altogether.

The reasons for this attitude among the medical profession are manifold and clearly complex. It cannot be easy for a doctor whose training and ethic is directed towards curing illness and saving lives, even to consider for a moment that he/she may be responsible for causing illness or death. I would like to consider, however, two of the more obvious reasons which, because they involve matters which are fairly easy to correct provide, if not a solution, at least a major amelioration of the problem.

The first is one that is put forward by the medical profession itself: fear of litigation. The way this fear is expressed becomes daily more graphic as the pressure on the profession mounts as a result of more litigation and the inevitable increase in the amount of damages being awarded by the courts. In a recent BBC Panorama programme, an eminent surgeon was shown saying that he was aware of the lawyer looking over his shoulder as he was operating! It is beyond the scope of this chapter to discuss the question of this particular aspect of medical attitudes, which is known as defensive medicine. Suffice to say, it is a concept borrowed from the United States of America where, if it really is a major problem (which is still open to doubt), it exists because of the very different circumstances which apply to the practice of medicine in that country, not least the fact that medicine there is big business. The importance of defensive medicine in this country is seriously doubted even within the medical profession (see the editorial in the *BMJ*, 23 August 1986[4]). The relevance of such statements to my discussion is simply that they demonstrate that one of the major influences on doctors' attitudes towards the question of accidents is the fear of litigation.

People who are not members of the medical profession can be forgiven for believing that the major component in the fear of litigation is the question of money – the size of the claims, the amount of damages which are being paid out and the consequent increase in the subscriptions which doctors have to pay to their defence organisations. That belief is engendered by the accent which the profession and its defence organisations place on the financial implications. There is an abundance, if not an over-abundance, of articles and correspondence on this topic flowing out of the medical press. And there is the concentration on the fear of litigation itself. The uninformed bystander might naively believe that what concerns a doctor when an accident happens is not the consequences for him or her of that accident – the potential criticism by peers, the possibility of litigation, the appearance in court and, worst of all, the finding of negligence – but the consequences for the patient. If one reads the medical press, however, one will get the opposite view entirely. Almost all discussion of medical accidents deals with the legal and financial consequences and one is led to believe that the trauma for the doctor starts with the receipt of a lawyer's letter, not with the accident itself. (See for example an article in the Journal of the Medical Defence Union.[5])

I do not believe that if doctors were left to themselves that attitude would prevail. They are not, however, left to themselves. Their response to a medical accident is governed by advice which has been given to them over the years by their defence organisations who concentrate on the legal aspect. That advice today is that their members should not admit legal liability. This raises two questions: first, whether doctors understand what 'not admitting legal liability' means or whether they simply interpret it as meaning they should say nothing without reference to their defence organisation? The evidence is that the latter is the case. Whenever I speak to a group of doctors the impression I get from the overwhelming majority is that they believe that their defence organisations require them to say nothing at all. Indeed, at the last such discussion in which I spoke jointly with a representative of one of the organisations, not only did the young doctors indicate that that was their general impression but one of them, who had been involved in a minor way in an accident, related that when he had telephoned his organisation for advice he had been specifically told to say nothing. If further evidence is needed, I would refer to the statement, reported in *Hospital Doctor*, made by a consultant at the 1986 BMA conference that 'it was deplorable that a doctor was not allowed to express sympathy to the patient or his relatives after a mishap'.[6]

The second question is why this advice is given at all? This raises the issue of the role of the defence organisations in influencing attitudes in this very emotive area. The defence organisations are run by doctors for doctors. They are non-profit making. Their insurance role is simply to pay compensation to a patient who has been injured by a member's negligence. In carrying out that role, their sole function should be to ascertain the true facts. They should in no way seek to influence a member's relationship with his or her patient. A member should be entitled therefore, in the interests of the patient, to say anything to that patient, or relatives of the patient, even if what is said amounts to an admission of liability. After all, a doctor is not going to say anything which is untrue. If the truth makes the case indefensible for the defence organisations so be it. On the other hand, if the doctor expresses an opinion as to the cause of the accident which subsequently turned out to be incorrect, that opinion will have no bearing on the outcome of the case once the true facts have come out.

I have no doubt that the vast majority of, if not all, doctors would be far happier to pay an increased premium in return for being allowed, and indeed encouraged, to continue to treat their patients in a more sympathetic and open manner and to continue to maintain a true doctor-patient relationship. This approach is not a new one. One of the most senior judges in England, the Master of the Rolls, Sir John Donaldson, urged a similar approach when speaking to the Medico-Legal Society on the 14 February 1985. He referred to the duty of solicitors to inform their clients if a situation has arisen in which their client should take independent advice, and to make all relevant information available to the new adviser. He went on 'But what about doctors? Should not the same rule apply? Indeed, I think that there is a much stronger case for such a rule in the case of doctors. The relationship between doctor and patient is so much closer than between lawyer and client. The patient is therefore so much more trusting and reluctant to complicate the possibility of negligence. Is not a policy of keeping silent when you think you may have been negligent an abuse of that trust? . . . If a doctor thinks that he may have been negligent and damage has undoubtedly resulted, the question that I want to float for your consideration is whether it should not be part of the doctor's professional duty to give full and frank disclosure to the patient of what he did and why he did it and to suggest to the patient that he takes independent medical and legal advice.'[7] The situation of victims would be immeasurably improved at a stroke if the organisations not only adopted that attitude but made positive efforts to educate their members along those lines.

This brings me to the second of the more obvious reasons for the current somewhat paranoid attitude of doctors towards the problem of medical accidents, and that is the question of education. Everyone accepts that the topic of medical accidents is a complex one, but until recently it was not seen as an important one. The very fact that the BMA could in evidence to the Pearson commission brush aside the suggestion of 'no fault' compensation shows how it perceived the problem in those days. As a result, it is an issue that is largely ignored in the medical students' curriculum. It is significant that in law schools, however, the subject has in recent years gained increasing importance and there are now a number of institutions at which it forms a significant part of the syllabus.

Yet notwithstanding that the problem of medical accidents and how they are dealt with by doctors is in danger of compromising the essential trust between patients and doctors, the subject receives derisory, if any, attention in medical schools. How can a doctor be expected to know how to cope with an accident if he/she has not been taught about it, or even warned that it may be a real possibility at some time during his/her career. This ignorance, coupled with the fear of litigation, is a far greater stumbling block to the improvement of the situation for victims of medical accidents than the procedures for getting compensation. And it is these issues which must be addressed urgently in the interests of doctors and patients alike. If all the interested parties (other than the victims) direct their energy and effort towards seeking the Holy Grail of 'no fault' compensation, who will be seeking solutions for the here and now?

Notes and references

1 Department of Health and Social Security. Report of the Committee on Hospital Complaints Procedure (Chairman: Sir Michael Davies). London, HMSO, 1973.

2 Royal Commission on Civil Liability and Compensation for Personal Injury. Report. Cmnd 7054 (Chairman: Lord Pearson). London, HMSO, 1978.

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5 A Simanowitz. Negligence claims. Journal of the Medical Defence Union, vol 2, no 2, pages 15–16.

6 Statement by a consultant at the 1986 BMA conference. Reported in Hospital Doctor, 3 July 1986.

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LAW AND MEDICAL PRACTICE

Lord Scarman

The subject of this paper is one field of the law, the law dealing with the relationship between a doctor and his patient. The law can move and, in moving, can affect and is bound to affect the ethical conventions of the medical profession. It is interesting that the law so far as it concerns the doctor–patient relationship has been, at any rate within the United Kingdom, static for a number of years, indeed for a number of generations. It just has not moved and, of course, those who have some knowledge of the history of English law will know that the common law is a system of law which, depending as it does upon the judicial initiative of High Court judges, goes through cycles. It will have a period of intense activity – for instance, the seventeenth century, the middle of the nineteenth century and the middle of the twentieth century – but it will also have periods of great stagnation. A notable period of great stagnation was after the great procedural reforms of the Judicature Act 1873 – nothing really happened by way of major reform of common law principle until the post-war years and the arrival of the Labour Lord Chancellor in the person of Lord Gardiner.

So, there is nothing very surprising in the fact that we suddenly find this highly limited branch of the law on the move. It is immensely interesting, not only because it is on the move but because it touches the medical profession and through the medical profession, every citizen: all of us are sooner or later, in death if not earlier, bound to be the subject of medical attention. The two decisions of 1985, judicial decisions of the House of Lords, which illustrate that the law is on the move, are known as the *Sidaway* decision[1] and the *Gillick* decision[2] and I shall be discussing both.

I suppose one could say that the two decisions have highlighted a legal truth about medicine which had become obscured by the activities of the doctors themselves. That legal truth is simply this – that the doctor–patient relationship is subject to a wider law than can be encompassed within the limits of a medical or a clinical judgment. A doctor in his relations with his patient has to pay regard to values other than the strictly medical – he has to have regard to those social values which have given rise to a number of legal rules. The *Sidaway* and *Gillick* cases in their different ways, both emphasise and illustrate this legal truth.

Sidaway was the case of a lady who had had a surgical operation which had untoward consequences and it gave rise to a number of well-known problems. First, the problem of informed consent of the patient to an operation – is it necessary under English law? Second, the more profound question: has the patient the right to know from the doctor what are the disadvantages, as well as the advantages, the benefits and the dangers of medical treatment that the doctor is recommending? That is what *Sidaway* was essentially all about.

Gillick was, of course, concerned with the duty of a doctor to a parent or guardian of a child under the age of 16 when the child seeks from him advice and treatment without the assent of his or her parents. The question really was: did the doctor owe the parent any duty? Could the doctor take the child on without the assent of the parent? I suspect that until Mrs Sidaway and Mrs Gillick brought these questions with great pertinacity to the attention of the Judicial Committee of the House of Lords, everyone, including very distinguished lawyers, had thought that they were not legal questions at all; that they could be resolved against the background of medical ethics and by the application of ethical principles, which themselves would be determined by the medical profession.

I shall now examine the *Sidaway* case and the *Gillick* case in greater detail. I shall forbear going too deeply into the medical detail of these two cases, as both Mrs Sidaway and the Gillick family are still alive.

Mrs Sidaway had a lot of pain in her neck. She had had, many years ago, an operation to relieve this pain and the operation, after a number of tribulations, had been reasonably successful. Unfortunately, the pain came back; she found it intolerable; she went to the same surgeon and she accepted his advice to have a further operation on her neck. There was a risk involved in this operation which was, mark you, an operation not to save life but to relieve pain; the condition was not a threat to Mrs Sidaway's life. But there was a risk in this operation to relieve pain and that was that it might make her condition worse – it might not only fail to relieve pain, it could leave her with a partial paralysis and, in the event, it did so. She brought an action for damages for personal injuries suffered, as she says, as a result of the negligence of those who were treating her including her surgeon. And her case was simply this. The risk of partial paralysis was never explained to her. She did sign the consent form to the operation – it was presented to her by a junior doctor who knew very little about the possible consequences of the operation, and he certainly did not explain to her what the risks were. The surgeon who operated knew – but he did not explain the risks either. The conclusion of her case was that she would not have had that operation had she known of the existence of this risk.

Mrs Sidaway lost her case. It is very important to appreciate why she lost her case. She lost her case because she failed to prove that her surgeon, who was dead by the time the case reached court and had been dead for a number of years, had *not* warned her of the risk. The judge, although he believed Mrs Sidaway when she said that she would not have had the operation had she understood that there was this risk, was not prepared to believe her when she said the surgeon had not attempted to explain it to her. The reason, in fact, why the judge came to that conclusion was a perfectly good one. He was not certain that Mrs Sidaway's recollection was to be relied upon on that crucial matter – the surgeon had operated before and it was this surgeon's practice to explain, save in exceptional circumstances, the nature of the risk associated with this type of operation, which was an operation not to save life but to relieve pain. So she failed on the *facts* and for reasons which I am sure every one of you will appreciate were good reasons.

But the House of Lords, sitting in its judicial capacity, took the opportunity to explore the problem of the patient's right to know. The English law of this subject is totally undeveloped. In fact, insofar as advice, diagnosis and treatment are concerned, English law (English case law), with one or two minor and very recent exceptions, has not explored anything beyond what was conveniently known in the profession as medical negligence. What do lawyers mean by medical negligence? Briefly, medical negligence is a failure by a doctor in advising or treating his patient to comply with the standard of care required of him by law. But the law's standard is, in effect, set by the medical profession. If a doctor can show that his advice, or his treatment, reached a standard of care which was accepted by a respectable and responsible body of medical opinion as adequate, he cannot be made liable in damages to his patient if anything goes wrong. It is a totally medical proposition erected into a working rule of law; and the only contribution that legal science had given to this very limited rule is that the law did, and does of course, impose a duty of care upon the doctor. But the standard of care which has to be observed in order to meet that duty is left entirely to doctors to determine according to the formula which I have just set out. To succeed against the doctor, a plaintiff has to prove that there is no body of opinion which could be said to be respectable and responsible that supported what the doctor did.

In *Sidaway*, it is fair to say that four of the five Law Lords who heard the case moved the law away from exclusive reliance on this working rule of medical negligence. They took a look at the law in the United States; they took a look at the law in Canada and they considered whether the doctrine of informed consent (or the patient's right to know), which has been developed in some of the case law in the United States and in Canada, had any place in English law. Only one of the Law Lords said 'the right to know is basic human right and although there may be exceptional circumstances in which the right can be overridden, the doctor must respect it and his practice must faithfully reflect it'. This Law Lord went further than the others. Three of the majority, however, went some of the way with the speech to which I have just referred. They recognised the existence of the right to know but held that the patient should prove that circumstances existed in which the right to know took precedence over the duty of the doctor to do, what in his judgment, was medically best for his patient. The three therefore agreed with the first Law Lord that the right to know exists, could never be disregarded and, on occasions, would itself prevail over the doctor's right to deal with his patient in the way that he thought best.

This was a remarkable development because it means that the law now does impose upon the medical profession an obligation which arises outside the medical field, that is, the duty to satisfy the patient's basic right to know. Where, then, as a matter of history, does the right to know come from? Historically, it might be thought to come from the necessity of obtaining a patient's consent to surgery. This, of course, has nothing whatever to do with medical science or medical ethics at all – it is a trespass to the person, an assault if you like, to incise a person with a surgical knife, or indeed with any knife, without that patient's consent. Therefore, historically, the consent form is necessary to surgical operation, or indeed to any medical treatment which involves any physical contact. You can see how important the medical profession (before *Sidaway*) thought that this right, this necessity, of the patient's consent to operation was: they thought it was an absolute *formality*. As in Mrs Sidaway's case the practice was to send down the junior doctor, who knew nothing of the specialty in which his senior would be operating, to get the patient's consent: he was not sent down to give a reasoned explanation to the patient, even to make a judgment as to whether the patient was fit to receive the information or not; he was just sent down to get the consent. This became hospital practice before *Sidaway*. It was a perfunctory practice, perfunctory because its origin was the piece of history about trespass to the person. *Sidaway* has exploded all that, taking its inspiration from United States law and from a certain amount of Canadian jurisprudence. In *Sidaway* the judgment of four Law Lords based the right to know on a human right, nothing to do with history at all. If you like, you can say that the human right started with the United Nations Covenant for the Protection of Human Rights entered into immediately after the end of the war – you can say that if you like. I speak as a lawyer with a longer memory. It seems to me to be part of the natural rights of man and that is now its jurisprudential position; it is an integral part of the 'Law's Empire'.[3]

So the law, as left by *Sidaway*, is that if there are no medical reasons which should be operative against informing your patient as to the consequences of the operation you are proposing, the doctor is obliged by law to give an explanation of those consequences, the cons as well as the pros, to his patient. I have little doubt that as the case law develops (as it will develop) on the basis of *Sidaway*, the law will come to include the necessity of the doctor indicating the possibility of other treatment than that which he personally recommends. However, that is where the law now stands. There are, of course, all sorts of medical objections to it, and some doctors feel that it puts too heavy a burden upon them. If they discharge their duty, then they frighten their patient; or their patients do not want to know anyway. These are problems with which I do not have space to deal with here; they can be resolved in the painstaking way in which our common law invariably develops by looking at each set of circumstances and each problem in turn, dealing with them on a case by case basis, and keeping the law in line with basic principle. Of course, the law does not require a doctor to explain to an imbecile or to an unconscious patient, or to a patient whose health would be badly put at risk by knowing – the doctor does not have to explain to such patients. But the doctor can no longer hide behind these legitimate exceptions to deny the existence of the right.

I now turn to the *Gillick* case. It illustrates the same legal truth as *Sidaway* but in a very different field. The principle of law which *Gillick* established is this: that a doctor can lawfully treat a person under the age of 16 in certain circumstances without the consent of the parent or guardian. The principle has been in our law, though not always stated in quite such bald terms, for a very long time indeed. By statute, or course, persons over the age of 16 can now lawfully assent to medical treatment. There is no statute which says that a child under the age of 16 can give a lawful assent; but it has been considered for a very long time that a child can in certain circumstances. The House of Lords has reformulated the ancient principle. The House of Lords has gone back to certain dicta in our law as old as the eighteenth century, in which the courts, although they set ages at which certain consequences were to arise, were faithful (at any rate, in their words) to the principle that a child under the age of 16, if of sufficient understanding, can give a lawful assent to medical treatment. There is nothing in any Act of Parliament to negate the principle; and it is now a judicially evolved rule. It was explicitly recognised by the House of Lords in *Gillick*.

The first consequence of the *Gillick* case is that a young woman (or man, but it happened to be in that case a young woman) under the age of 16 who has sufficient understanding and maturity to follow and comprehend the implications of the advice that is given, may receive medical (including contraceptive) advice or treatment without the assent of her parents, *if that is what she wishes*. She is, in law, capable of assenting to medical treatment without the consent of any person other than herself, even though she is a minor and even though she has parents or a guardian living and available. Of course, that greatly extends the liberty of the doctor, at any rate, as previously considered. *Gillick* is different from *Sidaway* in this respect, in that it increases the range of medical or clinical judgment.

What if a young person seeking medical treatment – or, of course, contraceptive treatment which has recently become (it never was in the old days) medical treatment – *is* in the view of the doctor *not* sufficiently developed mentally or emotionally to understand the full implications of the treatment that she is seeking? Now here *Gillick* is firm against the doctor. The doctor is *not* to treat such a person without the assent of the parent or guardian *unless* he satisfies himself that it is necessary to do so. You could really say that he has got to be satisfied that there is in his medical judgment an emergency. 'Emergency' is a big word – it does not sound like a very apposite word at first – to cover a young woman who wants to avoid the risk of pregnancy – and I will come back to that in a moment. I think, basically, that is what it is – he has got to be satisfied that in medical terms there is an emergency, or that there are circumstances which render treatment necessary, even though the assent of the parent cannot first be obtained.

In the case of a child of insufficient understanding, unless he is so satisfied, he cannot treat the girl without her parents' consent. If he says, 'I must tell your parents', she may say, 'Well, please do not. I tell you, you must not do it'. Then he can say, 'Very well, I cannot accept you as a patient'. He is entitled to say that – it may go against the grain – and he would not say it if he thinks, of course, that treatment is necessary. If he does say that, is he under an obligation to tell the parents that the girl has been to see him for advice? He has told her she ought to have their consent, she has refused and he has therefore sent her away without advice. The answer is 'no', because there now emerges another duty of the doctor, to which I have not yet made reference, the duty of respecting the confidence of those who seek his advice, whether they become his patients or not. This girl technically has not become his patient because he has refused to accept her; but the duty of confidence is there and the law would not, I think, require the doctor to break that confidence. So what is the way out of the difficulty if he cannot treat her without the assent of her parent or guardian *unless* it is necessary? The *Gillick* case set out some of the circumstances in which a doctor can treat a patient contraceptively and give contraceptive advice without consulting the parents, even though the child be of insufficient understanding herself to give a lawful assent. The circumstances we know all too well: the orphaned girl (she may be orphaned through her own choice) coming south to live alone in London; parents indifferent, irresponsible, unavailable; indeed, all sorts of family situations, or situations of human abandonment which one can visualise for oneself. In circumstances such as these the doctor may say: 'Well, something must be done to protect this girl. It really is a nonsense to go searching for the parents – either they cannot be found, or if they are found they will wash their hands of her, or there are other physical conditions associated with the girl herself which make it necessary'. Such circumstances are all too familiar. One does not have to define them: they will be developed on a case by case basis insofar as they are not already covered by the Lords' decision in *Gillick*. In all these circumstances, the doctor can treat the patient, can offer contraceptive advice or treatment, without the assent of the parent.

Therefore, *Gillick* again indicates, within a very different context from *Sidaway*, how medical practice now requires, as a matter of law, that doctors should concern themselves with values and rules outside the limits of clinical judgment. *Sidaway* reveals that, save in exceptional circumstances, a patient has the right to know the risks as well as the advantages of the treatment proposed and the alternative options to the treatment proposed. *Gillick* establishes the right of a minor under the age of 16, if of sufficient understanding and maturity, to give a valid consent to treatment without the necessity of consulting the parent or guardian. The law, therefore, is on the move. The message going forth from the House of Lords is that medical practice remains subject to the rule of law, and that there are human and social values which in some cases will override medical priorities. Medical ethics must be formulated within the law, and are subject to the rule of law.

Notes and references

1 *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] 2 WLR 480.

2 *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 1 All ER 533.

3 The term 'the Law's Empire' is borrowed from Professor Ronald Dworkin's book of that name. London, Fontana Press, 1986.

WOMEN IN MEDICINE

Wendy Savage

Women use the National Health Service (NHS) more than men, and the reasons for this are complex. They bear children and have a more complicated reproductive system than men, which is more likely to cause symptoms; they tend to use contraception that requires medical input; they are more likely to care for children, disabled or old people and attend with them when they may have the opportunity to mention minor symptoms; and, of course, they live longer and older people consult their doctors more frequently. However, in this chapter I am going to concentrate on women doctors rather than women as patients or as other workers in the NHS.

The NHS is the biggest employer of labour in the United Kingdom with about a million employees, the majority of whom are women. The structure of the NHS is different from that of a large business or manufacturing organisation, being made up of a series of professions: medicine; nursing; physiotherapy, radiography, and so on; laboratory and other technicians; ancillary staff such as porters, auxiliaries and cleaners; and the administrative staff which includes managers, clerks and medical secretaries. All these staff have their own hierarchical structure while being part of a multidisciplinary team looking after patients. In teaching hospitals there is the additional complication of the university medical appointees with honorary consultant contracts who are also part of the university structure and hierarchy with its internal politicking.

Within the medical profession, although there is equality of pay and terms and conditions of service, one finds that women

Table 5 Proportion of women consultants in various hospital specialties: September 1985, England and Wales

	Total consultants	*% women*	*Total SRs**	*% women*
All hospital	14,242	12.9	3,284	24.7
General medicine	1,167	4.3	200	5.5
Geriatric medicine	487	11.5	113	23.0
Paediatrics	603	18.6	157	38.8
General surgery	957	0.6	182	2.2
Paediatric surgery	39	15.3	6	16.6
Obstetrics and gynaecology	772	11.6	138	20.3
Anaesthetics	1,912	18.8	100	26.0
Adult psychiatry	1,186	16.9	101	31.0
Child psychiatry	356	37.0	93	49.0
Mental handicap	164	28.0	15	34.9

* Doctors must spend time in the SR grades before becoming consultants.

doctors are poorly represented at the top of the profession, and less likely to receive merit awards which boost the salaries of a third of hospital consultants. They are underrepresented in teaching hospitals so that female students may lack role models. For example, there is not one professor of obstetrics and gynaecology who is a woman, although this is a specialty dealing exclusively with women. If one looks at the proportion of women who have become consultants by specialty, there are some interesting differences (see Table 5).

For some years now, at least ten to my recollection, the medical press has carried articles discussing the 'fact' that soon 50 per cent of medical graduates will be women, some suggesting that this is already the case. This is usually presented as a 'problem'. If we look at the evidence given in the latest DHSS paper on career prospects, although the proportion of women entering medical school has risen from 24.2 per cent in 1967 to 44.3 per cent in 1984–5, even by 1990, when the latter entrants qualify, women will still not have reached 45 per cent of those entering the profession. It is true that in some of the provincial schools 50 per cent or more of the students entering medical school are women. But in the more prestigious London schools it is less, and in the London Hospital Medical College the proportion of women entrants has never risen above 33 per cent. When some years ago I spoke to a former dean about this low figure he told me that parents did not like to send their daughters to the East End, and when I suggested that maybe a woman on the interviewing panel might be a good idea he replied that a father of teenage daughters was just as good as a woman. This to me completely missed the point that it is very intimidating for a young woman to be interviewed by a panel consisting entirely of middle aged men, especially if they all concur in putting to these young women questions about their future plans for marriage and children which are rarely, if ever, asked of men.

The scarcity of women to act as role models in the more popular specialties of medicine – surgery and obstetrics and gynaecology – may be one reason why young women decide not to pursue a career in one of these. Certainly in my own specialty an increasing number of young women state after qualification that they want to become obstetricians and gynaecologists, but the proportion of women at consultant level has remained at approximately 12 per cent over the last 25 years, and over the five years 1979–84 only 10 per cent of new consultants appointed were women. Nor is there a higher proportion of female senior registrars who will be the consultants appointed in the next few years. Despite the setting up of a subcommittee in the Royal College of Obstetricians and Gynaecologists (RCOG) to look into the question of women in this specialty, we still lack hard evidence as to why women wanting to do this work do not succeed in climbing up the ladder. Anecdotal evidence suggests that the attitudes towards women and the way the work is organised cause many women to give up (and some men who have sympathetic attitudes towards women patients).

There is also a difference between the sexes in the choice of specialty which may reflect intrinsic differences between men and women but also reflects the reality of the situation as women perceive it as students. A system in which women are continually reminded that they should plan for their careers with the knowledge that they will be responsible for child-

Table 6 First career choices of doctors qualifying in 1974–80 and 1983 (percentage of doctors followed by percentage of women)

Specialty	*1974–80*	*1983*
Medicine	20.3 (27.9)	14.1 (32.7)
Paediatrics	5.6 (51.9)	4.2 (48.9)
Surgery	16.2 (11.9)	12.3 (14.3)
Obstetrics and gynaecology	3.3 (40.6)	3.3 (48.9)
Anaesthetics	5.3 (37.2)	4.5 (40.6)
Psychiatry	3.4 (36.9)	4.1 (45.5)

bearing and rearing, and where they are discouraged from selecting specialties by the attitudes of the male consultants and their male peers, will obviously make some women decide to take a career pathway in which such conflict is avoided. The male suggestion that women are not 'tough' enough for surgery or obstetrics and gynaecology, or academically tough enough to do medicine, is I think shown to be false by looking at the proportions of women who reach consultant posts in anaesthetics (18.8 per cent), paediatric surgery (15.3 per cent), and ophthalmology (7.7 per cent), which are all just as exhausting in the training grades as general surgery (0.6 per cent), and the difference between general medicine (4.3 per cent), geriatrics (11.5 per cent) and paediatrics (18.6 per cent). What general medicine has is prestige in comparison with geriatric and paediatric medicine.

In Table 6 I have charted the proportions of women choosing to do different specialties soon after qualification, and one can compare the earlier figures from 1974–80 with the senior registrar (SR) figures in Table 5 to see approximately how successful they were in achieving their aims. If one speaks to male consultant surgeons about the small number of women reaching the top in surgery they almost without exception say what a hard life surgery is, and how women do not want to work like this, or mention their 'biology'. Women are rarely seen on the council of the Royal College of Surgeons and, if they do succeed, may display attitudes that are little if any

Table 7 Women as a proportion of newly appointed consultants 1979–84

Specialty	*NHS posts*	*% women*	*Academic*	*% Women*
Medicine	238	5.5	67	9.0
Paediatrics	150	19.3	39	15.4
Surgery	165	1.2	41	0.0
Obstetrics and gynaecology	154	10.4	32	6.3
Anaesthetics	524	21.0	27	18.5
Psychiatry	320	26.3	35	25.7

different from their male colleagues. In Table 7, which shows the percentages of newly appointed consultants between 1979 and 1984, this trend continues. But general surgery has fallen below 1.0 per cent, bad news for those women with breast cancer who would prefer to see a woman surgeon. Breast cancer is the commonest malignancy in women and about one woman in 12 will suffer from it, but it is only in the last few years that the psychological implications of the treatment have really been discussed openly, and the feelings of women seem often to be ignored by surgeons.

Having brought the difference between consultant anaesthetists and surgeons to the attention of some of them, the usual response is 'well, anaesthaesia is suitable for married women because one can get sessional work whereas surgery is a full-time job'. A plausible explanation until one realises that, at least in London and the bigger provincial cities, the majority of surgeons are part-time and some spend a considerable amount of time in private practice. Why should women not be part-time and be at home with their children rather than in Harley Street? Might there not be some men who would prefer to have some family life rather than work 12 hours a day and at weekends? Does working full-time make better doctors who are more able to understand their patients' emotional needs? Why, as one woman doctor said, it is better to say you have to go early to collect your car from the garage than admit you must collect your children from school as part of the car pool?

A similar discrepancy exists between medicine and paediatrics, with twice as many women appointed in the latter specialty over the last five years. Yet in both the training grades and on appointment as a consultant, if there is any neonatal work involved, the amount of emergency work is far greater in paediatrics. But somehow, because the patients are children, women succeed more easily in this specialty. While some of this may be choice on the part of women, one feels that maybe men who want to work in paediatrics (a specialty which does not attract a lot of private practice), who like and can relate to children, may also rate women higher as people and get on better with them.

I believe that the major reason for these discrepancies, and the underrepresentation of women in the royal colleges, the General Medical Council and the British Medical Association, is the male domination of medicine, which like all our institutions is effectively ruled and organised by men. If we look at business, the professions and Parliament, we are behind many of our European partners in treating men and women as equals. It is a sad commentary that the first woman Prime Minister in this country, in a Parliament in which only 4 per cent of the MPs are women, should have presided over an administration which has been so negative towards her own sex. I refer to the following: her support of Mr Corrie's bill to amend the 1967 Abortion Act, a legal initiative which has done so much for women's health and without which women cannot compete professionally or in the labour market with men; the attack on maternity benefits; the way that women caring for the disabled or fighting against early retirement or equal pay have had to pursue cases to the European Court; her emphasis on so called 'Victorian values', a climate in which women are seen to be better employed at home rather than working for pay outside it; and the double standard applied to women as shown so starkly in the Parkinson/Keays affair. I believe that she has adopted the strategy of becoming an 'honorary man' in order to succeed in a man's world – although her remark in the recent by-election, 'I have never squealed', made me wonder if it wasn't a schoolboy's world!

Women doctors initially choosing to do obstetrics and gynaecology may not wish to adopt this strategy, and find that they do not want to work in the way the service is organised. They opt out, choosing to do general practice or another specialty such as paediatrics where they are not forced to adopt such a role.

An additional factor is that many male doctors do not see women as equals and consciously or unconsciously discriminate against them. The consultant who was quoted in the *Guardian* a few years ago as saying 'women make good SHOs and registrars but they are not consultant material' was expressing what many men feel, although few of them would say this publicly today. It is very difficult for women medical students or trainees to maintain their conviction that they will succeed in this kind of environment, as these attitudes are not confined to those that teach them but shared by some medical students.

In a questionnaire study that I carried out in the late 1970s to see whether or not our teaching in obstetrics and gynaecology had any effect on the attitudes of the students towards women, some unexpected findings emerged.[1] Women students differed markedly in their attitudes towards women patients compared with male students, and were more likely to change their attitude to obstetric care in a positive way than were male students. The latter were more likely to hold stereotyped views about women and many showed negative attitudes towards their fellow female students with, for example, 50 per cent agreeing with the statement: 'Increasing the number of women entering the medical profession is short-sighted, and should be limited to perhaps 30 per cent, since most of these will be lost to the profession for *most of their useful working lives*' (my italics, 1987). There is no evidence for this statement, and Audrey Ward's survey of two cohorts of women doctors in the 1950s and 1970s showed that despite the fact that more women doctors were marrying and having children, the majority of them worked full time for most of their careers.[2] A proportion took on part-time work when their children were small so that they did not progress up the ladder in a linear way but had a plateau in the middle. This, of course, may explain why some women – as in the case in the Civil Service – do not progress to the top as this may be the crucial time for getting the 'best' jobs in order to later obtain the most prestigious consultant posts (that is, those in teaching hospitals). Frey in Sweden in 1980 surveyed male and female doctors and found that women did 80 per cent of the work of male doctors because of the time taken off for child care.[3] She also noted that women doctors were more interested in patients and less interested in money and prestige than their male counterparts. Bewley and Bewley in 1976 also looked at what happened to male and female doctors and found that many male doctors were lost to the profession as they went into other jobs such as medical journalism and the drug companies and that they were more likely to become alcoholic or drug addicted.[4]

Walton in Edinburgh looked at the performance of male and female students doing psychiatry and found that the latter were more conscientious, got on better with the patients and were more likely to challenge their teachers – an attitude that many of us, as he did, would see as commendable![5]

A majority of both sexes (63 per cent of men and 85 per cent of women) disagree with the statement: 'Historically women have had to fight to be accepted into medicine; but today there is no bias shown towards women as medical students or graduates on account of their sex'. But a third of men and only 6 per cent of women agreed with the statement: 'Women's particular ability to empathize with others equips them for the caring role of nursing rather than the hard decision making of medicine'.

What was also striking about the responses of the students was how rarely they said 'don't know' in response to questions which there was no reason for them to know about. This I believe is a result of the selection of students at too early an age from a limited social background, and because of the high A-level grades required favouring those who have had a public rather than a state school education, with all the selfconfidence that this type of education fosters. This may well explain the tendency of the medical profession to run like 'an Edwardian gentleman's club' (*British Medical Journal*, leader, 2 August 1986) and for progression up the medico-political ladder to be heavily influenced by the 'old boy network' and, some suspect, the Freemasons. The medical politicians who work their way up the ladder to the pinnacles of presidency of the GMC or the royal colleges are rewarded by a knighthood, and the closeknit network of those who succeed (predominantly men) believe strongly in the right of the profession to be self-regulating and for its members to conform and not rock the boat.

Women find it difficult to be members of this club and remain true to their ideals. Yet unless they take their place in this medico-political committee structured world they, like hundreds of male doctors who don't like the system, will continue to find themselves not fulfilling their potential and working in a profession that increasingly is not giving patients what they want and, I believe, have a right to expect in the latter part of the 20th century.

My own experience of being unjustly suspended from my post is not unique; what was unique was the fact that the battle was fought in public thus exposing the bureaucratic dishonesty which I believe is endemic today in many of our institutions. A BMA secretary quoted in the *Independent* said of these suspensions: 'a doctor is accused of incompetence or misconduct when the basic problem is that his face does not fit' and this is a problem for large numbers of women doctors, many of whom resolve the dilemma by retiring from the battle and doing unpopular jobs for which their patients are eternally grateful.

Most couples today have only two children and the time needed to carry and deliver those babies is short compared with a lifetime career. Both men and women can care for children and both sexes need time at home to be with their families. Forty years after the NHS began it is time to take a long hard look at the way that medicine is organised to make it more responsive to the needs of the patients and to careers which allow both sexes adequate time for leisure and reflection. Those at the top, many of whom are academics, should serve on committees for a strictly limited time so that the power is shared out more equitably and those speaking for the profession are not so unrepresentative or cut off from the lives of ordinary doctors and ordinary people – especially women.

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INDEX

Page references in **bold type** indicate authorship of papers in this volume.

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Studi
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Rights and Wrongs in Medicine: King's College Studies 1985-6

edited by Peter Byrne

This is the first in the annual series of volumes on medical law and ethics based on lectures given at the Centre of Medical Law and Ethics, King's College London. The contributors, who came from a wide range of disciplines and represent diverse interests, review important issues in the forefront of recent controversy, relating particularly to artificially assisted reproduction and to the Gillick judgment. It is hoped that their essays will stimulate reflection and debate on the ethical and legal issues that surround contemporary medical practice.