THE CHURCH IN SOCIETY COMMITTEE

MEMBERSHIP

The Bishop of Clogher, The Rt Rev Dr MGStA Jackson (Chairman)
The Archbishop of Armagh, The Most Rev Dr RHA Eames (retired December 2006)
The Archbishop of Armagh, The Most Rev AET Harper (elected January 2007)
The Archbishop of Dublin, The Most Rev Dr JRW Neill
Rev Canon Dr IM Ellis (Honorary Secretaries' nominee)
Dr R Corbett (Medical Ethics Panel)
Rev KRJ Hall (Social Justice and Theology (NI) Sub-Committee)
Mr SR Harper (Legislation and Politics (RI)) Sub-Committee (Honorary Secretaries' nominee)
Rev WD Humphries (Environmental and Ecological Panel)
Rev Canon WA Lewis (Legislation and Politics NI Panel)
Dr K Milne (European Affairs Working Group)
Very Rev FJG Wynne (Social Justice and Theology (RI) Sub-Committee)

OBJECTIVES

The Church in Society Committee of the General Synod of the Church of Ireland seeks to identify, contribute to, challenge and develop areas of living today where the mission of the Church can be active and the love of God shared. It does this through the development of reports, resource materials and by developing projects that apply theological perspectives to public issues in a challenge to Christian living.

EXECUTIVE SUMMARY

This year's major projects included:-

- Holding an Ecological Workshop in Dromantine Conference Centre, near Newry, to share experiences and model good environmental practice at parish level.
- Developing an environmental policy for central and Church offices.
- Publishing and promoting the *Local Partnerships, A theological and pastoral reflection* booklet.
- Maintaining dialogue with the political groups in Northern Ireland.
- Preparing responses to consultations and legislation. The following were prepared: Response to the Office of the First Minister and Deputy First Minister on their *Victims and Survivors (Northern Ireland) Order 2006* (Appendix E); Submission to the Joint Committee on Child Protection (Appendix K).
- The Chairman prepared a number of statements also. These were: A response to the death sentence of Saddam Hussein (Appendix A); a Forum for a Bill of Rights for Northern Ireland (Appendix B); a response to the Anti-Poverty

Strategy for Northern Ireland, *Lifetime Opportunities* (Appendix C)*;* and a response to the Statement from the Police Ombudsman for Northern Ireland (Appendix D).

- Contributing to the National Forum on Europe and facilitating presentations from the Forum at various diocesan events.
- Preparing statements on issues of medical issues: 'Advance Directives'*,* 'Ethical Issues and Care of the Elderly', 'Stem cell research'
- Developing further the Committee's relationship with the Methodist Council for Social Responsibility. A joint conference is being organised for 2008.
- Providing support to Archbishop Eames' initiative on child poverty.

COMMITTEE REPORTS

SOCIAL JUSTICE AND THEOLOGY (RI) SUB-COMMITTEE

The work of the group in 2006 comprised the following:

1. **Publication of document** *Local Partnerships*. *A theological and pastoral reflection.* This booklet reflects theologically and pastorally on the Church's place in social care and engagement at the local level. It shows how much is done by partnership between the statutory agencies and voluntary work. It recommends full participation by Church people in this area.

2. **The International Community in Ireland**. The booklet by the Rev Patrick Comerford designed to help parishes in their approach to the "new Irish" is in preparation. The title will be *Welcoming Difference: the Church of Ireland in a Plural Society*. It is intended that publication will be available by May 2007.

3. **Glenstal Ecumenical Conference, 2006**. The Chairperson gave a paper on the group's work. The conference was most useful and productive as a source of inspiration and information.

4. **Child Poverty Initiative**. The group keeps a watching brief on this endeavour.

5. **Rural Ireland after Sugarbeet**. The group is drafting a booklet reflecting upon the implications for Church and society of the radical changes now taking place in rural Ireland. Input has been invited from the Methodist Church in Ireland.

6. **Pastoralia in a Digital World**. Work is beginning as regards the significance of the electronic revolution for pastoral and social care.

SOCIAL JUSTICE AND THEOLOGY (NI) SUB-COMMITTEE

A response to the Victims and Survivors (Northern Ireland) Order 2006 was submitted to the Office of the First Minister and Deputy First Minister (Appendix E). This was a follow up to the sub-committee's response to the *Services for Victims and Survivors* consultation process in March 2005.

The Rev Kenny Hall, Chairperson of the sub-committee, also issued a statement with regard to the Report from the Interim Victims Commissioner, Mrs Bertha McDougall in January 2007 (Appendix F).

The sub-committee welcomes Mrs Mary Cardwell of the Armagh Child Contact Centre who has recently joined as Secretary. Mrs Caldwell attended, and made a presentation to, the Child Poverty Workshop in Armagh on the 5th December 2006.

EUROPEAN AFFAIRS WORKING GROUP

Following the rejection of the Constitutional Treaty by the electorates of France and the Netherlands, the EU embarked on a period of reflection. In Ireland, this process has been conducted by the National Forum on Europe. It is anticipated that considerable progress will be made under the current German presidency towards solving the difficulties that stand in the way of making such changes in the modus operandi of the EU that are rendered necessary by its greatly enlarged size. The Forum invited its members (including the Church of Ireland) to make submissions on how we envisage the future of the continent, not simply of the European Union itself. Our response is appended. (Appendix G)

An important development during 2006 was the holding of meetings, in several dioceses with representatives of the Forum and its secretariat. These presentations, at diocesan synods and clergy conferences, were highly effective in achieving the European Union's objective of bringing its work closer to the citizens of the Member States.

Two regional women's meetings with Forum involvement were held during the year, and the panel thanks the Mothers' Union for providing representation on these occasions.

The Most Rev Diarmuid Martin, Roman Catholic Archbishop of Dublin, who is vice-president of COMECE (the Commission of Bishops' Conferences of the European Commission), which works closely to the Conference of European Churches, addressed the Forum on 18th January, 2007 on 'the values underpinning European integration', and Dr Kenneth Milne responded. Archbishop Martin has indicated his willingness to meet with the panel to discuss matters of common concern.

Resulting from meetings between the Church in Society Committee and the Methodist Council on Social Responsibility, it was agreed to invite the Methodist Church to nominate a representative to our working group.

Our membership of the Institute continues to provide opportunities to hear speakers from many parts of the European Union and to receive its publications.

The panel is continuing with its policy of seeking meetings with MEPs, north and south and arrangements are ongoing.

MEDICAL ETHICS, SCIENCE AND TECHNOLOGY SUB-COMMITTEE

In the past year, the Medical Ethics sub-committee has completed its work on issues relating to the Care of the Elderly (Appendix H). This subject is undoubtedly one of great importance to each of us as a result of the changing demographics happening within Ireland. The sub-committee was also invited to make representation to the Irish Council for Bioethics on two issues during the year. The Chairman made oral representations and followed this up with written submissions on Advance Directives (Appendix I) and then on Embryonic Stem Cell Research (Appendix J), two particularly challenging dilemmas.

ECOLOGICAL AND ENVIRONMENTAL SUB-COMMITTEE

The sub-committee continues to develop Eco-Congregation Ireland, an environmental project that aims at encouraging good ecological practice within parishes. The programme's website www.ecocongregationireland.org contains downloadable resources for parishes, as well as news and information from other parishes and churches involved. The programme has gained much from its ecumenical approach and the sub-committee would like to thank Ms Helen Shiel, of the Methodist Church in Ireland, Catherine Brennan SSL, of the Roman Catholic Church and Mr Joe Furphy from the Presbyterian Church in Ireland for all their support and enthusiasm.

In order to provide a forum for parishes to exchange experiences and identify areas for the improved use of resources, an Eco Workshop was held in Dromantine Conference Centre, near Newry, on Saturday, 30th September 2006. Positive feedback from this workshop has encouraged the sub-committee to organise another one, this time in Dublin and aimed at parishes in the Republic. This workshop is due to be held on 6th October 2007.

A particularly important development this year has been the developing of an Environmental Policy for central and Church offices. Work is continuing on this policy which will be brought to the Standing Committee.

LEGISLATION AND POLITICS SUB-COMMITTEE (RI)

The Chairman attended the Law Reform's Annual Conference in the O'Reilly Hall in UCD on Friday, 1st December, 2006. This year's topic was 'Cohabitation: Models for Legal Reform' and speakers included the Tánaiste, Michael McDowell TD, Professor Tony Fahey of the ESRI, the Law Reform Commissioner, Ms Patricia T Richard-Clarke and the Chair of the Working Group on Domestic Partnership, Ms Anne Colley. The event was chaired by the Hon. Mrs Justice Catherine McGuinness.

The sub-committee also attended the launch of the Report on Child Protection by the Joint Committee on Child Protection in Leinster House on Thursday, 30th November, 2006. The panel submitted a response to this Joint Committee and plans to investigate further some of the issues raised in the report (Appendix K).

APPENDIX A

CHAIRPERSON'S RESPONSE TO THE DEATH SENTENCE OF SADDAM HUSSEIN

'When a dictator is finally convicted, the death sentence can seem to many the only adequate conclusive punishment. The crimes for which Saddam Hussein stands condemned are in all probability not the only crimes committed by him and his regime deserving adequate punishment. It is important that the justice process continue in what is still a fledgling democracy and that other sufferers and victims are not deprived of visible justice. The impact of death by hanging of Saddam Hussein on wider efforts to create and sustain a stable infrastructure in Iraq needs to be weighed seriously. So also does its impact on those who hitherto have supported him. They too must be participants in the new future.

The Role of the Church Committee in 1990, reporting to General Synod, warned against vengeance as sufficient motivation in punishment. My own view is that the death sentence denies the dignity of the human person, no matter how degraded a human individual has become through his or her own actions. I therefore do not agree with its being applied in the case of Saddam Hussein.'

APPENDIX B

CHAIRPERSON'S RESPONSE TO THE CONSULTATION PAPER ON A FORUM ON A BILL OF RIGHTS FOR NORTHERN IRELAND

1. The Church of Ireland's Church in Society Committee welcomes the proposal to create a body to engage with the preparation of a Bill of Rights for Northern Ireland. The Church in Society Committee previously responded to a consultation regarding a proposed draft bill in 2004 with concerns regarding the approach to be adopted and to call for the appropriate budgetary planning, training and provision of infrastructure and services to support the rights enshrined in any such legislation in the future. We attach this earlier response and would recommend that our own response and others gathered previously by the NIHRC would be reviewed and given serious consideration by the proposed Forum.

2. The Church in Society Committee also welcomes the inclusion of Churches in the proposed membership of the Forum. We would urge that both main traditions are represented within the constituency of the Forum to ensure the participation and ownership of the process within the two main communities in Northern Ireland. Church membership in Northern Ireland is significant. Churches represent the needs of a large number of people. Church affiliation still helps to define a

significant part of identity for many people in Northern Ireland. The Church of Ireland estimates that its membership in Northern Ireland is some 290 000 people. Therefore, we urge that at least two places are allocated to the Churches.

3. We also welcome the inclusion of minority interests in the community and view this as a positive element in the composition of the Forum. The widest possible inclusion of both majority and minority participants representative of civic society should be emphasised, while paying due accord to the role of political parties in NI society and the contribution they may make to the development of a Bill of Rights.

4. The Church in Society Committee agrees with the proposal in the consultation that a Chairperson with international experience of human rights issues should be appointed, but would also ask that, in seeking a person to fill this appointment, more emphasis is given to the need for some firsthand knowledge of NI as this Bill of Rights is specifically intended to address the NI context.

5. The Forum's independence from both the NIHRC and the political process must be safeguarded to ensure the credible delivery of it consultative and advisory functions.

6. A public education programme should be implemented to ensure that the various distinctions between the Forum and all other bodies are well signposted and understood. An appropriate budget should be included in the funding allocation to enable the Forum to engage in a public information process regarding appointments made to it, its objectives, its consultation process and advice rendered by it in terms of developing a Bill of Rights. Careful panning needs to be done to ensure that this programme is effectively delivered locally.

7. The work already undertaken and published by NIHRC should be placed before the Forum for consideration.

8. The Forum should pay attention to the context of rights articulated in other regions of the UK and in the Republic of Ireland.

9. Adequate funding to enable a broadly-based consultation process is essential to civic participation and subsequent support for the proposed Bill of Rights.

10. The recommendations of the Forum must be credible to all parts of NI society. For a Bill of Rights to gain widespread acceptance, the Bill must clearly enshrine the values of justice, accessibility and equality.

11. The consultation seeks comment on the timeframe for the production of a Bill of Rights. The Church in Society Committee believes the time frame is too short. The difficulty of some of the issues to be addressed and the need for public consultation, participation and agreement on the fundamental values will require a much more lengthy process. The recognition of human rights might be viewed as a significant part of the healing process in Northern Ireland. It would be better to engage society deeply and at length in consultation and development of consensus around the key components of any possible Bill, rather than to rush that process.

APPENDIX C

CHAIRPERSON'S RESPONSE TO THE ANTI-POVERTY STRATEGY FOR NOTHERN IRELAND, *LIFETIME OPPORTUNITIES*, DECEMBER 2006

The Rt Revd Dr Michael Jackson, Bishop of Clogher and Chairperson of the Church in Society Committee, has issued the following response to the Government's Anti-Poverty and Social Inclusion Strategy for Northern Ireland, *Lifetime Opportunities*:

'*Lifetime Opportunities* sets out comprehensively the Government's aims for Northern Ireland in addressing poverty and social exclusion. The Secretary of State describes it as a 'cross-cutting priority' in the current Comprehensive Spending Review. He further promises the establishment of a Ministerial-led Poverty and Social Inclusion Forum to progress implementation with strong support for continued partnership working.

I broadly welcome *Lifetime Opportunities* for a number of reasons. First, it witnesses to a joined-up approach at departmental level which is allied with the co-ordination of services at local level. Secondly, it recognizes that poverty is a feature not only of towns and cities but also of the countryside. Thirdly, it takes a broad-brush approach to social exclusion and inequalities together, based on three explicit criteria: religion, gender and disability. Fourthly, it openly recognizes poverty as a social ill which severely impedes and truncates the life-expectations of children and pensioners. We are told that 327,000 people in Northern Ireland live in poverty, including 102,000 children.

Economic regeneration does not create community. In some cases, it can provide little more than bigger opportunities, publicly funded, for individual success. The key to proofing Northern Ireland society with the ideals and aspirations of *Lifetime Opportunities* will be the active engagement in the delivery phase of local stakeholders, critically selected and professionally monitored. The Churches have much to contribute as stakeholders in terms of local knowledge, long-term commitment and hope in a shared future. In my opinion this has to be done in co-operation with others in an emerging multi-ethnic and multi-faith society.'

This statement comes ahead of the Church of Ireland Child Poverty Workshop which is being held in the Armagh Synod Hall tomorrow, 5th December 2006. Here various groups from within the Church will meet to share experiences and discuss the implementation of an integrated approach for tackling the issue of child poverty on this island.

APPENDIX D

CHAIRPERSON'S RESPONSE TO THE STATEMENT BY THE POLICE OMBUDSMAN FOR NORTHERN IRELAND, JANUARY 2007

"The Police Ombudsman for Northern Ireland, Mrs Nuala O'Loan, has done Irish society, North and South, an important service in publishing the findings on her investigation into the circumstances surrounding the murder of Raymond McCord Junior.

Her references to collusion cannot but cause alarm to everyone who today seeks the confident assurance that the rule of law, objectively and consistently applied, holds sway in policing in Northern Ireland.

In light of what has now been revealed, my thoughts are those of continuing concern for the people who have been made victims in this way throughout many years. My concern is also for the bereaved and family members together with the communities traumatized and intimidated by the paramilitary activity which went unchecked throughout the time under scrutiny. Our thoughts inevitably turn to questions relating to the distortion of responsibility at the heart of policing. In expressing genuine gratitude for the good work done by the majority of members of the RUC, and their successors in the PSNI, throughout the Troubles in the execution of their duty, appreciation must also be expressed for the considerable courage shown by those individuals who have insisted on disclosure in a situation described as one of systemic injustice.

While noting the local nature of the findings of the Report, I seek assurance that appropriate enquiries will be mounted more widely as a matter of urgency. I further express my hope that every effort will be made, with renewed determination, by all with political influence to resolve the current impasse in relation to policing issues and to re-establish devolved government to Northern Ireland for the benefit of all its citizens."

APPENDIX E

THE VICTIMS AND SURVIVORS (NORTHERN IRELAND) ORDER 2006

SUBMISSION TO THE OFFICE OF THE FIRST MINISTER AND DEPUTY FIRST MINISTER, SEPTEMBER 2006

Social Justice and Theology Sub-Committee (NI)

This response was prepared by the Rev Canon Trevor R Williams, Rector of Holy Trinity, Ballysillan and Immanuel, Ardoyne

We welcome The Victims and Survivors (Northern Ireland) Order 2006.

Some comments:

The appointment of the Commissioner

The appointment of The Commissioner for Victims and Survivors for Northern Ireland must be made in a manner which will command the greatest possible public support. The provision that the appointment be made by the First Minister and Deputy First Minister jointly is welcomed in this respect.

It must be noted that should the Assembly not function, an appointment by the Secretary of State, while it may be necessary, is not a satisfactory arrangement. However this

provision ensures that the Commissioner can be appointed and the work can be done. This is to be welcomed.

The term of the appointment

Four years is a reasonable period of appointment in the first instance. Clearly a review and evaluation of the work and the needs of victims at this stage would be appropriate. We welcome the fact that a further four years is considered. However the concerns and needs of Victims and Survivors may not be fully addressed within this period. For instance the recovery from trauma can be prolonged, and to suddenly cut off services before an effective recovery has been achieved may do great harm.

Similarly, due to the effects of trauma, the needs of a victim may not be able to be articulated within this given time span. We therefore would see the role of the Commissioner as working during their term of office to secure long term services which will be available to Victims and Survivors to assist their full recovery.

APPENDIX F

RESPONSE TO THE REPORT OF THE INTERIM VICTIMS' COMMISSIONER JANUARY 2007

Social Justice and Theology Sub-Committee (NI)

Responding to the Report of the Interim Victims Commissioner, the Rev Kenny Hall, Chairperson of the Church and Society Social Justice & Theology Panel (NI) said:

"The Interim Victims Commissioner, Mrs Bertha McDougall, has called for an £8 million fund and forum for victims to be established. In supporting this call, I would urge all victims to take part.

"A new Commissioner will spearhead plans and priorities for the Victims and Survivors Forum. Many victims, both from a security forces background and from a civilian background, feel that they are the forgotten part of the peace process. It is therefore important that this new Commissioner is acceptable to all.

"Many people in Northern Ireland remain frightened to speak what they perceive as the truth. This often results in their remaining silent. A background of fear is capable of disrupting trust and communication. The proposed Forum must be a place where people do not feel under threat and are able to express their thoughts and concerns. This is a prerequisite for movement towards reconciliation. All must work together for the benefit of each other and build a society that is at peace with itself."

APPENDIX G

SUBMISSION TO THE NATIONAL FORUM ON EUROPE, JANUARY 2007

Working Group on Europe

The European Union's relationship with Russia will almost certainly be the greatest challenge facing Europe in the course of the next fifty years, with the possible exception of climate change. A good relationship with the Russian Federation will determine the security of our eastern border, and of those states that were formerly part of the Soviet Union, especially in the Balkans and the Black Sea region. There is much unfinished history here, reaching far back into the cultural tensions between Byzantine and Latin Europe, as the Serbo-Croatian conflict has reminded us. The Union's efforts to contribute to international security, particularly in the Balkans, are greatly to be encouraged, as also its emergence as an international peace-maker, available to the UN for tangible and critical support, is of profound importance. Turkey, is in a different sense, part of that same history, with its complex status as half in and half out of Europe.

Economically, the relationship with the Russian Federation must increase as the Federation becomes more prosperous. European dependence on Russian energy, with all its potential and its dangers, is one aspect of this tangled and inevitable relationship. Secure economic relations with the Federation also reduce European dependence on the Middle East, which must be a long-term concern. A key to successful relations with Russia is the non-military nature of the Union, which should help to allay Russian anxiety about military threat. The fact that NATO has no clear role since the end of the cold war is another aspect of this unresolved relationship between eastern and western Europe.

The relationship with Turkey has to have far-reaching implications for European relations with the middle-east and the Islamic world beyond. A prosperous and democratic Turkey is a prize worth striving for. Indeed, the possibility of excluding Turkey could have deleterious consequences that would far outweigh the balance of the benefits of Turkey's inclusion. If the Ukraine, Georgia and perhaps Armenia eventually join the Union, or form close links with it, then the Black Sea will become a European lake! Constantine had good reasons to found Constantinople, and these reasons persist. The very prospect of membership for Turkey has been and could be a powerful incentive to positive political, humanitarian and social reform, more so than the kind of relationship implied by the European Neighbourhood Policy.

The role of civil society, 'Europe of the regions' and the politics of consensus all point to interesting possibilities for the conduct of global politics, and have the capacity to act as a model for other regional arrangements, the African Union being the most obvious example. Europe continues to be deeply involved in the affairs of sub-Saharan Africa. Here the historical, cultural and religious links are no less important than economic relationships. It is likely that the western part of the EU in particular will continue to shape the future of sub-Saharan Africa. In a somewhat analogous post-colonial sense,

Europe will continue to have an important role in the Spanish- and Portuguese-speaking world, particularly on the South American continent.

It is hard to see any fundamental change occurring in EU relations with the north Atlantic area. A question now being posed is whether or not a genuine Atlantic partnership is to be sought – built upon new or revised institutions, or whether the EU and the USA will drift into complementary but distinct global players with intensifying competition. China and India are likely to be more closely bound up with European trade and more generally with Europe's geopolitical status.

It is good to see that there has been a burgeoning of concern about climate change of late, with public opinion more engaged with the issue than previously. This is an area in which the Union is an indispensable agent for achieving co-operation. Indeed, it is difficult to imagine how the policies that are required if the environment is to be preserved (and their enforcement) could be agreed and executed without the powers vested in the Commission and the other agencies of the Union.

In conclusion, we are convinced that the Union will continue to impact powerfully on Ireland, economically, politically and culturally. As the impact of immigration works itself into the life of Irish society, older moulds will inevitably mutate, and the historic North-South issue will recede in importance. But the construction and defence of an open civil society, rooted in law and democratic institutions can never be presumed. They are never given. In a dangerous and unstable world the European Union must remain not only as a bastion of civilised political discourse, but also as a beacon of hope and aspiration on the planet.

APPENDIX H

ETHICAL ISSUES AND CARE OF THE ELDERLY

Medical Ethics, Science and Technology Sub-Committee

SCOPE OF STUDY

For the purposes of this paper care of the elderly is defined as "*the full continuum of older people's experiences from that of growing old to that of being in need of significant health and social care in the late stages of life"*. The UK National Service Framework provides a useful definition of three stages of ageing. These are described as follows:

(i) Entering Old Age

This is a socially constructed definition and extends from the age of 50 right up to the end of life. People in this category are active and independent and remain so into late old age. In this category the goals are to promote and extend a healthy active life.

(ii) Transitional Phase

This phase refers to those who are between a healthy active life and frailty. The goal for this category is to identify emerging problems thereby ensuring effective responses which will prevent crises and reduce long-term dependency.

(iii) Frail Older People

This category refers to those who often have multiple long-term conditions and are vulnerable as a result of, for example, stroke or dementia. They often have complex social care needs. The goal with this group is to anticipate and respond to problems recognising the complex interaction of physical, mental and social care factors which can compromise independence and quality of life.

Drivers of Increase in Numbers of People Surviving into Old Age

Before analysing each of these stages in turn, a brief summary of the main factors accounting for a greater number of people surviving into old age. This includes:

1. Demographics

The changes in the age structure of the population are well known. Survival into old age is resulting in an increase in the number of older people and, in particular, very old people – those over the age of 85. At the same time the birth rate is declining so the proportion in the older age groups is also increasing.

Older people in Northern Ireland account for 15.9% of the population and in the Republic of Ireland 13% of the population is over 65. In the UK as a whole over 65 year olds make up 18.4% of the total population.

The actual number in Northern Ireland over 65 is predicted to increase from 274,000 in 2004 to 458,000 in 2042 representing an increase of 67%. The number over 85 is predicted to increase by 139% in the same period.

2. **Age Discrimination**

In the past, age was a criterion for some medical procedures such as renal dialysis. It is now unacceptable to use age as a criterion for the delivery of health care. The key determinants today are the condition of the patient, expected outcomes in relation to the burden of treatment and the wishes of the patient.

3. Technology

Older people are the beneficiaries of new technology. New techniques including scanning and non-invasive or minimally invasive treatments, e.g. endovascular, coronary angioplasty, stenting and minimally invasive surgery together with new anaesthetic techniques are all particularly suitable for older people.

REVIEWS OF UK GOVERNMENT PLANS

The Healthcare Commission, the Audit Commission and the Commission for Social Care Inspection have all delivered reports suggesting that government policy is betraying the elderly in particular in the area of respect for their dignity. The reports have concluded that, despite occupying two thirds of hospital beds, only 40% of funding is allocated to the elderly and that their views are neither sought nor valued with needs of the elderly too often ignored. Some specific findings include:-

- There remain mixed sex wards nine years after Labour pledged to abolish them.
- Patients are shunted from ward to ward to free up beds.
- Patients are malnourished because food is removed before they have a chance to eat.
- On the one hand patients are often discharged too soon whilst others who would wish to die at home are unable to do so.
- Staff are described as patronising, thoughtless and in some cases not properly trained, for example, Alzheimers sufferers are routinely sedated.

The UK Government has also introduced a 'respect for dignity' policy with a specific member of staff in each care establishment to be held responsible for its implementation.

RESEARCH & CLINICAL TRIALS

- **The Ageing Process**

  Research into the ageing process highlights the intellectual poverty of single discipline approaches to defining questions and answering them.

  Moving to trans-disciplinary research is not easy and requires a more integrated training of scientists, larger research groups, willingness to collaborate and a vision broad enough to accept that no one discipline has all the answers. In order to provide answers to such questions as 'What are the causes of increased life expectancy?' and 'What are the effects of increased life expectancy?' the disciplines of, for example, biologies, sociology, epidemiology, demographics, economics and environmental science are needed.

  The World Health Organisation has, for example, published some studies on worldwide changes in life expectancy and on the differential life expectancy of different populations.

  For the Church, interest should be shown in Healthy Active Life Expectancy. This requires new national cohort studies to be established and maintained – such data will allow the monitoring of the success or failure of health and social policies on ageing.

- **Economic and Social Consequences of Ageing**

  The economic and social consequences of ageing deserve further research and the Church should be supportive of social research directed at the aims, aspirations and needs of the population in caring for the elderly.

- **The Prioritisation of Ageing Within Large Studies**

  There is also a need to prioritise ageing within government-sponsored research. At present it is often assumed that policy initiatives have the capacity to tackle ageing and longevity with the consequence that it has no central priority.

  Likewise, the Medical Research charities have a disease focus without having a priority or focus on ageing.

  The Church could influence the prioritisation of ageing within studies when it has the opportunity to comment on policy.

- **Clinical Trials**

  There have been considerable improvements in the last decade in the inclusion of older people in clinical trials. Up until then there were perhaps misconceptions that the elderly were too frail and might not see the benefit of trials or would react unfavourably to the toxicity of interventions.

  The new era of drug development more concerned with the biological nature of disease has perhaps contributed to this more inclusive trend in that there is more current emphasis on molecular targeted approaches and less on toxic compounds (if Northwick Park experience is regarded as an exception).

- **Cancer Trials**

  In cancer trials, for example, there is no cut off based on age. Entry into trials is based on the clinical condition and history of the patient.

  However, the proportion of people above age 70 in cancer trials is under 15% and the average age of participants is 58.

  There is general agreement amongst cancer specialists that these numbers of older people need to be increased given the age profile of the population.

  Clinicians would inform that a sizeable proportion of older people do equally as well as younger people where there is a good medical history. However, there is a second category of older person with a complicated medical history and who experience toxicity quickly and cannot therefore continue the trial.

- **Church Role**

  In the area of clinical trials the Church may have a role in articulating the importance of older people participating in trials. Otherwise drugs will be licensed only for younger members of the population with the result that certain treatments might have to be accepted on an individual risk basis for the older person. The relative safety of trials for those with a good medical history could be emphasised, whilst at the same time recognising that the Northwick Park experience may have negative impact for some time.

ARE MORAL CLAIMS AGE RELATIVE?

Moral claims could be age relative in three obvious ways -

(i) They could vary with elapsed time or increase in proportion to the amount of lifetime an individual has experienced or consumed.

(ii) They could vary not with a lifetime lived but a lifetime in prospect.

(iii) They could vary according to quality of life – poor quality of life could be considered a worthless expenditure on resources.

Quality adjusted life years and reasonable lifespan approach take into account these propositions. There are also of course lifestyle choices which may affect moral claims or entitlements. All make health related choices about, for example, drug, alcohol use, exercise, choice of domicile, occupation etc. and wealth related choices about for example how much of disposable resources are put aside to support healthcare, retirement, old age, insurance against health risks etc. There is an increasingly vocal lobby favouring an element of individual responsibility for adverse health related to the choices made about lifestyle and personal funding for health.

If the age relative view described above is taken once the old, however defined, had been ruled out, the middle aged would become the old and the cycle of discrimination could have a tendency to extend indefinitely.

In addition, if the ageist age relative view is extended to other aspects of life one corollary of that view might be that murder victims, for example, would be considered to be less serious when victims are old or terminally ill.

The anti-ageist view expounded by John Harris, Professor of Bioethics, Manchester University is to be preferred with his hypothesis resting on the concept of something we all value equally 'the rest of our lives'. So long as we do not know the date of death the 'rest of life' is of indefinite duration and whether 17 or 70 in perfect health or suffering from a terminal disease we have the 'rest of our lives' to lead. So long as we each fervently wish to live out the rest of our lives however long that turns out to be, then we suffer the same injustice if our wishes are deliberately frustrated and if we are cut off prematurely.

The limitations of the fair innings concept is illustrated by, for example, Nelson Mandela who arguably has had his most important achievements after reaching his fair innings when still in prison. The fair innings value of a life measures life in units of a lifetime – the more the better up to a certain point but thereafter extreme discounting. People value particular events within their life disproportionately to the time required to experience such events – again Mandela is a case in point. Life years are not a commodity.

The anti-ageist case has a very strong moral base. If this approach was accepted by the Church there could be some articulation of the equal value of 'the rest of our lives', whether 17 or 70, and the equal injustice if any are thwarted by a premature end. This

argument can be reinforced by the fact that some people experience their best moments after reaching a fair innings and that life events are not valued in a way that is proportional to the time taken to experience them.

ROLE OF THE CHURCH IN THE THREE PHASES OF AGEING

The following paragraphs look at the three phases of aging as described earlier and the implications for the Church. There will inevitably be some overlap of needs and possible interventions in each category.

(i) Entering Old Age:

Prevention

This is the phase in which more time needs to be devoted to prevention. Many problems occur in the elderly as a result of, for example, high blood pressure in their 40s and 50s. These include heart failure, stroke and dementia. Public Health Initiatives here could have significant effects in elderly morbidity in 15 years time. The theme of prevention recurs in the other two categories and is an area in which the Church could encourage both individuals to take a more proactive approach, and those making government health policy to put prevention higher on the list of priorities. An important selling point for governments is that the costs of not treating and preventing the illnesses of old age are high. For example, the cost of not treating depression includes expenditure on falls, reduced immunity to other disease and longer-term cognitive decline.

A recent article in the BMJ concludes that a forward-looking policy for older age would be a programme to promote successful aging from middle age onwards rather than simply aiming to support elderly people with chronic conditions.

There are broadly three interleaved components of thought on successful aging – the biomedical definition, the psychosocial definition and the views of older people themselves.

The biomedical definition concentrates on absence or avoidance of disease and of risk factors for disease, the maintenance of physical and cognitive functioning and an active engagement with life including the maintenance of autonomy and social support. The psychosocial definition emphasises life satisfaction, social participation and social functioning as well as the presence of psychological resources including personal growth. Older people as well as accepting the above definitions also add additional specific characteristics and perceptions of successful ageing. These including accomplishments, enjoyment of diet, financial security, belonging to a good neighbourhood, physical appearance, productivity and contribution to life, sense of humour, sense of purpose and spirituality.

It is on the psychosocial and lay approaches that the Church can have most influence. Awareness and pursuit of appropriate prevention measures as previously discussed apply to the medical approach, e.g., encouragement of regular checks of blood pressure and appropriate action where results unsatisfactory.

Psychosocial and lay definitions of successful ageing include satisfaction with ones past and present life and continued social functioning. Psychological resources for successful aging include a positive outlook, a sense of self worth and control over life, autonomy and effective coping and adaptive strategies in the face of changing circumstances. If high social functioning is accepted as part of aging successfully the implication is that people need encouragement to build-up their social activities and networks from a very young age, and the provision of enabling community facilities is needed. The Church has a key role in both provision of such physical facilities, and in the development of social activities associated with life satisfaction. These in turn foster the development of relationships associated with better health and functioning.

The Church can also encourage the thought processes of its members and of governments to recognise the importance of the psychosocial aspects of ageing as well as the biomedical approach. This emphasis could in turn assist in reducing the media and other concentrations on the burden of old age and the decline and failure of the body

(ii) Transitional Phase

Prevention

In the transitional phase between a healthy active life and frailty the emphasis is on the prevention of illness or in ameliorating the impact of illness, should it occur. Whilst the Church cannot make a direct intervention it can encourage the development of policies with a preventative focus. For example, in some areas of the United States and in pilot studies in England, there are concerted hospital/community care policies which reduce hospital admissions. In practical terms this works by identifying patients most likely to require emergency admission and by providing a case management approach from a highly skilled practitioner who both treats and stabilises the condition as well as co-ordinating inputs required to maintain the individual at home.

Early Diagnosis

Other policies which the Church could vocalise and support are those which seek to proactively assist individuals to identify illness thus reducing long-term disability and enhancing well being. For example, a recognition of the symptoms of stroke could reduce the time taken from confirmed diagnosis to treatment and thereby ameliorate the disability aspects of stroke. Another

example would be the early detection of cognitive problems which could have important benefits for mental health.

Easy Access to Care

Additionally, the Church could lobby for easy access to health checks to improve basic functioning. These could include access to oral health, eye checks, hearing, falls prevention and healthy feet.

(iii) Frail Older People

The third category refers to those who develop complex chronic conditions and who are intensive users of health and social care. This group needs to be distinguished from fit older people with an acute medical problem requiring, for example, cardiovascular services and who return from hospital with an improved quality of life. This third category is often characterised by repeated hospitalisation, deterioration of function and self confidence and the emphasis is on developing strategies to manage their conditions and to take control of their own care where possible.

The Church could influence both the policies and the quality of care for these people in several ways:

a) Creating a Culture which Values Older People

By its pronouncements, the Church could help create a culture in which older people are valued and are treated in such a way that reflects values such as dignity, equality, respect and choice. This could be manifested, for example, in supporting policies to ensure that those in caring professions are trained to respond to the specific needs of older people, that screening services do not exclude older people, and that there is flexibility in care packages.

b) Equality and Inclusion

In relation to equality and inclusion it is important that the Church and their associated community groups continue to recognise and act on the important role they have in being inclusive. This could be done by vocalising the need to ensure that services are accessible and usable by older citizens and that sheltered housing schemes are included in development plans by government and their delivery agents. People in this group can suffer from social isolation and loneliness. The Church could ensure that its human resources are used to prevent such loneliness and could also assist in the provision of practical everyday services essential to maintaining independence. Where these services are provided by the government, or where they don't exist, it would be incumbent on the Church to ensure their development and adequacy.

In terms of equality and inclusion older people are concerned when the ability to pay for private treatment determines access to services from the same consultants who provide treatment for them. It would be difficult for the Church to intervene

in this issue but some thought could be given as to what measures might be put in place to protect the timely intervention in care of the elderly and to ensure they are not disadvantaged by others' ability to pay.

c) Carers

The role played by carers is very important for this group. A recent report for Department of Health in Northern Ireland estimated that 1 in 6 carers are now older people themselves. The contribution carers make towards helping people remain in their own homes and to stay independent cannot be overstated. In Northern Ireland their importance is acknowledged in this report which expresses the aim of providing better practical and emotional support to carers. The Church could vocalise its support of these policies and encourage its members to assist this group of older carers whose numbers are likely to increase due to the demographics described earlier. Some may be caring intensively for others while suffering from health problems themselves. More overall support is needed to alleviate this impact of caring in old age and the Church through its organisation and membership may be able to offer practical help.

Finally, for this group and indeed for others a strong lobby is required to ensure that the provision of palliative care is increased and extended outside of cancer. Plans for the delivery of care at the last stages of life must be planned to allow for home and community care. The Church has a role in the encouragement of governments and other providers to extend community based palliative care.

FURTHER ISSUES OF INTEREST TO THE CHURCH

The following paragraphs describe issues which may be of interest to the Church in terms of these broader factors influencing the increase in survival into old age and in each of the stages of aging described earlier. In terms of these broader factors there are two issues in which the Church should have an interest:

Portrayal of Demographics in the Media

The first concerns the portrayal of the demographics in the media and elsewhere. The growing number of older people is often portrayed as an intolerable strain. This assertion needs to be examined not only in terms of its validity but also because of the ageist attitudes this description can generate. Whilst most people age successfully, it is true that NHS use increases with age and expenditure peaks in the final five years of life. This unfortunately is regarded as a problem and the success of ageing is replaced with the stereotype of dependency. It is estimated for example that only 15% of elderly people have multiple complex health problems. The theme of successful ageing will be returned to in the discussion of the three categories of aging. In this regard, the Church may have a role in both shifting the perception of ageing from the negative to the positive aspects of successful aging and may indeed also find an active role in assisting its members to age successfully.

Age Discrimination

The second matter is to do with age discrimination. Whilst overt age discrimination is outlawed there is perhaps an undercurrent of older people having disadvantage in other ways. For example, the shortage of orthopaedic surgeons and facilities for hip and knee replacement affects a disproportionate number of older people. Another example is in the area of screening. For example, preliminary studies have illustrated the efficacy of screening for Abdominal Aortic Aneurysms (AAA) but there is no public or other demand for screening to be considered pending the outcome of further studies. Could this in part be because AAA is predominant in the older age categories of the population? Without labouring these points they are worthy of reflection.

There are also the topical media issues such as cardiopulmonary resuscitation for the elderly and the alleged refusal to resuscitate in some establishments such as continuing care homes. The Church may have a role in clarifying some of the issues and in particular the fact that UK guidelines presume that patients should be resuscitated unless they have clearly requested otherwise. Resuscitation is not always appropriate and can cause rather than avoid harm and consequently there may be a case for redefining the guidelines. Whatever the outcome the theological belief in the sanctity of life may take precedence for the Church and for some individuals. However, in all cases there needs to be transparency in order that patients and relatives may make informed choices. Lack of clarity gives rise to media frenzy which in turn raises concern for members of the public. The Church can be vocal in demanding transparency.

Sources

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APPENDIX I

ADVANCE DIRECTIVES

SUBMISSION TO THE IRISH COUNCIL FOR BIOETHICS, JUNE 2006

Medical Ethics, Science and Technology Sub-Committee

In this short response it is assumed that in considering Advance Directives that it is treatment that the person involved would not wish to be given, in certain circumstances, and not instructions for treatment that they wished to have whatever. But where is the demand coming from for these directives? Is it a failure of communication between the public and the medical profession? Is it a non-event? Is it an item of the chattering classes? Much of the written material seems to come from those who are deliberately muddying the waters by using this approach to lead to the legalisation of patient-assisted suicide and euthanasia. There have been changes in names to much more euphemistic sounding titles such as "Dignity in Dying" the new title for the Voluntary Euthanasia Society, and Doctors for Assisted Dying. In a letter published in the British Medical Journal one of its main arguments for advance directives is that the cost of terminal cases was only one third for those making Advance Directives compared to patients who did not have a directive. Entering "death with dignity" onto Google produced over 25 million hits.

If you ask people about the concept of Advance Directives or Living Wills generally the response is favourable. And it seems not to be to put off death, though there is a contradiction in that people do seem to feel that death is a failure of the medical profession, with a subsequent pressure on medical attendants to do more than they might wish, so as not to be challenged, but rather it is to avoid the perceived indignity, degradation and loss of autonomy in certain terminal conditions. But when you start teasing out the issues then it becomes much more complex.

Within the Church of Ireland we would argue that there is not a need for Advance Directives, as a legally binding contract, but if they aid communication between patients, their families and the caring professions then they could be of value. But if they are available then they should be indicative, helpful in decision making for the health professionals and the family and friends, and ease the pain of the family and friends at a difficult time, to know that the wishes of a loved one were being followed.

But if they are to become a reality then who should be able to, what conditions should it include, should it be written and should it be legally enforceable?

It is generally accepted that only adults can sign Advance Directives, but what about teenagers who can give their own informed consent to medical treatment, before they are legally adults, though they must be competent to make those decisions. Should it only include those conditions that are causing most lay concern, that is severe degenerative brain disease e.g., Alzheimer's, severe brain damage, e.g., injury, stroke, severely

incapacitating nerve or muscle disease, or should it include any severe injury such as quadriplegia and should any patient of any age be able to make their list? Who should they discuss the details with? If it is someone already in the system with a disease should it be with a medical expert who is not their medical carer, who has access to their medical information? Should it be with a lawyer, as it should be written? Or should it be written with both a lawyer and a doctor present or at least discussing the document, so that the person was clear as to what they had signed up to? It certainly should be time limited, as both medicine advances and people change in their thinking. "I wouldn't want to live past 85, said aged 60, but now I am 84½. Ah!"

The biggest argument resides around the nature of this document. Should it be very tightly worded and very specific or should it be more indicative in its phraseology, perhaps with the inclusion of a proxy. The tighter it is worded the less opportunity there is for difficulty in interpretation, but that may cause problems that treatment is withheld when it is not desired. What about the situation of a patient who in liver failure stated in the past that he would not wish to have surgery, until he is informed that he has reached a stage that without a liver transplant he will rapidly die? There is a complete change of instruction. Or the younger person who if asked what they would wish to happen if they, through disease or injury, were quadriplegic, on a respirator and being dialysed. There is little doubt as to the answer, but ask the patient who is alive following that acute situation, but still quadriplegic, and there is frequently a different answer.

So often in medicine there is a problem of obtaining fully informed consent for a treatment or a surgical procedure to be carried out in the here and now, with all the arguments expressed. How then can people consent to things that are abstract and in the future? We would argue that rather than being legally binding, with all its attendant difficulties, Advance Directives should be regarded as having a presumption of being followed, in the spirit of indicativeness expressed, but that there must be opportunity for all concerned to discuss any situation, as to whether it meets the stated directive. This, unfortunately, may well not include the patient as they would be in the very situation that they have listed in their directive.

The most common situation that has caused this issue to be discussed is that of patients with dementia and wasting diseases. For that group there is a fear of a degrading and drawn-out death process. It is felt, in many cases, that the medical profession is not prolonging life but rather prolonging death. The situation that has developed with the provision of good palliative care, especially in the hospice movement, has removed so much of the fear of the dying process, that it has been virtually banished, and it is entirely likely that the same effect can be expected in the sort of scenarios considered in this context.

One of the most difficult issues to deal with, if Advance Directives are in force, is dealing with temporary changes in status especially in the dementing patient, who may in the early stage have quite lucid periods but through an infection becomes totally demented, and has specified no antibiotic therapy if they should get an infection, but if treated will return to their previous state. There is a problem then of interpreting the patient's

desires; there is the problem of defining terminal, incurable and irreversible, terms usually used in a document of this type. The patient is terminal, maybe in a period of years, and the underlying condition is both incurable and irreversible, but not the present acute state. Studies using this scenario have produced quite a spread of opinions, in focus groups asked to debate this scenario, in how to respond to the Advance Directive i.e., Thomson et al 2003 had as many treating as not, and each side was able to cogently argue their case.

Do we therefore ask for a looser indicative type of format? Whatever type, there will be a subjective element in it, as decisions are made on value items, such as severity, doing good, trying to decide what the patient would want in a particular situation. Is there a role for a proxy? If so, should it be a non-family member?

There is already an issue of signed directives where a person wishes to either leave their organs for transplant after death or their body for medical research, but these can be over-ruled by the family. What influence should family members have in the final decision making? If the document is legally binding, then they could expect not to have any.

There are many philosophical arguments that can be considered both in the secular world as well as by Christians, but many will have a special weight for the latter group when considering issues such as the place of suffering; quality decisions of a "good life versus a bad"; and whether those decisions are either "right or wrong". If the argument is based only on the perceived good and bad quality of life then the resulting decision made might well be to kill someone who was felt not to be having a good life, but that would not be a right decision. As Christians, who are we to make judgements as to the wholeness of a person, even one with severe dementia.

For people as they get older their desires are to remain independent, that is preserve freedom and dignity and not be a burden. But Christian belief raises hard questions about our present ideas, attitudes and practices in respect to chronic illness, dying and death.

First of all we cannot elevate autonomy to its present secular level, of total centrality. Through our creation, though we have autonomy, it is limited both by our belonging to God and as humans we are dependant both on God and on each other as social animals. It is impossible for us to claim the autonomy of personhood in all dimensions of life especially at the hour of death. We cannot escape the dependence and interdependence that is a part of the good life given us by God, and it is through death that we enter into eternal salvation.

Second Christian belief holds that all believers are bound together in Christ as one body - St Paul's "if one suffers, all suffer". The members owe one another appropriate care in all dimensions. Finally in respect of our redemption, though we see death as the final and great enemy, we believe that through Christ and his Resurrection death no longer has dominion over life.

Therefore in making arrangements for our final times we would be better to think of simple Advance Directives and powers of attorney that place us in the hands that care for

us and not try to extend our autonomy. They should be less expressions of our autonomy and more provisions that can guide those who care for us. They are aids for those who are caring for us, when no longer fully autonomous, to allow them to refuse to prolong our dying for the sake of prolonging our lives. Let us look at them, Advance Directives, as expressions of love, not autonomy, for those who love us to provide proper care at these stages of our lives.

In all these arguments we must be careful not to let the agenda be hijacked by those who would use hard case examples to argue to the general situation, but rather let the argument be based on the normal situation and then extended outwards. We must be careful in how compassion is used without any thought as to its implications. Does our compassion say that that is no longer a life that is good to God? We must avoid the compassion that says there must be no suffering at whatever the cost even if it should mean the taking of life. We do not have the right to take life. Rather we must fight for adequate palliative care. It may be perceived as compassionate to kill or aid the suicide of a sufferer, but it is without awareness of God's dominion over human life, its sanctity, its goodness, of Christ's victory.

How are the older members of society going to feel, as they get frailer, if there is a change in attitude over caring when they are amongst the weakest members of that society, as to the care that they might receive? The slippery slope of no quality of life, then economic burden and a feeling of pressure from family, and rapidly there will be a swing from advance refusals to physician-assisted suicide or euthanasia.

Compassionate witness is more compelling than argument, and the commitment of Christians to the development of a caring community is the best possible counter to these dangerous demands.

Saunders said, "When someone asks for euthanasia or turns to suicide, I believe in almost every case someone or society as a whole has failed that person". The same applies to Advance Directives.

Summary

As members of the Church of Ireland we feel that, with appropriate communication between patients, their families and the health professions, there should be no need for formal Advance Directives.

If there are to be Advance Directives, then:

1. they should apply to conditions that are terminal, incurable and irreversible.
2. they should be to list treatments that should not be carried out, in the event of certain events.
3. they should not be to force any particular treatment to be carried out.
4. they should not be legally binding.
5. they should not require an illegal action by others.
6. there should be a presumption that the wishes expressed will be carried out.

7. but, at the same time, are seen as indicative of a wished course of action.
8. they should be time limited.
9. they should need positive renewal.
10. there is a great need for more palliative care physicians and nurses, and other appropriate care workers, to meet the needs of these patients.

For Christians:

1. life is God given and determined.
2. killing another is wrong.
3. it is not our decision as to whether the value of any life is "good or bad".
4. compassion based on our assessment of poor quality of life may produce a wrong decision.
5. we are not totally autonomous people, but dependent and interdependent on others.
6. Christian love will produce the right compassionate care.

Problems:

1. Should all age groups be able to sign Advance Directives?
2. Should they only apply to certain situations?
3. How are the terms "terminal, incurable and irreversible" to be defined?
4. How does a person give fully informed consent to an action or inaction, for an abstract situation in the future?
5. Is artificial nutrition and hydration a medical intervention, (*when carried out at home, by family*)? If commenced then how is it to be withdrawn, and by whom?
6. What is the role of a proxy?
7. If a written signed directive, can family over-rule it?

Discussions about Advance Directives must not be allowed to be used as a "back door" route, by certain pressure groups, to patient-assisted suicide or euthanasia.

APPENDIX J

STEM CELL RESEARCH

SUBMISSION TO THE IRISH COUNCIL FOR BIOETHICS, FEBRUARY 2007

Medical Ethics, Science and Technology Sub-Committee

[Please note, the questions that are outlined in this document are those of the Irish Council for Bioethics and the submission follows the format of these questions.]

The Church in Society Committee of the General Synod of the Church of Ireland seeks to identify, contribute to, challenge and develop areas of living today where the mission of the Church can be active and the love of God shared. It does so by seeking an informed understanding of the societies in which we live and aims as much to listen as to speak and to be informative and practical in the fruit of its work. The sub-groups of the Church in

Society Committee are authorized to issue statements and reports in their own names. The following submission has been produced by the Medical Ethics, Science and Technology Sub-Committee and, as such, may not represent the views of the Church of Ireland as a whole.

This Sub-Committee welcomes the opportunity to discuss the ethical and moral issues surrounding the issue of stem cell research and thanks the Council for the invitation to contribute to the debate.

Introduction

So often in the excitement of a new procedure, drug or therapy the ethical issues are not considered thoroughly and calmly, and in as much depth as can be determined at the time and prior to the introduction, but rather compassion and care seem to overwhelm any reasoned debate. Often, this debate only happens after the event and when issues become problems, most of which were predictable at the time. This is true of the issues now surrounding *in vitro* fertilisation, the embryos that are the product of this technique, and especially the status of the supernumerary embryos.

For Christians we believe that we have the potentiality to be human beings from our beginning. We are made in the image of God and, as such, each embryo requires and deserves a deep sense of reverence and respect for its human life in its potentiality. However a distinction is made between an adult human being and the embryo, between being and potential, when punishment for the death of the embryo and injury or death of the mother (Ex 21:22-25) is determined.

Humanity is fallen. Some people can have difficulty in conception, and God uses the medical and scientific professions as a means of healing. This is the restorative role given not, as Dryden has said, "God never made his work for man to mend". We believe that full use should be made of advances within the context of a Christian ethic, fully informed by Scripture and by prayer. With the increasing complexities of the ethical problems arising there cannot be a simplistic response but, with a theologically informed mind, people may determine whatever solutions are right to meet those human needs. We accept that there may not always be unanimity in the answer. Even if there is an initial agreed solution there are often unexpected side issues of effect that will require further consideration and may require the development of original decisions.

1. What do you think the status of an embryo is?

We believe that the embryo is a potential human being.

2. When should rights (full or partial) be assigned to the embryo?

From the moment of fertilisation, we believe that the embryo has rights equal to those of the unborn as laid out in Article 40.3.3 in the Constitution:

> "The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right."

3. Should supernumerary embryos (embryos that are not to be implanted) be used for research?

Ideally, we would suggest that supernumerary embryos should not be created as part of the *in-vitro* fertilisation process. It is hoped that one day, the technique will be developed enough to allow only those embryos that are going to be implanted to be created. We also believe that it should be made much clearer to couples undergoing IVF that it is their choice and right not to have excess embryos made and stored.

However, we do recognise that it has been considered necessary to produce a number of embryos in excess of those likely to be implanted at one time in order to increase the likelihood of success and to prevent the excess of pharmacological and surgical interference to the woman. It has therefore been regarded as inevitable that there would be excess embryos. We feel very uncomfortable with the destruction of these embryos. We are also not comfortable with the use of these embryos for research as the use of cells from them is not to the embryo's benefit. However, it is perhaps the lesser of two evils. The Committee intends to keep this area under review, as medical research will undoubtedly produce more knowledge and we believe that our current position may have to be reviewed in the future. The Committee further believes that research into the use of adult stem cells and umbilical cord blood cells should be given much higher priority.

4. Is it acceptable to create embryos specifically for research?

No. We believe that it is unacceptable to create life with the intention of destroying it. This would be contrary to the sanctity of life of the embryo.

5. Is it acceptable to import embryonic stem cell lines into Ireland?

This would only be acceptable on the grounds that the stem cells were not specifically created for research and are in keeping with our feelings above. We should not benefit from something which we are not prepared to do ourselves.

We would also be very concerned that any such importation could lead to the production of embryos on a commercial basis and careful regulation would be required.

6. Is it acceptable to use therapies that may be derived from embryonic stem cell research?

Yes, provided that this research has been carried out ethically and only on supernumerary embryos as already stipulated.

7. Is there a need for specific legislation with respect to embryo research in Ireland?

Yes. Legislation would be required in order to ensure that such research is maintained along strict, ethical guidelines. There is currently legislation in the UK and in the wider EU to uphold standards in this area.

8. What role should the Irish public have in formulating policy in stem cell research?

In the interests of transparency, we think that it is important for the public to be consulted regarding issues that affect them. However, in the case of the formulation of a policy on stem cell research, it would be essential that any such consultation process would be in the context of an educational programme to ensure a fully participatory and informed debate.

9. Should Ireland invest in stem cell biobanks? If yes, should these biobanks store all or only some of the following: embryonic stem cells, adult stem cells, umbilical cord blood stem cells?

With regard to adult stem cells and umbilical cord blood cells we think that investment in biobanks would be acceptable. Indeed, we believe that further research into the benefits and possible uses of adult stem cells and umbilical cord blood cells should be given a high priority.

With regard to embryonic stem cells, we would be agreeable to the creation of biobanks, *only if* the embryos used would otherwise have been destroyed and they were not created specifically for such research. The use and sourcing of any funding required to develop and maintain such banks on a national level would have to be carefully considered.

10. Should patents be granted for human stem cells or products derived from them?

No. We firmly believe that there should be no financial gain with regard to research carried out on human stem cells. We see the commodifying of medicine, as has been taking place, with great anxiety. It seems as if the value of life of a human being comes second to profit, and do not see a role for patenting. We would not wish to see "Research Ratings" and the draw of research scientists being made on the profits of this work and with this origin.

11. Should the formation of human/animal chimeric embryos be permitted?

For the purposes of this paper, we have taken 'human/animal chimera' to refer to an embryo with two distinct cell lines present. We would believe that the formation of such embryos is not necessary at the current time and should therefore not be permitted.

APPENDIX K

SUBMISSION TO THE JOINT COMMITTEE ON CHILD PROTECTION, AUGUST 2006

Legislation and Politics Sub-Committee (RI)

Introduction

The Church in Society Committee of the General Synod of the Church of Ireland seeks to identify, contribute to, challenge and develop areas of living today where the mission of the Church can be active and the love of God shared. It does so by seeking an informed understanding of the societies in which we live and aims as much to listen as to speak and to be informative and practical in the fruit of its work. The sub-groups of the Church in Society Committee are authorized to issue statements and reports in their own names. The following submission has been produced by the Legislation and Political (RI) sub-group and, as such, may not represent the views of the Church of Ireland as a whole.

While the content of this submission has been prompted at this point by the recent changes in legislation in the Republic, in particular the recent 'C.C.' Case and the Criminal Law (Sexual Offences) Act 2006, we feel it is important to reflect on the broader aspects of the issues of the rights and behaviour of children and young people, and those who come into contact with them, and to consider the responsibilities of society, the State, parents and the Churches in this area.

This document has been submitted at this point to meet the deadline as set out by the Joint Committee on Child Protection. However, as this is an ongoing discussion within the Church, we would consider this an interim response and we would like to reserve the right to contribute further on this issue at a later date.

Changes in Society

It first must be acknowledged that children today grow up in a very different society to that of previous generations. Societal mores have changed. Children often receive very mixed messages from advertising, media, and from the behaviour of adults who may often adopt a "do as we say and not as we do" attitude to such issues as alcohol and drug consumption. We live in a society that encourages independent thought from our young people, but often forces them to become adults before their time. These issues raise the difficulties of how we, as a society, can offer support to our children in such an atmosphere. How do we create a sense that the wellbeing of society as a whole is dependent on the concern of everyone?

Children & young people

It would seem that there are many different ideas as to when "childhood" ends. The 1985 Age of Majority Act reduced the age of majority from 21 to 18 and this latter age remains the legal age at which one becomes an "adult", and with this such rights as voting are conferred. This is confirmed with the 1991 Child Care Act which defines a child as "a

person under 18 years other than a person who is or has been married." However, for the purposes of the Education (Welfare) Act 2000 a child is one who has not reached the age of 16 and compulsory education ends with the completion of three years of post-primary education. The Criminal Law (Sexual Offences) Act 2006 keeps the age of sexual consent at 17, with stricter punishments for those who engage, or attempt to engage, in sexual acts with a 15 year old. The 2001 Children's Act, regarding the age of criminal responsibility, states that a child under 12 years of age is not capable of committing an offence, with the "rebuttable presumption" that a child over 12 but under 14 may "not have the capacity to know that the act or omission concerned was wrong." However, this rebuttable presumption has since been abolished in the Criminal Justice Act 2006 which was recently signed into law. While retaining the criminal age of responsibility at 12, the 2006 Act includes a section for children aged 10 or 11 who can be charged with regards to such serious offences as murder, manslaughter or rape. It also includes a provision, whereby if a child "under 14 years of age is charged with an offence, the Court may, of its own motion or the application of any person, dismiss the case on its merits if, having had due regard to the child's age and level of maturity, it determines that the child did not have a full understanding of what was involved in the commission of the offence."

It is clear then that there appears to be a series of points which mark approaching adulthood but there is no coterminous point and, apart from this last section in the 2006 Criminal Justice Act, there is little recognition of the vast individual variation in physical and mental maturation. For the purposes of clarity in this document, we shall consider any individual under the age of 18 as a "child" or "young person".

Amongst all the media frenzy and high profile cases, it is easy to forget that not all young people are sexually active. However, there is no doubt that the constant pressures that they face everyday from their own peers, television, magazines, etc., can make it extremely difficult for a young person to decipher what is "normal" behaviour. They are getting bombarded with huge volumes of sexual information from such a young age that they may not have developed the skills to know how to deal with this information.

A culture which continues to embrace hyper-sexuality and condones, and even encourages, the sexualized appearance of children, and which propagates the belief that self-worth and self-esteem are based on one's perceived attractiveness and sexual experience, can lead many into a behaviour that they are not ready for and may not fully understand.

The State

The State has a number of responsibilities in the area of children and young people:

- *Education*

  We welcome and acknowledge what is already being done by schools in the area of relationships and health education and would like to see these programmes continue. However, the Social Personal and Health Education (SPHE) programme is currently only available at the junior cycle and we would like to see the development of the Relationships and Sexuality module, within the overall SPHE programme, as part of the core subjects at senior cycle. We also acknowledge that much of the pressure on

young people comes from the attitudes of peer groups in school. Current guidance services are mainly career oriented and there are inadequate counselling services in many schools. There is a need for well-trained and dedicated pastoral counsellors to be readily available to young people, as well as the provision of training for parents. Indeed, there is an urgent need for a specific pastoral presence in all schools. In a society where both parents work and where there are few extended families, the State must provide formal training for parents at stages which correspond to key points in children's development.

- *Health*

  A sexual health strategy for young people is urgently required in this country. Young people need to be better educated about the possible consequences of sexual activity, such as pregnancy and sexually transmitted diseases, together with a programme which develops self-awareness and a sense of personal integrity. Discreet, supportive and easily accessible screening and treatment must be provided throughout the country. The provision of mental health services is also of paramount importance and there is currently a lack of appropriate mental health facilities for 15-18yr olds.

- *Advertising and the media*

  We believe that the sexual imagery and content in some television programming and advertising can have a confusing and potentially damaging effect on young people. We would ask the State to encourage responsibility within the media to maintain appropriate standards regarding the content of such programming and advertising. It should be noted that there is already a ban on cigarette advertising on television, replaced now by adverts that are designed to highlight the damaging effects of this habit. A media strategy to outline the possible consequences of early sexual behaviour would be equally appropriate.

  We would also welcome a complete ban on credit card companies facilitating the downloading and purchase of child pornography.

- *Legislation & the age of consent*

  While we would not consider lowering the age of consent merely to reflect a "reality" in society, neither do we believe that, from a legal point of view, criminalizing young people is in any way desirable. The Church of Ireland would accept the current legal position that no question of criminality arises if the parties to consensual sexual intercourse are aged 17 or over, despite the fact that one or both of them may still be children or young persons.

  It must be acknowledged that, while we do not condone such behaviour, there is a difference between two 16 year olds having consensual sexual intercourse, and an older person preying on a vulnerable teenager, particularly through the misuse of a position of authority. Perhaps the introduction of a "peer law", where young people who are up to two years apart might not be committing a criminal offence, could be considered. However, an absolute minimum age would always be necessary. Of

course, the whole area of what actually constitutes *consent* to sexual intercourse may need to be further defined in law.

The Constitution

In its response to the All-Party Oireachtas Committee on the Constitution regarding the rights of the family, the Church of Ireland recommended that the rights of the child be expressly guaranteed in the Constitution:

> Save in relation to the courts' divorce jurisdiction, there is no specific reference to the rights of the child in Article 41. The courts have however interpreted the Constitution as conferring unenumerated Constitutional rights on children arising particularly under Article 40.3. For the sake of clarity, and in line with the Constitution Review Group's report, we recommend the express guaranteeing of the rights of the child in Article 41.[1] We also strongly endorsed the UN Convention on the Rights of the Child and asked for the inclusion in our Constitution of the list of children's rights contained therein, as well as the principle that in all actions concerning children, primary consideration should be given to the best interests of the child.

We wish now to reiterate these statements and to re-emphasise the importance of the protection of children in all situations.

Parents

As the primary carers, parents have the primary responsibility of educating and guiding their children. However, the pressures and difficulties that face parents today must not be ignored and support and training for parents to enable them to deal with issues as they arise is vital. They need reassurance that skills are not automatic and providing information to parents regarding where they can go for counselling and advice must be an important consideration. We believe that parenting courses, such as those provided by the Mothers' Union, would be of excellent assistance in these situations.

The Church of Ireland

At the 2006 General Synod in Armagh, an additional chapter making provision for ministry with children was included in the Constitution. While clear, formal guidelines in the form of *Safeguarding Trust: The Church of Ireland Code of Good Practice for Ministry with Children* have been in place in the Church of Ireland for over 10 years, it was considered essential that the Code be given formal recognition and constitutional standing by creating a new Chapter in the Constitution. This addition has had a positive effect on the facilitation of youth leadership and offers protection to both children and the adults that work with them.

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[1] The General Synod of the Church of Ireland, *Submission to the All-Party Oireachtas Committee on the Constitution on Articles 40.3, 41, 42.1 and 42.5 of the Constitution relating to the Family*, January 2005

The Church has a role in upholding its Christian values, while acknowledging the reality of today's society. Young people need to be made aware of a standard of behaviour and those who do choose to live appropriately must be encouraged. We should celebrate these children and promote holistic friendships and relationships.