TRIPLE HELIX

Autumn 2002

For today's Christian doctor

POVERTY AND HEALTH

FERTILITY FURORE

ABORTION AND DEPRESSION

MORNING AFTER PILL

GOOD NEWS CENSORED

ICMDA WORLD CONFERENCE

BATTLE FATIGUE

STEALING DOCTORS

SAMARA

ISSN 1460-2253

Triple Helix is the quarterly journal of the
Christian Medical Fellowship
157 Waterloo Road
London SE1 8XN

Tel 020 7928 4694
Fax 020 7620 2453

Email admin@cmf.org.uk
Website www.cmf.org.uk

A registered charity no 1039823

Subscriptions
Triple Helix is sent to all members of CMF as part of the benefits of membership, but individual subscriptions are available to non-members at £2.95 a copy including postage (UK only).

For special offers see the coupon enclosed.
Enquiries: Tel 020 8559 1180 (Monday-Friday, 9am-5pm).

Contributions
The editor welcomes original contributions which have both a Christian and medical content. Advice for preparation is available on request.

Authors have reasonable freedom of expression of opinion in so far as their material is consonant with the Christian faith as revealed in the Bible. Views expressed are not necessarily those of the publishers.

Design S2 Design 020 8404 7470

Cover PA

CONTENTS

NO. 21. AUTUMN 2002

EDITORIALS

GMC Guidance
A big improvement on the first draft

The General Medical Council finally published its guidance on withdrawing treatment in August 2002 after a consultation period of over a year. The final version of *Withholding and Withdrawing Life-prolonging Treatments: Good practice in Decision-making* is a far more balanced document than the original draft, and a considerable improvement on the BMA's own guidance published in June1999. The BMA guidance condoned the withdrawal of artificial nutrition or hydration from patients who have suffered a 'serious stroke or have severe dementia', with the agreement of a 'senior clinician'. Many felt this gave doctors a licence to starve or dehydrate seriously brain-damaged (though not terminally ill) patients to death; and the Scottish Deputy Minister for Community Care, Iain Gray, had accordingly warned that 'To withdraw hydration and nutrition from a non-PVS patient with the purpose of hastening death would leave a medical practitioner open to criminal prosecution.' (*Triple Helix* 2000;Summer:3)

The GMC guidance, by contrast makes it clear that when death is not imminent, artificial nutrition or hydration can only be withdrawn in circumstances where 'the patient's condition is so severe, and the prognosis so poor that providing artificial nutrition or hydration may cause suffering, or be too burdensome in relation to the possible benefits.'(Para 81)

This should provide a safeguard against the slippery slope that could follow if doctors start to treat thirst and hunger (or the confusion caused by them) with sedation rather than food and fluids.

We were also pleased to see provision for juniors conscientiously to object to being executives for non-treatment decisions that they believe are unethical or morally wrong (Para 29) without being forced to participate by personally delegating the task to others.

The fact that the guidance has substantially changed for the better is a further encouragement to ensure that we continue to participate at all possible levels in such discussions. The CMF submission to the consultation is still available on our website at *www.cmf.org.uk/ethics/subs/withdraw.htm*.

Peter Saunders
Managing Editor of Triple Helix

Pray for Rowan Williams

Church affairs are generally outside the scope of *Triple Helix*, but the choice of Rowan Williams as 104th Archbishop of Canterbury warrants an exception to the rule. We urge CMF members and the wider readership of *Triple Helix* to uphold Dr Williams fervently in their prayers, especially over the next few months as he begins a period of spiritual preparation before formally taking over as Archbishop.

Those who rely solely on media accounts of Dr Williams' views are likely to think him at best as somewhat enigmatic. As we have reported in this journal (*Triple Helix* 2002; Spring:4), Dr Williams lines up firmly with members of the pro-life constituency on issues such as abortion and therapeutic cloning. On the other hand much attention has centred on his views on human sexuality, not least the question of homosexuality. This has caused disquiet, especially within the evangelical constituency, for example prompting the Church of England Evangelical Council to seek an early meeting with Dr Williams to clarify the situation.

It is important that evangelicals do not simply write off Rowan Williams on the basis of media accounts of his thought and beliefs. Professor Allister McGrath, Principal of Wycliffe Hall Oxford and one of the most influential evangelical 'heavyweights', has make a thorough study of Dr Williams' writings. McGrath's verdict is that here is a Christian leader who is crystal-clear in his commitment to the authority of the Scriptures and on key issues such as the resurrection of Jesus. McGrath discerns the possibility that Dr Williams' utterances on sexuality, which took place primarily in teaching or classroom contexts, may turn out to be of a somewhat different order when in the future he speaks as a principal custodian of the faith as handed down through all the ages (*Church of England Newspaper* 2002:9, 8 August). What is certain is that Dr Williams is someone who understands evangelicals and takes them seriously. He could be an important ally.

Rowan Williams takes on a job that is frankly impossible. He is, however, someone with immense gifts. His leadership will be crucial, not least in whether or not the Church can reverse the trend of decline that has blighted its witness in this generation. Pray for him.

John Martin
Associate Editor, Triple Helix

Fertility furore
Reaping the whirlwind

Black twins to white parents? Custody disputes over frozen embryos? An embryo superstore? This summer season's fertility fiascos have further highlighted the fact that the end of providing infertile couples with babies, does not justify unethical means (Romans 3:8).

Whilst welcoming ethical technologies to help infertile couples my own sympathies in responding to many of today's infertility dilemmas lie with the Irishman who when asked for directions said 'I wouldn't start from here'. In making provision for egg donation and embryo freezing, disposal and experimentation the 1991 Human Fertilisation and Embryology Act opened a Pandora's box of ludicrous scenarios. We are still living with the consequences.

I continue to have severe misgivings about any infertility techniques that involve creating 'spare' human embryos for freezing, research or disposal. In God's economy, the strong make sacrifices for the weak, not vice versa! (Philippians 2:5-8) And to my mind enabling unmarried (or homosexual) couples to conceive, or using donated eggs (or sperm) threatens the 'lifelong', 'heterosexual', 'monogamy' and 'nurture' aspects of the marriage bond that God has ordained (Genesis 2:24, Matthew 19:4-6).

Rather than opening the floodgates to allow what we are now seeing, we would have done far better to reduce the appalling tide of 180,000 abortions a year in England and Wales (thereby encouraging adoption) and to seek treatments (and preventions) for infertility which respect both the humanity of the human embryo and the integrity of marriage.

Peter Saunders
Managing Editor of Triple Helix

Photo: PA

We need a robust theology of the poor to grapple with global poverty, insists **Eldryd Parry**

Poverty and Health

The plight of the poor is a standing rebuke to the consumer society

This is a tale of two vehicles. The rugged Land Rover dipped and jolted: the track had not been cut decisively through the bush with its twined undergrowth because few vehicles ever went that way.

The track was for people. The dry season was at its driest and there was dust everywhere: black hair had become brown and clothes had a subtle change of colour. The sun was high so that we stuck to our seats till we reached the village. It had one tiny booth, which was its shop – salt, candles, cigarettes, soap, a kerosene lamp (there was no electricity), tins of fish and a few other unlikely things.

We had come with the hospice visiting team to see a patient; she was already the mother of seven children and now she was in the last days of her eighth pregnancy. But she had cancer of the breast: although she had had a mastectomy, secondaries had been found and so we feared the worst. Our fears were confirmed but she was fit enough to come with us back to the teaching hospital where she had been cared for before.

When we went into her house, cheerful and lively children, wearing miserably poor clothes, pushed and shoved and laughed: no men were to be seen - they were all drinking heavily at a table in another part of the village. They had a very potent home brew. Two, needing each other for support, bothered to come to see who the strangers might be.

When we left, our patient brought her second daughter while the eldest stayed to look after the smaller children. She was delivered of a fine male child, but within four weeks both mother and baby had died: she just became another number in the cold statistics of life expectancy and of infant mortality in a poor country.

Now the second vehicle. The polished Range Rover carried international administrators, cocooned by its slick air conditioning from the bustle of the capital city, with its frenzied noise and sweat. They had just arrived after an easy journey in spacious seats and were staying in one of the big down town international hotels, the preserve of people like them. Their brief mission was to ensure that the poverty reduction strategy of the country was acceptable, a rigid condition before any more development assistance could be allowed.

Conditions and their chilling derivative – conditionality – must not repeat the mistakes of the earlier structural adjustment programmes. 1 The reduction of poverty is one of the admirable international Millennium Development Goals, championed by DFID. 2 The administrators were working to policies with a firm theoretical base, but the gulf between what is inevitably only a theoretical goal and the practical reality, which our patient displayed, can be very wide indeed.

The Almata Declaration of *Health for All by the Year 2000* was heralded with acclaim in 1977. It promoted rural primary health care in poor countries but it became an empty slogan when the hope that it embodied was dashed, its goal hopelessly missed. Will the millennial goals fare any better? Is there the international will to make a real difference?

The poor… have needs which must not be submerged by a wave of international goals and resolutions or swept aside with a barrage of numbers and targets

In Africa, progress towards the goals is lagging behind what is needed: if they are to be met, much more will have to be done. The village in the dry season is a vignette of a desperate problem, scarcely surprising when there is less than $10 per capita for health in so many countries. While this example may seem extreme, it could be replicated, no doubt even more cogently, from poor countries all over the world. Nor is the problem only of remote rural people. The outcome of common diseases is unacceptably grim, even when good care is given in hospitals.

As I write this, *The Lancet* carries a commentary 'Rich nations, poor nations and bacterial meningitis'.[3] The commentary could have used the name of almost any disease. Most of us feel impotent as we consider the poor world, the stage on which the tale of two vehicles is played to increasing numbers year by year. We are often reminded that more than 1.2 billion people live in absolute poverty: they are the excluded from the great banquet of the industrialised world. Our government has pledged to increase the share of our gross national income that is to be used for international development, but rich governments remain parsimonious and protective, with honourable exceptions chiefly in northern Europe, and fall short of the minimum UN target.

It is abundantly evident that the poor in the poorest countries are excluded, but many who practise in the United Kingdom, including most of those who read *Triple Helix*, are only too aware of the relationship between domestic poverty and ill health among those who are excluded here.[4,5] The Black Report, the Acheson Report, and a flow of papers and of brave comments present inequality as unacceptable. The plight of the poor, euphemistically described and analytically graded as the socially deprived, is a standing rebuke to the consumer society, and their health is a challenge which is not getting any less.

Much is being done by various government initiatives, but this is only the tip of the iceberg. An issue of the *British Medical Journal* last year and its title, *Health of the excluded*,[6] was a needed reminder. The cover picture was a song without words - five children, on what appeared to be an estate, three without shoes and all without much of a chance.

Those who work for or among the excluded are the very stuff of motivation and inspiration for

Photo: PA

many. Who has not heard of Mother Theresa and the destitute of Calcutta? At which modern public figure's funeral, would a poor man say, as was said at the funeral of the seventh Earl of Shaftesbury, 'We shall never see his likes again: we loved him and he loved us'? When Dr Matthew Lukwiya died of Ebola fever in Gulu, Uganda, the *BMJ* leading article emphasised that he had chosen to work 'in the same isolated hospital for 15 years'. It also commented that, while some deprived areas in the United Kingdom face overwhelming difficulty in recruitment, the doctoring of deprived areas cannot rely on exceptional people.[7]

The poor, the deprived, the excluded, whether in the subsistence societies of the poorest countries or at the margins of our affluent consumer society, have needs which must not be submerged by a wave of international goals and resolutions or swept aside with a barrage of numbers and targets.

If we are to grapple with them and their demands on us, we need to have a theology of the poor. The thinking and biblical foundation of Ronald Sider's *Rich Christians in an Age of Hunger*[8] is an excellent place to start, together perhaps with a rereading of the book of Amos. At the beginning of his ministry, Christ announced that he had come to preach good news to the poor,[9] and at the end of his ministry he charged his disciples to go and make disciples of all nations.[10] In much of the twentieth century, the Christian medical response to the call of Christ was to go overseas, 'into all the world', and serve the poor, the stigmatised and the Kingdom. The new radicalism of the CMF might find expression, both in bringing the needs of the UK poor to its members and in championing work in deprived areas. It was often very hard for the early workers overseas: it is no less hard in any deprived society today.

Eldryd Parry is Director of the Tropical Health and Education Trust (THET)

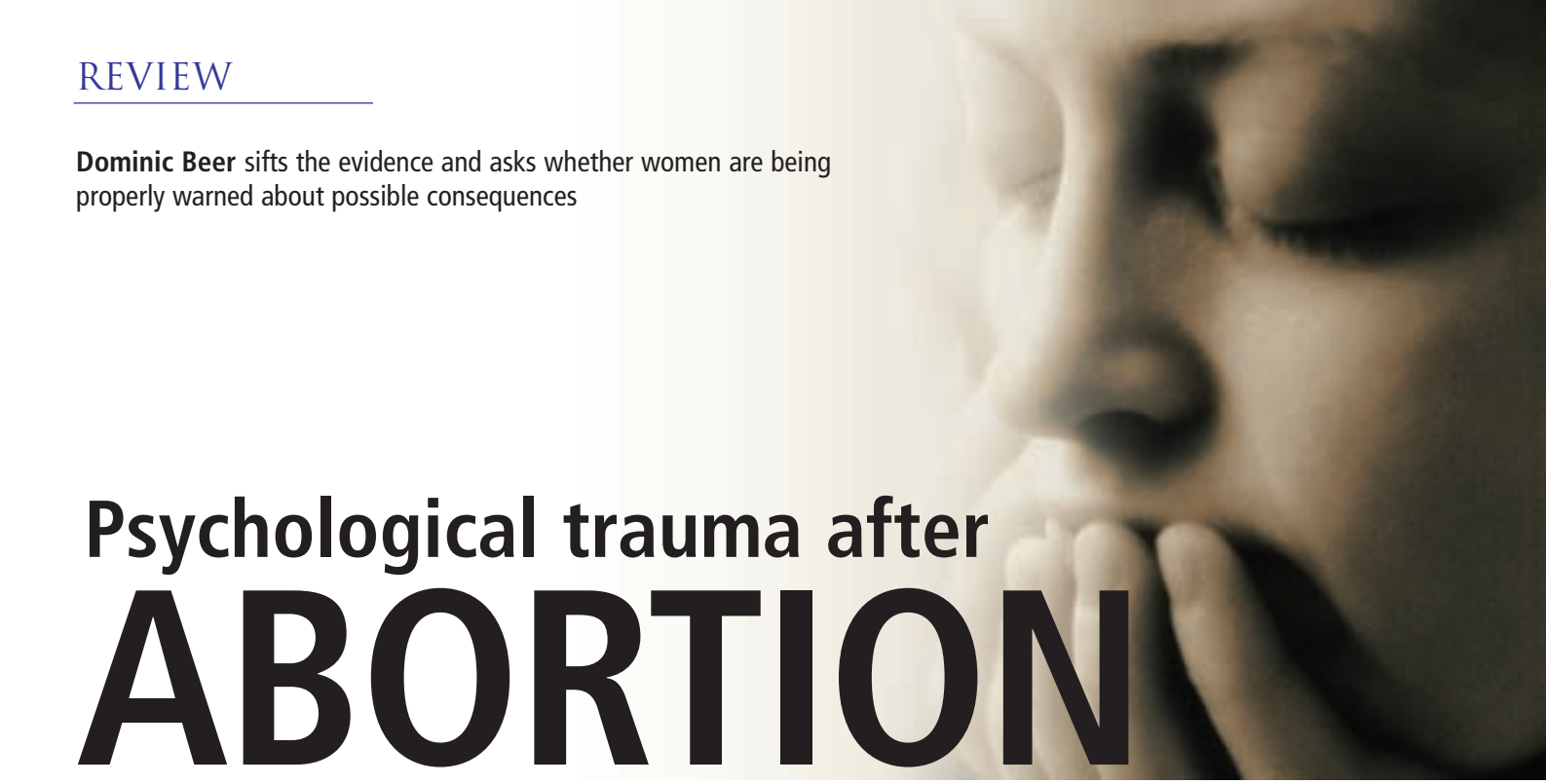
KEY POINTS

The Department for International Development (DFID) aims to reduce poverty as one of its development goals. And yet starting with the 1977 Almata Declaration of *Health for All by the Year 2000*, similar initiatives have so far failed to deliver. 1.2 billion people still live in absolute poverty and many countries spend less than $10 per capita on health, whilst rich countries remain parsimonious and protective of their own lavish lifestyles. As Western Christians we are often no different. We need to be reshaped by the biblical theology of the poor so clearly evident in the Old Testament prophets and in the life and teaching of Jesus Christ himself.

References

1. Cullinan T. Structural adjustment and health sector reform in Africa. *Tropical Doctor* 2002;32:65
2. DFID. *Poverty: Bridging the Gap*. London: DFID, 2001:36 (www.dfid.gov.uk)
3. McCracken G. Rich nations, poor nations, and bacterial meningitis. *The Lancet* 2002; 360:183
4. Horton R. What the UK Government is (not) doing about health inequalities. *The Lancet* 2002; 360:186
5. Watt G. The inverse care law today. *The Lancet* 2002; 360:252-254
6. *British Medical Journal* 2001; 323:July 28.
7. Hastings A, Rao M. Doctoring deprived areas. *British Medical Journal* 2001;323:409-410
8. Sider R. *Rich Christians in an Age of Hunger.* London: Hodder and Stoughton, 1997. 4th edition
9. Luke 6:16-19
10. Matthew 28:18-20

Dominic Beer sifts the evidence and asks whether women are being properly warned about possible consequences



Psychological trauma after ABORTION

KEY POINTS

There is strong evidence that women who choose abortion subsequently suffer from higher rates of depression, self-harm, psychiatric hospitalisation, attempted suicide and suicide than those who carry their babies to term. Factors associated with a negative psychological outcome include low social class, financial problems, poor support from close relationships, smoking, negative religious or cultural attitudes to abortion, previous psychiatric history or mood disturbance, abortion for fetal abnormality and serious medical complications. But whilst the Royal College of Psychiatrists has concluded that there is no psychiatric justification for abortion, the Royal College of Obstetricians and Gynaecologists appears to have taken the evidence far less seriously.

Do women experience psychological reactions after abortion? If so, what are they? Can we predict them? What do we make of the case of a woman who is applying for legal aid to sue the NHS for the psychological trauma she claims to have experienced after an abortion?[1] What are the links, if any, between depression and induced abortion?

Firstly, we must recognise that research design problems are considerable in this field of research. Obviously, prospective baseline assessments and control groups before becoming pregnant are impossible. Moreover, women who have abortions often may not be amenable to questions on how they feel and they may be less likely to return for follow-up.

Reactions after abortion

So do psychological reactions occur after abortion? A study[2] of all pregnant women in the entire population of Denmark comparing women within three months post abortion with pregnant women who declined abortion, showed that psychiatric hospitalisation was higher amongst post-abortion women (1.84/1000) than in those who declined abortion and delivered (1.2/1000).

The Rawlinson Report on the Operation of the Abortion Act in 1994[3] reported this study as superior to – because of its comprehensiveness – an English study[4] on a sample of women which found a lower incidence of serious mental disturbance causing hospitalisation in those who had an abortion (0.3/1000) than in those who delivered (1.7/1000).

An American study[5] linked 173,000 women who had abortions or gave birth in 1989 to death certificates. Women who had abortions were 2.6 times more likely to die from suicide compared to those who delivered their babies. This is backed up by a recent study[6] in Finland looking at the death certificates of all fertile-aged women (1987-1994). Those who had had an abortion in their last year of life were seven times more likely to die from suicide than those who had given birth in their last year.

A study from Wales[7] reported double the rate of attempted suicide following abortion than after miscarriage or delivery. The women who had had abortions were also almost twice as likely to harm themselves after the abortion than before. Another study[7] in Britain showed that in women with unplanned pregnancies and no history of psychiatric illness, deliberate self-harm was commoner in those who had abortions than in those who did not request an abortion. A further study[8] on unplanned pregnancies showed that those women who aborted the pregnancy had more depression than those who gave birth and who had the social support of a marriage.

Emotional consequences

So who is at risk? Psychological problems following induced abortion undoubtedly occur, but who suffers from them? A meta-analysis[9] of 24 studies with different assessment methods and follow-up periods found about a 10% incidence of negative psychological outcome. A meta-analysis of ten articles from 1998[10] showed that the levels of depression and anxiety decreased once abortion had taken place, but that 'induced abortion may yield both negative and positive effects. Women who experience decision-making difficulties and may lack social support may experience negative emotional consequences to induced abortion'.

In a German study[11] of 263 women screened before the abortion and at one year, 79% had adjusted without problems; 14% were still 'in a state of emotional imbalance'; 7% were impaired emotionally and in their everyday functioning. 21% of the women with adjustment problems had a history of depression. Significantly correlated with later emotional difficulties were low social class, financial problems, 'lack of intrapsychic differentiation between sex and reproduction', no partner or poor support from partner.

An American study[12] showed that those who have had depression in the past are significantly more at risk of depression, lower self-esteem and a negative view of the abortion after two years.

Women with high levels of mood disturbance prior to abortion, are smokers or who have medical complications following abortion, were at highest risk of a mood disorder, according to a Scottish study.[13] An Italian study[14] found that women tested as neurotic on the Eysenck Personality Inventory tended to have high degrees of psychological distress before the abortion and got worse afterwards.

Risk factors

The following risk factors for psychological disturbance after abortion have been proposed in a review article:[15] previous psychiatric history and/or degree of psychological disturbance at presentation; poor support from close relationships; negative religious or cultural attitudes to abortion; those having abortion because of foetal abnormalities or serious medical complications.

Another phenomenon occurring in women (30/83) reporting continuing depression up to ten years following abortion is the 'anniversary reaction' at the date the aborted baby would have been due. It was more often associated with ambivalence whether to abort or not.[16]

Advance warning

So are women warned about possible adverse psychological effects of abortion? The Royal College of Obstetricians and Gynaecologists[17] states:

'Psychological sequelae: only a small minority of women experience any long term, adverse psychological sequelae after abortion. Early distress, although common, is usually a continuation of symptoms present before the abortion. Conversely, long-lasting, negative effects on both mothers and their children are reported where abortion *has been denied*.' (my emphasis)

This last sentence seems to be economical with the evidence and appears to misrepresent, for instance, findings from a huge meta-analysis of 225 studies.[18] 'Abortion for medical or genetic indications, a history of psychiatric contact before the abortion, and mid-trimester abortions often result in more distress afterwards. When women experience significant ambivalence about the decision or when the decision is not freely made, the results are more likely to be negative.' (pp 583-84)

Therefore, in an atmosphere where abortion is made easy and there appears to be little information given to women about the psychological sequelae of abortion, it is of concern that in one study, women themselves only instigated 30% of abortions.[16]

The Commission of Inquiry into the Operation and Consequences of the Abortion Act[3] heard from witnesses representing the Royal College of Psychiatrists who stated that 'although the majority of abortions are carried out on the grounds of danger to the mother's mental health, there is *no* psychiatric justification for abortion. Thus the Commission believes that to perform abortions on this ground is not only questionable in terms of compliance with the law, but also puts women at risk of suffering a psychiatric disturbance after abortion without alleviating any psychiatric problems that already exist' (p15).

The Commission stated that 'far from being a choice of several alternatives, the decision to have an abortion often appeared to be the only "choice" available to them. Such a decision does not represent a free choice' (pp 15-16). Since that time, there may be more 'choice' because of the work of Christian organisations such as LIFE and CARE who offer counselling and practical help.

Conclusions

Many studies show that adverse psychological reactions occur after induced abortion. Repeated studies consistently show that certain risk factors have been identified, especially a history of depression. It is likely that patients are not being warned of this. As Christians and doctors who are concerned with evidence-based medicine, we should insist that they are appropriately counselled and forewarned.

Dominic Beer is a Senior Lecturer, division of Psychiatric Medicine (Guys, Kings & St Thomas' Institute of Psychiatry) and an Honorary Consultant in Challenging Behaviour and Intensive Psychiatric Care (Oxleas NHS Trust).

Many studies show that adverse psychological reactions occur after induced abortion

References

1. Dyer C. Woman sues for not being warned about psychological effects of abortion. *British Medical Journal* 2002;324:1477
2. David H. Post-abortion and post-partum psychiatric hospitalisation. Abortion: Medical Process and Social Implications. *Ciba Foundation Symposium* 1985;115:150-164. Pitman: London
3. The Rawlinson Report: The Physical and Psycho-Social effects of Abortion in Women (1994). A Report by the Commission of Inquiry into the Operation and Consequences of The Abortion Act.London: HMSO
4. Brewer C. Incidence of post-abortion psychosis: a prospective study. *British Medical Journal* 1977;I:476-477
5. Elliot Institute. Suicide Rate Higher After Abortion, Study Shows. Elliot Institute presents new findings at International Women's Health Conference. 2002. *http://www.afterabortion.org/PAR/V9/n2/suicide.html*
6. Gissler M et al. Pregnancy – associated deaths in Finland 1987-1994 – definition problems and benefits of record linkage. *Acta Obs Gyn Scand* 1997;76:651-657
7. Morgan C et al.Mental health may deteriorate as a direct result of induced abortion. *British Medical Journal* 1997;314:902 (letter)
8. Reardon D, Cougle J. Depression and unintended pregnancy in the National Longitudinal Survey of Youth: a cohort study *British Medical Journal* 2002;324:151-152
9. Rogers J et al. Psychological impact of abortion: methodological and outcome summary of empirical research between 1966-1988. *Health Care for Women International* 1989;10:347-376
10. Martucci J. Meta-analysis: Psychosocial predictors of psychological sequelae of induced abortion. Dissertation Abstracts International: Section B: the Sciences and Engineering 1998; Vol. 59 (4-B), Oct 1998, 1860, US: Univ. Microfilms International.
11. Barnett W et al. A regional prospective study of psychic sequelae to legalised abortion. *Fortschritte der Neurologie-Psychiatrie* 1986;54(4):106-118
12. Major B et al.Psychological responses of women after first trimester abortion. *Archives of General Psychiatry* 2000;57 (8):777-784
13. Henshaw R et al. Psychological Responses following medical abortion (using mifepristone and gemeprost) and surgical vacuum aspiration: a patient-centred, partially randomised prospective study. *Acta Obs et Gynecol Scand* 1994;73(10):812-818
14. Rizzardo R et al. Personality and psychological distress before and after legal abortion: a prospective study. *Journal of Psychosomatic Obstetrics and Gynaecology* 1992;13(2):75-91
15. Zolese G, Blacker C. The Psychological complications of therapeutic abortion. *British Journal of Psychiatry* 1992;160:742-749
16. Franco K et al. Anniversary reactions and due date responses following abortion. *Psychotherapy and Psychosomatics* 1989;52(1):151-154
17. Royal College of Obstetricians and Gynaecologists. *The Care of Women Requesting Induced Abortion. Evidence-based Guideline No. 7. RCOG Clinical Effectiveness Support Unit, 2000.*
18. Dagg P. The Psychological Sequelae of Therapeutic Abortion – Denied and Completed. *American Journal of Psychiatry* 1991;148:578-585

Phil Howard asks what exactly happens the morning after the night before

Photo: PA

The morning-after pill

KEY POINTS

Levonelle-2 replaced Yuzpe as the preferred method of 'emergency contraception' on the basis of a 1998 WHO trial. The manufacturers Schering and the government have repeatedly asserted that Levonelle-2 cannot affect an established pregnancy, and yet in the trial it reduced expected pregnancy rates even more than Yuzpe (which is known already to have a post-implantation effect), even when intercourse took place again after the drug was given. This suggests that Levonelle-2 acts mainly by disrupting implantation. And yet, although pregnancy tests were taken on entry to the trial, the percentage of positive tests that didn't lead to established pregnancies was never published. Have vested commercial and political interests led to a suppression of the truth?

'Don't say a prayer for me now, save it till the morning after.' (Save a Prayer, Duran Duran)

The Morning After Pill (MAP) is an umbrella term for various regimens of hormonal emergency contraception. It is licensed for use up to 72 hours after unprotected sexual intercourse, provided the woman's menstrual bleed is not overdue.[1]

In January 2001, amidst much public and medical debate, MAP became available over the counter to women over 16 years of age. Schering Health Care Limited, manufacturers of leading brand Levonelle-2 (Levonorgestrel) and Yvette Cooper, the Public Health Minister, have repeatedly asserted that MAP cannot affect an established pregnancy.[2] However, where is the positive evidence for this?

Theoretically, of course, there are several stages at which MAP could act…

True contraceptive effect?

MAP may have a true contraceptive effect by inhibiting ovulation. This would depend upon its ability to inhibit the LH surge and on the timing of administration in relation to the menstrual cycle. There would still remain a risk of pregnancy if MAP merely delayed, not prevented, ovulation.

Levonorgestrel has only a limited effect on preventing ovulation (less than 15%), even when deliberately administered just before the LH surge.[3,4] In one study, 361 peri-ovulatory women took levonorgestrel 0.75mg after intercourse. Using basal body temperature analysis, only 14.4% showed ovulatory inhibition.[5] Another study looked at levonorgestrel as a postcoital contraceptive. 77 women took 0.4mg per coitus for 1,011 cycles, resulting in seven pregnancies (Pearl index 8.3). 27 women took 0.75mg per coitus for 226 cycles, resulting in two pregnancies, one due to faulty drug administration (corrected Pearl index 5.3).

Pearl index – the number of unwanted pregnancies that occur during one year of 100 normally fertile women having regular coitus.

Thickened mucus?

Two studies have detected sperm in the uterus very soon after intercourse: after 30 minutes and four hours (in eight out of ten women) respectively.[6,7] MAP administration is advised up to 72 hours after intercourse and cervical mucus changes then take another 24 hours.[8] Relying on thickened mucus the next morning is analogous to closing the stable door after the horse has bolted.

Tubal motility

There is a theoretical possibility that MAP may alter tubal motility, altering the passage of sperm up the Fallopian tubes. Alternatively, the transit of the egg or conceptus moving towards the uterine cavity could be affected.

Implantation disruption

Depending upon both dose and timing, MAP can disrupt implantation or cause the loss of a newly implanted embryo. Post-coital studies in post-ovulatory mice have shown that levonorgestrel can cause resorption of already implanted embryos.[9]

The Yuzpe method (ethinyloestradiol 0.1mg and levonorgestrel 0.5mg both given twice 12 hours apart) is thought to have a similar mode of action to

Levonelle (levonorgestrel 0.75mg taken twice 12 hours apart) although it may be less effective. Very recently, the Yuzpe method was shown to be effective between 72 and 120 hours after unprotected intercourse.[10] This provides evidence of a post-implantation effect.

WHO study

1998 women were given either levonorgestrel 0.75mg (repeated 12 hours later) or the Yuzpe regime (0.1mg ethinyloestradiol and 0.5mg levonorgestrel, repeated after 12 hours) starting within 72 hours of a single episode of unprotected intercourse. The primary outcomes were crude (compared with expected) pregnancy rates and side effects.[11] Included women were healthy with regular menses and no recent pregnancy. Women were excluded if they had recently been pregnant, recently taken the oral contraceptive pill or were breastfeeding. Blood or urine samples were taken at entry for pregnancy tests.

Overall levonorgestrel caused an 85% (74-93%) and Yuzpe a 57% (39-71%) reduction in expected pregnancy rates. In both groups, the majority of women did not have further intercourse over the next few days; these women had an 89% reduction in expected pregnancy rate if taking levonorgestrel and a 73% reduction if taking Yuzpe.

However, about one third of the women in both groups did have further intercourse. Assuming that the expected pregnancy rates for these women were between one and two times those for women with a single episode of intercourse, there was a reduction in the pregnancy rates of 79-90% in the levonorgestrel group and 28-64% in the Yuzpe group. Hence in the levonorgestrel group, these pregnancy rates were not significantly higher than those after a single episode of pre-treatment intercourse. This suggests that levonorgestrel acts mainly by disrupting implantation rather than a contraceptive effect on cervical mucus or ovulation.

Where is the positive evidence that levonorgestrel does not work after implantation and affect an established pregnancy? Disruption of implantation is clearly abortifacient as the early human embryo is expulsed from the womb, leading to its inevitable death.

Ethical constraints

Was the WHO study ethical? Nearly 2,000 women were given MAP after blood or urine had been taken for a pregnancy test at enrolment. However, pregnancy was not an exclusion to participation in the study. Of the women later found to be pregnant, almost 10% (four out of 42) were discovered to have been pregnant before taking MAP. How many of the women who did not sustain a pregnancy had actually been pregnant at admission into the trial? The study would have provided data on precisely this point but the results were not published.

Recently, I debated Dr Graham Barker, Schering's deputy medical director, at the Royal Society of Medicine. He conceded that levonorgestrel often acted post-fertilisation and that the WHO study probably was unethical.

Does it matter?

Distinguishing between a true contraceptive and an abortifacient effect is of importance to many women as well as their doctors. Indeed, in America, it is feared that some women may sue their doctors for failing to give adequate information for consent prior to taking MAP. 'Without accurate information presented before prescribing, patients may experience emotional distress from an unanticipated result, an unforeseen side effect or the later discovery of a mechanism of action that is in conflict with their value system.'[12]

Doctors with a Judeo-Christian ethic have even more reason to be informed about MAP's exact mechanism of action. The above evidence shows clearly that MAP often does work after fertilisation and strongly suggests that it can disrupt implantation. It is therefore imperative to be clear on the status of the human embryo.

The evidence shows clearly that the Morning After Pill often does work after fertilisation and strongly suggests that it can disrupt implantation

The Bible does not give any simple proof-texts. Christian thought has identified several stages at which human life could begin: for instance, fertilisation, implantation and physical formation.[13] Whilst there are various reasons for each of these suggestions, it is only at fertilisation that a completely new genetic being is formed. The other stages merely represent points along a continuum of development from fertilisation to birth.

Biblically it is clear that God's care for each human starts at a very early stage. Psalm 139 tells us, 'Your eyes saw my unformed body. All the days ordained for me were written in your book before one of them came to be'.[14] Similarly, Jeremiah was told: 'Before I formed you in the womb I knew you, before you were born I set you apart'.[15] All human life is made in the image of God: this sets it apart and gives it special status.[16]

Bearing all this in mind, Christians should be very wary of sanctioning a drug that is known to act after fertilisation. God has special concern for humans who are vulnerable and cannot speak for themselves.[17] The popular 1980s song 'Save a prayer' talks of a one night stand, requesting that prayer be kept back until the next morning.[18] With increasing use of MAP, this is highly appropriate: newly formed embryos need our prayer and protection.

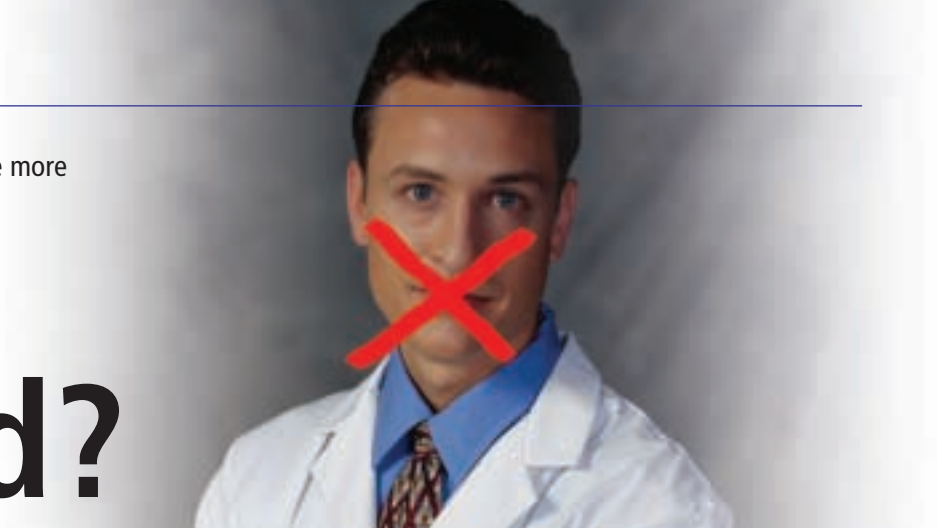
Phil Howard is a Consultant Physician and Senior Lecturer in medicine in London.

Photo: Wellcome

References

1. *British National Formulary*. London: BMA/Royal Pharmaceutical Society of Great Britain, March 2001:383
2. *Hansard* 2000, 19 July:221W
3. Shi YE, Zheng SH, Shu Yhm He CH, Yu PP, Fortherby K. Pharmaco-kinetic study of levonorgestrel used as a post-coital contraceptive. *Contraception* 1988;37(4):359-369
4. Hapangama D, Glasier AF, Baird DT. The effects of peri-ovulatory administration of levonorgestrel on the menstrual cycle. *Contraception* 2001; 63:123-129
5. He CH, Shi YE, Xu JQ, VanLook PF. A multicenter clinical study on two types of levonorgestrel tablets administered for postcoital contraception. *Int J Gynaecol Obstet* 1991; 36(1):438
6. Rubenstein BB *et al*. Sperm survival in women. *Fertil Steril* 1951;2:51-19
7. Williams M *et al*. Uterine flushing: a method to recover spermatozoa and leucocytes. *Human Reproduction* 1993;8:2019-2026.
8. Cyclic changes of cervical mucus in normal and progestin-treated women. *Fertil Steril* 1966; 17:63.
9. Shriley B, Bundren JC, McKinney S. Levonorgestrel as a postcoital contraceptive. *Contraception* 1995; 52(2):277-81
10. Rodrigues I, Grou F, Jolly J. Effectiveness of emergency contraceptive pills between 72 and 120 hours after unprotected sexual intercourse. *Am J Obstet Gynecol* 2001;184:531-7).
11. Von Hertzen H *et al*. Randomised controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. *Lancet* 1998; 352:428-422
12. McGaughran A. Informed consent and emergency contraception. *Am Fam Phys* 2000;62:2219 (15 November)
13. McFarlane G, Moore P. *What is a person?* CMF File 10. London: CMF, 2000
14. Psalm 139:16
15. Jeremiah 1:5
16. Genesis 1:26
17. Psalm 82:3-4; Proverbs 31:8-9
18. Duran Duran. *Save a prayer*, from the album *Decade*. EMI records, 1989

The approach to faith in medicine needs to become more balanced writes **Adrian Treloar**



Good News Censored?

'Doctors warned against preaching to patients' was the headline provoked by the Spring edition of *Triple Helix*.[1,2] The place of evangelism in doctors' daily work is a sensitive issue and the response was a strong instruction that doctors may not force their beliefs onto patients. 'It is totally inappropriate to impose a moral or religious view onto somebody,' said Dr Wilks of the *BMA*. Dr Emma Sedgwick, medico-legal adviser to the Medical Defence Union, said that if it was shown that a doctor's role was primarily a religious one, that would be a breach of trust. Their reactions were broadly reflective of the current culture in British medicine: our ability to embrace spirituality can be close to zero.

IT IS STRANGE THAT INFORMED DISCUSSION OF FAITH IS SO STRONGLY DISCOURAGED WHILST UNINFORMED ENCOURAGMENT OF MORALLY LADEN TREATMENTS CAN BE SO ROUTINE AND UNCONTROVERSIAL

As doctors we are called to heal: health involves physical, social and mental well-being, the latter being linked to spiritual health.[3] Therefore, spiritual matters can be an essential component of a health care episode. Conversely, health care choices that are contrary to an individual's morals or beliefs may be profoundly negative to that patient's spiritual or mental health; examples include severe psychiatric reactions following abortion and poor psychiatric correlates of homosexuality and bisexuality.[4,5,6] Personally, I have seen grateful patients return to faith during critical health crises, supported by their doctors.

As doctors are being warned against preaching to patients, hospital chaplains have now been excluded from the confidential network of caring professionals. The old days when ministers could look through the ward list and visit those declaring church membership have ended.

Many therapeutic options offered to patients are given without any information about their moral or philosophical significance. At times, procedures such as antenatal screening and selective reduction of pregnancies are presented with an enthusiasm that suggests that they are not controversial treatments; information about their purpose is sometimes downplayed or obscured. Doctors who genuinely believe that such options are a good thing are not required to declare their beliefs to patients. Some psychotherapies that are based upon determinism or atheistic humanism may by their very nature erode the faith of faithful people who have not been told what effects these treatments may produce. All sorts of clear advice is given by doctors: from the 'thou shalt not smoke' ethic right through to the 'do anything but use a condom' message, our profession does not hesitate to advise. While few would object to the smoking message, commonly given medical advice on moral issues such as abortion, sexuality, work ethics, withdrawal of treatment and even euthanasia will frequently be influenced strongly by the moral views of the doctor giving the advice.

The medical profession is strongly in favour of informed consent and yet doctors who do not inform patients of the effects of their treatments may impose humanistic values. It is strange that informed discussion of faith is so strongly discouraged whilst uninformed encouragement of morally laden treatments can be so routine and uncontroversial.

As Christians, what should we do? We know that we are to be a leaven in society, placing our lamps on a stand so that those who come in can see the light.[7,8] Jesus was quite clear that we are not to deny our faith; the apostle Peter was forgiven, though clearly not approved of, for denying Christ.[9] Yet Christ did not ask us to stand up and try to prevent the inevitable: Peter was not asked to prevent the Crucifixion and he was told not to use his sword to defend Christ.[10]

We should be willing to own our faith before our patients. Indeed, we need to become better at routinely discussing matters of faith during routine clerkings and assessments. Such discussions are not always productive and we should not force it onto the agenda. However, we should not be criticised for discussing matters of faith with a background of informed consent and an attitude of openness and respect for individual beliefs. Indeed, we should be critical of those who do not allow patients to know that the judgements made about a healthcare choice are influenced by hidden value systems. Crucially, this prohibition must be applied just as much to those without faith as it is to those with faith. Otherwise, faithless doctors may continue to impose their views without check or safeguard.

Adrian Treloar is a Consultant in Old Age Psychiatry and a council member of the Guild of Catholic Doctors

References

1. Hayes D. Doctors warned against preaching to patients. *Hospital Doctor* 2002; 2 May *www.hospital-doctor.cc/*
2. Scott R. Good news in the Surgery. *Triple Helix* 2002; Spring:6-7
3. WHO definition *www.who.int/about/definition/en/*
4. Laville S. Mother of six uses doctors for abortion trauma. *Daily Telegraph* 2001; 14 December *www.telegraph.co.uk*
5. Lauzon P et al. Emotional distress among couples involved in first trimester induced abortions. *Can Fam Physician* 2000; 46:2033-40
6. Jorm A et al. Sexual orientation and mental health. *Br J of Psych* 2002; 180:423-427
7. Matthew 13:33; Luke 13:21
8. Luke 8:16
9. Luke 22:61; John 21:15-19
10. John 18:10-11

Liz Croton reflects on the 2002 ICMDA World Congress, held in Taiwan

Faith moving mountains

There's always a big temptation to sign up for a Christian Conference on account of the exotic location. I had always wanted to visit Taiwan. It had always captured my imagination even though I knew little about it and had met few people who'd been there.

So there was a slight pang of guilt about my motives as I filled out the application form for the World Congress of the International Christian Medical and Dental Association (ICMDA) held in Taipei in July 2002. The theme was 'The Transforming Power of Christ in Medicine'. This event comes around every four years and brings together arguably the largest collection of Christian medics and dentists from around the globe.

Taiwan is self-governing and maintains an uneasy relationship with Mainland China, which lies little more than 160 km across the Taiwan Strait. Taipei, the capital, was certainly an exciting venue for an international Christian conference. There is respect for Christianity even though most of the people have a Buddhist and Taoist background.

The conference took place in one of Taipei's largest youth centres, run by the China Youth Corps. Delegates could either opt to stay in the centre, sharing dorms with Christians from around the world, or stay elsewhere in the city.

It became clear almost immediately on our arrival on the island that events involving a combination of foreign medics and Christians were not commonplace in this part of the world. The Taiwanese are fantastic hosts. The word got round and people we met, hearing that we were medical, immediately asked if we had something to do with 'that conference in Taipei'. This offered a number of us exciting opportunities to share our faith.

The ICMDA conference began with the student programme, with the same theme as the adult conference. The students numbered around 250 representing 45 countries. I was able to catch a few days of this. The speakers tackled topics such as sex and relationships, money and power as well as evangelism and mission-based themes.

The proximity of Taiwan to a number of countries where persecution of Christians is rife – namely Vietnam, Indonesia and China, enabled many of their students to attend. Sadly, other areas of high persecution such as the Middle East were largely unrepresented.

While all doctors know that saline is an excellent resuscitation fluid, the American contingent of the conference took this fact to another dimension by presenting the 'Saline Solution Seminar'. This seminar was designed to facilitate the sharing of faith in a professional context. I confess that I was slightly cynical about how well this would translate into non-American medical scenarios with patients. I was silenced however, by a number of moving testimonies from doctors around the world as to its great usefulness in their daily work. This seminar is due to be adapted to more closely fit the British working environment in the near future.

> THIS EVENT... BRINGS TOGETHER ARGUABLY THE LARGEST COLLECTION OF CHRISTIAN MEDICS AND DENTISTS FROM AROUND THE GLOBE

The doctors' conference had a more formal feel after the spontaneity of the student conference. The doctors brought the numbers up to around 800. Morning Bible expositions were set around the faithfulness of Daniel in the face of persecution. These were particularly challenging in the light of the many real and disturbing testimonies of daily life from many of the representatives of today's persecuted church.

Afternoons were taken up with international lectures and seminars. Of particular note were the excellent addresses from Professor John Wyatt on ethical issues surrounding the beginning and end of life as well as the biblical basis of humanity. Dr Trevor Stammers provided thought provoking material regarding human sexuality.

The proceedings attracted the attention of several well-known local political figures who gave speeches at some of the many social events around the city. These included the vice-president of Taiwan and her entourage, the minister for health and the foreign affairs minister. We were especially encouraged by a remark of the vice-president. She told how she had been very impressed by the Christian ethos of humility and service.

I was deeply challenged by the resolution and bravery of delegates from places where Christians are persecuted for their faith. We in Britain, despite freedom to proclaim the Gospel, can at times be anaemic in our witness. We do not have the threat of secret police invading our meeting like those in Beijing. Nor do we live with the fear of losing our jobs on account of our faith like so many of our other brothers and sisters around the world.

It is often through spending time with such people that we understand what Jesus meant when he said that faith as small as a mustard seed could move mountains (Luke 17:6).

The next ICMDA World Congress will be held in Darling Harbour in Sydney, 2006. Put the date in your diary now!

Liz Croton is a Senior House Officer in Birmingham

Photo: PA

David Chaput looks at work stress and devises a battle plan

Battle Fatigue

Half of consultants and a quarter of general practitioners are planning early retirement. Changes in the health service, patient demands, stress and dissatisfaction with their roles are dominant reasons. Our profession, devoted to patient care and health promotion, does little to prevent stress damage amongst its own members. Until recently the same was true of the armed forces. The average ratio of battle fatigue cases to the wounded is one in three but this can be reduced to one in ten by awareness of risk factors, effective prophylaxis and early treatment.

What is the battle?

Most of us struggle with adversaries bearing names such as bureaucracy, work pressure, stress, ambition and selfishness. In reality these are only munitions; our enemy is the Prince of this world.[1] Many antipersonnel munitions are designed to maim rather than kill; the art of modern warfare is to stress enemy soldiers to the point when they lose their will to fight. A cynical and chronically wounded Christian is far more useful to our Enemy than one who has left the church completely. As in conventional warfare, combat stress is often the deciding factor between victory and defeat in our daily professional lives.

Causes

Cognitive
- Time pressure
- Too much or too little information for decision-making
- Too many or too few possible choices of action
- Professional and personal isolation
- Relational difficulties within our work units

Physical
- Sleep deprivation (post on-call)
- Chronic tiredness

Armed Forces' combat stress control manuals also mention immobility and enforced passive postures. Doctors frequently feel helpless to defend themselves and their profession against disgruntled individuals and media offensives.

Signs and symptoms

Elimination of certain levels of battle stress is neither possible nor desirable. Stress increases alertness and vigilance, strength and endurance. Sharing work stress gives a sense of the elite, increasing cohesion within our working unit and producing considerable personal sacrifice. As stress increases we experience symptoms of autonomic arousal but also experience tiredness, headaches, trembling, anxiety and irritability.[2] We become angry with our partners and other team members, losing confidence in the team or ourselves. We may feel anger, guilt or grief over previous personal failures. Moaning and complaining become more common.

Soft signs
- Apathy
- Arguing
- Constant suggestions
- Lack of personal hygiene
- Memory loss
- Rapid emotional shifts
- Reckless behaviour to self, patients and staff
- Sleep disturbance
- Social withdrawal

Hard signs
- Abusing alcohol or drugs
- Fighting with colleagues
- Failing to attend to patients
- Inappropriate sexual relationships
- Time off work for no apparent reason

Risk factors
- Food deprivation
- First time in combat
- Home front worries
- Insufficient information
- Insufficient tough/realistic training
- Intense battle with many wounded or killed
- Poor unit cohesion
- Sleep deprivation

Battle fatigue is not new; it is recorded in the first Israelite combat.[3] They had just become a nomadic people: like many doctors in training, daily living essentials were no longer guaranteed. Their unity was under stress from water and possible food deprivation.[4] They had had little training for their first battle. In the same way, despite improvements in medical education, house officers frequently complain that they were ill-prepared for the realities of daily medical practice. Thousands of years later, 1973 studies on Israeli soldiers during the Yom Kippur war showed that battle fatigue rather than bravery decoration were predictable. Similarly, poor performance amongst medical students is often related to personal problems.

Prophylaxis of Battle Fatigue

Realistic training. I recently spoke to a young house officer at a

mission field refresher course. She was about to undertake her first tour of duty in Sudan: she had no idea of local medical or social problems nor what equipment would be available. She only knew that she would be the only doctor and was understandably stressed. On a positive note, most UK medical schools are incorporating a shadow house officer period for final year students. Working alongside experienced house officers, students are given a realistic run-in to house jobs.

New personnel. Inexperienced personnel are especially at risk; however, even experts will under-perform in a new situation, particularly after a rapid transition. The consequent underperformance is humiliating and stressful. This is a factor in a lot of often unintentional teaching by humiliation. New arrivals should be welcomed by a senior team member and introduced to other team members. Ideally they should be allocated a 'buddy' for a few days. Many medical schools have a 'Mummies and Daddies' system when senior students look after Freshers, teaching them the tricks of the trade and giving support and encouragement. Newcomers should be given a chance to exercise their skills before being exposed to potentially stressful situations. Instead, many junior doctors arrive to find both registrar and consultant on holiday, numerous complex ward patients, a solo clinic waiting and A&E referrals stacking up!

Understand family structures. The successful functioning of doctors and students is critically dependent on the support of their families and loved ones. Maximise access to these supports especially during crises.

Social interaction. Encourage social activities outside working hours. Sharing food has an ancient bonding power and is particularly useful after times of stress. The risen Lord Jesus cooked everyone breakfast before recommissioning Simon Peter.[5]

Team persona. Capitalise on the positive elements of your team by telling stories about previous successes under difficult conditions. Most doctors like to hear stories about each other. Tell new entrants about some of their predecessors who enlivened the team's medical practice.

Leadership. Ideally, team members should always have the same leader, responsible for maintaining a sense of mission and cooperation. The cornerstone of prevention is the protective power of personal relationships between team members. Working alone for significant periods has never been good![6] A team leader should look out for his team's welfare; for example, the medical registrar on call could ensure that his or her team all get a meal break in the mess and even make a round of drinks in A&E. Team members should know that their colleagues are looking out for them and not competing with them.

Food and Rest. Leaders should ensure that their team is well fed, hydrated and adequately rested. Thankfully, protected sleep for UK house officers is in place. Food and fluid should be freely available during periods of duty; unhappily, in many hospital trusts this has come to mean an under-stocked and often malfunctioning vending machine.

Debrief. From the start of medical school, doctors share in human tragedy. I was quite unprepared for dissecting cadavers and witnessing deaths. Strangely, I didn't discuss my feelings with colleagues until recently. All too often, doctors end an unsuccessful resuscitation by rushing on to the next emergency, almost as if nothing had happened. Critical event debriefing is a central element of combating stress. Debriefing not only allows lessons to be learned but also allows participants to resolve any misunderstanding or feelings of mistrust. The macho culture pervading most medical institutions often lets doctors avoid examining their feelings and psychological issues. Sharing feelings about a common experience reduces the sense of isolation and guilt.[7]

Treating established battle fatigue

Treatment for armed service personnel is guided by the 4R principle.

Reassurance. Many doctors, especially men, imagine that their professional status should render them immune from life's stressors. Most doctors experiencing battle fatigue are experiencing a normal stress response and should be reassured. A lot of doctors imagine that everyone else is coping well. Following my own depressive illness, the 'loonies lunch club' was formed, only open to staff who had received psychiatric treatment. I believe it went some way to overcoming the stigma still attached to doctors with psychiatric problems. Certainly, it encouraged a number of students to contact us about their own difficulties.

Replenishment. Adequate hot food and non-alcoholic drink are as important in treatment as in prophylaxis. It is paradoxical that the more potentially stressful the medical working environment, the less available any adequate replenishment seems to be.

Rest. This is the most important factor for a lot of doctors. Following his fight with the prophets of Baal, God prescribed rest for Elijah's battle fatigue.[8] It is also Jesus' promise to people with exhausting jobs.[9]

Restoration. Battle fatigued doctors should be involved in tasks that restore his/her professional identity as soon as possible. Generally speaking doctors don't like being patients and need to have their sense of competency and involvement restored. Zechariah gives a fascinating account of Joshua, the high priest, being accused by his adversary.[10] Although the angel orders his filthy working clothes to be replaced, Zechariah himself shouts out in his vision, 'Put a clean turban on his head!' The turban was a sign of authority; it is significant that the Joshua's reinstatement was instigated by one of his colleagues. Without reinstatement we cannot continue the battle and our enemy has scored.

Conclusion

Battle fatigue, until recently an unavoidable cause of reduced fighting capacity, is itself being fought by new initiatives.[11,12] It is time for doctors to do the same.

David Chaput de Saintonge is a Consultant in General Medicine at the Royal London Hospital.

Photo: PA

KEY POINTS

As Christian doctors we fight bureaucracy, work pressure, stress, ambition and selfishness, but our real enemy is the 'Prince of this world', who knows that our exhaustion is helpful to his cause. Stress increases alertness, vigilance, strength, endurance and cohesion, but if it overwhelms our coping mechanisms it can lead to discouragement and demotivation. Doctors can learn much from the experience of the military. Battle fatigue can be largely prevented through realistic training, extra support in starting a job, good leadership, effective debriefing, adequate food, rest and being made to feel part of the team. Those already fatigued need reassurance, replenishment, rest and relaxation. All these principles are biblically based.

References

1. Ephesians 6:12
2. Psalms 22, 38, 55, 88
3. Exodus17:8 -15
4. Exodus 17:1-3
5. John 21:1-19
6. Genesis 2:18
7. James 5:16
8. 1 Kings 19:1-9
9. Matthew 11:28-30
10. Zechariah 3:1-5
11. The Virtual Naval Hospital: Combat Stress Manual *http://www.vnh.org/combatstress*
12. 528th medical detatchment (combat stress control) *http://www.bragg.army.mil/528csc/default.htm*

Jason O'Neale Roach examines the ethics of international recruitment

Photo: PA

Stealing Doctors

Countries benefiting most from globalisation of the medical workforce have an ethical responsibility to frame their workforce policy in a manner that reflects global, not merely domestic, need

Staff recruitment and retention in the National Health Service (NHS) has dominated the media health agenda in the past few months. The latest NHS saga reveals a morally questionable twist in the story. Overseas recruitment of health care workers has emerged as a key strategy in the government's attempts to fulfil its promises in the NHS Plan. However, while active recruitment overseas may benefit developed nations, it may be detrimental to global health.

Examining the workforce

The medical profession is experiencing severe workforce shortages as part of a wider recruitment and retention problem that also affects NHS services as diverse as dentistry and physiotherapy. In 2000 there were 1,214 general practice vacancies in England and Wales; deprived urban areas were experiencing the most difficulty attracting applicants. As the number of qualifying GPs drops, the amount of doctors leaving rises. In 1998, the number of newly qualified GPs reached an all-time low of 1,636.[1]

Drop out rates are high among junior staff as well. Cohort studies reveal that in 1993, only 75.7 percent (1969 out of 2600) of newly qualified doctors definitely or probably intended to practise in the United Kingdom, compared with 89.2 percent (2812 out of 3154) of those qualifying in 1983.[2] Similarly, a postal questionnaire survey of doctors 18 years after their 1977 graduation revealed that only 80 percent were working in the NHS and nearly half of the female doctors were working part time.[3]

Almost a quarter of those persevering in the NHS plan to retire early.[4] For example, the NHS will also lose thousands of Asian GPs who will reach retirement age en masse during the next decade.[5] One in six GPs (4,192 out of 25,333) currently practising in the NHS qualified in a South Asian medical school and two-thirds of these doctors are likely to have retired by 2007.

There is controversy over whether so many doctors actually leave or in fact just take time out. The lack of accurate NHS workforce statistics is striking.[6] However, the fact that there is a shortage is beyond doubt. In July 2000 the government's promises to deal with this problem were laid out in the NHS Plan. It promised to recruit 2,000 more GPs and 7,500 more consultants by 2004.[7] Some of these additional staff are already in training, but others are being recruited from abroad as a stop-gap.

At present, about 76 percent of doctors in the NHS are from the UK. This proportion has decreased in recent years and the government's own analysis suggests that this trend is set to continue[8] (see also Table 1).[9] Two main factors are responsible for this trend, the first one being huge financial incentives for many overseas doctors, particularly those from developing nations, to work in the UK.

TABLE 1: 1995 NHS statistics on the origins of the surgical workforce in England and Wales

1995	Total number	European Economic Area (%)	Overseas (%)
Consultant	18400	310 (1.7)	2700 (14.7)
Staff Grade	1760	50 (2.8)	1130 (64.2)
Senior Registrar	4240	180 (4.2)	610 (14.4)
Registrar	6580	290 (4.4)	2430 (36.9)
Senior House Officer	12930	1120 (8.7)	3430 (26.5)

Analysing international recruitment

The second factor influencing the rise in numbers of overseas doctors is active international recruitment. This approach has recently become more aggressive in view of NHS Plan promises. The International Fellowship Scheme, a campaign spearheaded by heart surgeon Professor Sir Magdi Yacoub, allows overseas consultants to work in the NHS for up to two years, initially in four key specialities that have significant staff shortages: cardiothoracic surgery, histopathology, radiology and psychiatry. Alan Milburn, the health secretary, announced in July that about 500 doctors had been shortlisted to work in Britain.[10]

In January another scheme became available to overseas doctors - the Highly Skilled Migrant Programme (HSMP).[11] Applications from various professions are assessed on a points-based system of qualifications and experience. Under the HSMP applicants will initially be given twelve months' stay in the UK. Towards the end of that period, applicants can apply to remain in the same capacity for a further period of up to three years. After four years as a highly skilled migrant, applicants can apply for settlement.

The governments of developing countries simply cannot compete. The Zambian public health service has only managed to retain about 50 of more than 600 doctors that have been trained in the country since independence. The doctor:population ratio in Uganda is 1:24,700.[12] Employment conditions and general living conditions may not be conducive to retaining professionals but Zambian and Ugandan doctors have still been actively recruited to work in a number of richer countries including South Africa.

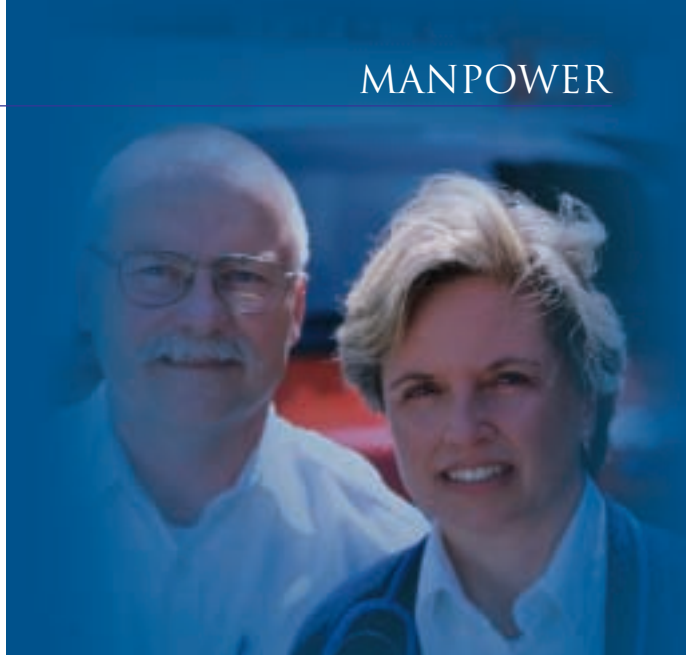
Alternative solutions

The government is already pursuing other ways of tackling the recruitment problem. The European Union produces surplus doctors and could replace those retiring. For example, Spain has more doctors and nurses than it needs and the UK has an official agreement that allows it to recruit Spanish staff.[13] Mr Milburn has also confirmed that he is in active discussions with private healthcare providers from France, Germany and Sweden to encourage them to carry out routine operations for the NHS, to reduce demand.[14]

It is estimated that some 2,000 refugee doctors live in the UK but are denied the opportunity to practise medicine here.[15] Allowing these doctors to work in the system would not only help avert disaster but allow us to learn from their valuable skills while allowing them to begin to rebuild their lives and support their families.

In 1997 the government proposed a substantial increase of about 1,000 in annual medical school intake, to be fully implemented by 2005.[16,17] However, it is unlikely that the new intake of medical students would be ready to enter general practice in large enough numbers within the next ten years to deal with the shortage completely.[18] In addition those health authorities with the greatest shortage of doctors are in some of the most deprived areas in the United Kingdom and have experienced the most difficulty in filling vacancies.[19]

In February 1999, the government published *Agenda for Change*, outlining new proposals for a radical overhaul of NHS pay, career



A Christian Doctor's Covenant

With gratitude to God, faith in Jesus Christ, and dependence on the Holy Spirit, I publicly profess my intent to practise medicine for the glory of God.

- With humility, I will seek to increase my skills, I will respect those that teach me and will broaden my knowledge. In turn, I will freely impart my knowledge and wisdom to others.
- With God's help, I will love those who come to me for healing and comfort. I will honour and care for each patient as a person made in the image of God, putting aside selfish interests.
- With God's guidance, I will endeavour to be a good steward of my skills and society's resources. I will convey God's love in my relationships with family, friends and community. I will aspire to reflect God's mercy in caring for the lonely, the poor, the suffering and the dying.
- With God's blessing, I will respect the sanctity of human life. I will care for all my patients, rejecting those interventions that either intentionally destroy or actively end the lives of the unborn, the infirm and the terminally ill.

Stevens D. In The Doctor's Life Support 2, ICMDA, 2002.

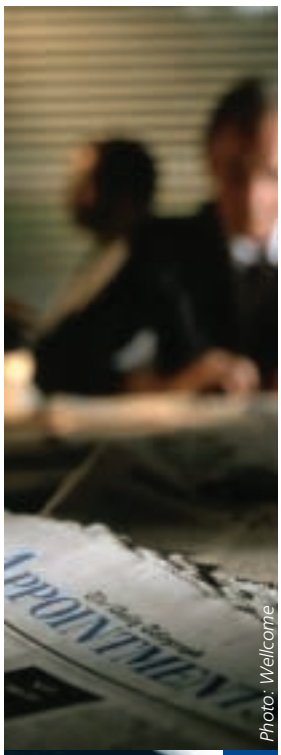


Photo: Wellcome

KEY POINTS

The government is actively recruiting doctors from developing countries in an attempt to make up for inadequate training numbers, part-time working and early retirement. While it is natural for skilled doctors in developing countries to be attracted by the better lifestyle and security offered in the UK, the needs in their own countries are far greater, and their loss is seriously compromising global health. Alternative solutions include recruiting European surplus doctors, training refugee doctors already resident here, improving links with developing world medical schools and increasing UK medical school intakes further. This may be more challenging and costly, but it is ethically essential.

structures and employment conditions; negotiations with staff organisations are proceeding slowly. However, as attempts at increasing numbers begin to offset required reductions in working hours, staff retention will become increasingly important in the short term.[20]

Conclusions

Struggling economies that cannot afford to offer better deals for their doctors lose out to richer nations. It is much cheaper to take a doctor from another country than it is to train one yourself, so the rich save money at the expense of the poor.[21] Developing countries need their doctors the most. Kenya pays its doctors less than US$256 per month and simply cannot compete with the salaries on offer in more affluent nations. Currently, the South African government will not issue work visas to doctors from developing countries. This change in policy may have been influenced by the fact that South Africa now loses more of its own doctors to other continents than it recruits from its northern neighbours.

One cannot blame doctors for seeking a better lifestyle with better remuneration and better working conditions. Concern for personal safety rather than monetary issues now underpins many doctors' wishes to emigrate. The question is whether it is ethical for developed countries to recruit actively in developing countries, deliberately enticing doctors and other health professionals.

IT IS MUCH CHEAPER TO TAKE A DOCTOR FROM ANOTHER COUNTRY THAN IT IS TO TRAIN ONE YOURSELF, SO THE RICH SAVE MONEY AT THE EXPENSE OF THE POOR

Jesus emphasised to his disciples a duty of care for the poor.[22] He also insisted that we love our neighbours as ourselves; this implies generosity to those in need.[23,24] Active recruitment of overseas doctors from poorer countries goes against these gospel principles.

There are potential solutions to this problem other than those currently being tried by the UK government. Active linkages between medical schools across the economic divide could be encouraged, allowing exchange without financial penalty.[25] Developed countries that recruit doctors from developing nations could pay compensation for each doctor lost. The government could simply try harder to learn from other countries about making the NHS more efficient.[26]

Countries benefiting most from globalisation of the medical workforce have an ethical responsibility to frame their own workforce policy in a manner that reflects global, not merely domestic, need. Implementation might be technically challenging but is ethically essential.

Jason O'Neale Roach is a pre-registration house officer in London

References

1. King's Fund. *General Election 2001 Briefing. Staffing the NHS*. King's Fund: London, 2001 *www.kingsfund.org.uk/eKingsfund/assets/applets/ebstaffing-12.PDF*
2. Lambert TW et al. Intentions of newly qualified doctors to practise in the United Kingdom. *BMJ* 1997; 314:1591-1592
3. Jean M Davidson et al. Career pathways and destinations 18 years on among doctors who qualified in the United Kingdom in 1977: postal questionnaire survey. *BMJ* 1998; 317:1425-1428
4. *Ibid*
5. Donald H Taylor et al. Retrospective analysis of census data on general practitioners who qualified in South Asia: who will replace them as they retire? *BMJ* 1999; 318:306-310
6. Richards P et al. British doctors are not disappearing: but career patterns are changing. *BMJ* 1997; 314:1567-1568
7. King's Fund. Op cit
8. Department of Health. *Planning the Medical Workforce*. London: DOH, 1997. *www.doh.gov.uk/medical/mwsca3.htm*
9. Youngson G. *Overseas doctors and UK training*. Royal College of Surgeons of Edinburgh: Edinburgh, 1999. *www.rcsed.ac.uk/education/tagrep.asp*
10. Batty D. NHS shortlists 500 overseas doctors. *Guardian* 2002: July 3.
11. Immigration and Nationality Directorate. Highly skilled people given opportunity to move to the UK.13 December 2001. *www.ind.homeoffice.gov.uk/news.asp?NewsID=111*
12. Couper I, Worley P. The ethics of international recruitment. Rural and Remote Health 2002. *rrh.deakin.edu.au/editorial/showeditorial.asp?EditorialID=14*
13. *news.bbc.co.uk/1/hi/health/1641483.stm*
14. Batty D. *Art cit*
15. King's Fund. *Op cit*
16. Department of Health. Op cit
17. Higher Education Funding Council for England Report 99/42. *Increasing medical student numbers in England.* HEFCE 1999. *www.hefce.ac.uk/pubs/hefce/1999/99_42.htm*
18. Richard P. *Art cit*
19. *news.bbc.co.uk/1/hi/health/264632.stm*
20. King's Fund. *Op cit*
21. Couper I, Worley P. *Art cit*
22. Luke 12:33
23. Matthew 22:39
24. Mark 12:31
25. Couper I, Worley P. *Art cit*
26. Richard GAF et al. Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente. Commentaries: Funding is not the only factor; Same price, better care; Competition made them do it. *BMJ* 2002; 324:135-143

Bruce Cleminson on how Christians are pioneering hospice work in Russia

A Shetland-Samara Partnership

In 1996, there was a severe downturn in the Russian economy after the collapse of communism. There was so little money available for the provision of health care that people dying of cancer in Samara, Russia's 4th largest city, were being given no medical and nursing care at all. The hospital service had stopped admitting these patients. So they received no radiotherapy, no chemotherapy, and no hospital nursing care, even if they needed it. There was no community nursing service such as we have in Britain. Moreover, there was no morphine for pain relief.

Until 1993 an act of parliament in the USSR forbade doctors discussing fatal illness with patients, reflecting the atheism of the political system and its lack of any hope beyond the grave

The problem was not lost on Christian doctors and nurses attending the Samara Central Baptist Church. They decided to visit the dying cancer patients after work hours in their own homes, on an unpaid basis, to try to bring them help on every level - physical, emotional, mental and spiritual. After three years they found the need had grown even greater. So they applied to the civic and medical authorities for permission to be constituted formally, as *The Samara Hospice Team*.

The most urgent need was for training. There had never been any training in Palliative Care for doctors or nurses in Samara, either at undergraduate of postgraduate levels. This was probably the situation all over the former Soviet Union. Indeed, until 1993, an act of parliament in the USSR forbade doctors discussing fatal illness with patients, reflecting the atheism of the political system and it lack of any hope beyond the grave.

Help came thanks to a visiting team from Switzerland, in Samara to help restructure health services. On their return they contacted their local Palliative Care Physician. So it was that Dr Nathalie Steiner, from Geneva, Switzerland, and Dr Bruce Cleminson, GP and Macmillan doctor for the Shetland Islands, went to Samara, with support from the *Shetland Aid Trust* in Britain, and *CDK* in Switzerland. At the invitation of the Samara Hospice Team, in June 1999, they ran the first three-day Hospice Conference. In 2000, the Samara Hospice organised a further three-day conference, this time for more than 100 people from all over Russia. One outcome was formation of *The Association of Russian Hospices*, to strengthen the hand of those involved in negotiations with local and national governments about funding and the supply of essential medicines.

I had the opportunity to visit Samara in 2001 as part of the teaching programme. We visited 'Olga' in her early 40s, in her own home. We found she was pain and symptom-free, but very unhappy. She felt that God was punishing her with cancer. We were able to reassure her that God loved her despite anything she had done. Jo, a specialist hospice nurse from Edinburgh and a member of the Shetland Aid Trust team, talked to her in depth about what her seven year-old son knew about her illness, and what would happen to him when she died.

We have been invited to continue the teaching for the Samara Hospice Team. Part of the task we will be to train the polyclinic doctors and nurses in the care of the dying in the community. A three-day conference is planned and as well as local staff training it will include training for the staff from three other hospices that have sprung up in the Samara region. As well it will include doctors and nurses from Ulianovsk, Saratov, and Astrakhan in southern Russia.

My thoughts

Although we sometimes complain about the NHS, all the essential drugs for palliative care, and most other drugs for other medical conditions, are readily available. In Samara there is still difficulty in getting the medicines needed for effective palliative care. There is some injectible morphine, but no oral morphine - sustained release or normal release forms. Other drugs are either scarce or often not available at all. Even if they can be obtained, the family may not be able to afford them.

Our incomes in the West ensure that anybody with a job, or even the old age pension, has something with which to pay the bills and buy food. In Russia, the weekly statutory national minimum wage is about 250 roubles. At 42 roubles to the pound, this is about £5.95. 70% of the people of Samara live below the poverty line. Their cost of living is cheaper but 250 roubles does not even buy enough food for one person, let alone allow family to survive. One kilo of apples alone costs about 30 roubles.

Bruce Cleminson is a General Practitioner in the Shetlands

EUTYCHUS

Stress and emotional exhaustion linked

Emotional exhaustion is the key precursor of stress according to a longitudinal study of UK doctors published in *The Lancet*. High levels of personal accomplishment increased stress, but by contrast depersonalisation - treating patients as objects rather than as people - lowered stress levels. Might this explain the Psalmists observation that 'the wicked have no struggles and are free from the burdens common to man'? (Psalm 73:3-5) The current emphasis on encouraging doctors to care more about patients as individuals and to reach higher personal achievements, without time and support, was adding to stress and burnout in doctors according to one of the research team, Professor McManus of University College, London. (*Lancet* 2002;359:2089-90; *British Medical Journal* 2002;324:1475, 22 June)

Coma case coming

A Scottish GP is taking her NHS Trust to court for seeking to withdraw life support when she was in a coma. Fiona Smith was injured in a car accident in Tours France in July 1995; in which her husband Jim, also a doctor, died. She was later allegedly diagnosed as being in a persistent vegetative state by doctors at Dundee Royal Infirmary, who she claims then discussed ending life support. Dr Smith, who woke up six months after the crash, is currently preparing a £100,000 lawsuit against Tayside University Hospitals Trust, and hopes her case will help to challenge Scotland's Adults With Incapacity Act and win a European Court ruling. A Trust-appointed review panel says she received 'good and proper care' in 2000. (*Doctor* 2002;19, 19 September)

Warnock advocates mercy killings

The courts should be able to sanction mercy killings for patients suffering terminal illnesses according to Baroness Warnock, former chair of the Committee of Inquiry into Human Fertilisation and Embryology. Writing in *Counsel*, the official magazine for barristers in England and Wales, she argues that if the law permits abortion for fetal abnormality, it should also allow euthanasia. In July Warnock backed the cloning of babies to treat infertile couples, saying there were no serious ethical obstacles providing the technique could be shown to be safe. (*The Independent* 2002;6 August)

Relativising gender

The public perception of transsexuals is likely to change further if government plans seeking new legal rights for the group go ahead. The Lord Chancellor's Department has convened a new working group to look at key issues affecting Britain's 5,000 transsexuals including rights to marry, adopt, inherit family titles and property and receive revised birth certificates. (*The Times* 2002;22 June)

Spiritual beliefs and bereavement

People who profess stronger spiritual beliefs seem to resolve their grief more rapidly and completely after the death of a close person than do people with no spiritual beliefs, a Marie Curie centre study has concluded. Although the study did not discriminate between different religious traditions, and was cautious to distance itself from suggesting that 'an intervention concerning spiritual matters is appropriate for people with no professed beliefs', it did however recommend more accurately identifying people who would have difficulty adjusting to loss. (*British Medical Journal* 2002;324:1551-4, 29 June)

The global neighbourhood

The Johannesburg Earth Summit could have gone much further in its recommendations to ensure justice for the poor and dispossessed, but progress here will always be limited by how we, as a global community, answer the question 'Who is my neighbour? Jesus' definition of neighbour included anyone in need who crosses our path, regardless of ethnicity, religion or social background (Luke 10:25-37). In tackling the issues raised by globalisation we can make a good start by remembering the words of Martin Luther King: 'We are all caught in an inescapable network of mutuality, tied into a single garment of destiny. Whatever affects one directly, affects all indirectly'. (*British Medical Journal* 2002;325:97,13 July)

Armageddon

A quarter of all Americans believe that Jesus will return in their lifetime and nearly two thirds believe Revelation's apocalyptic prophecies to be broadly accurate. In July this year a new thriller title *The Remnant* went straight to number 1 in the New York Times best seller list, the tenth such book in a series called *Left Behind* written by authors Tim LaHaye and Jerry Jenkins. Their 9th book *Desecration*: *Antichrist takes the throne* eclipsed John Grisham to become the best-selling American Novel of 2001. The series popularises the dispensational premillenialist view of the end times involving belief in a literal rapture, seven-year tribulation and millennium – albeit with variations on some of the finer details. (*The Times* (2) 2002;20 September)

Working too hard?

Overwork may be fatal according to a case control study showing that weekly working times were related to likelihood of myocardial infarction. Those working more than 60 hours per week have twice the risk of those working less than 40 (*Occupational and Environmental Medicine* 2002; 59:447-51). Jesus worked hard but did not go on responding to need when exhausted despite the fact that 'crowds of people came to hear him and be healed of their sicknesses'. Rather he 'often withdrew to lonely places and prayed'. (Luke 5:15-16)

Negligence claims

The total annual cost to the NHS of negligence claims rose seven-fold between 1995 and 2000, such that the cost of outstanding claims is now £2.6bn with a further £1.3bn predicted to arise from incidents not yet reported. Cases of cerebral palsy and brain damaged babies accounted for 80% of outstanding claims by value and 26% by number. (*British Medical Journal* 2002;324:1411, 15 June)

Spiritual care

More than half of the medical schools in the United States now have courses on religion and medicine that introduce medical students to spiritual issues in medical illness, according to a recent review in the *Journal of the American Medical Association*. Over 60 studies have examined the role of religion in medical conditions with the majority finding high rates of 'religious coping' (receiving comfort and support from religious beliefs). The author states, 'Even in Europe where religious involvement is low, studies find that those who are less religious experience more depression and recover more slowly from depression'. Readers are encouraged to take a spiritual history and be supportive of their patients' beliefs. (*JAMA* 2002;288:(4):487-493)

OPPORTUNITIES ABROAD

Specific Vacancies by Continent and Country

Posts often require you to be **UK-based** with your own **financial** and **prayer support**. The contact details given are to enable you to start researching possibilities. For many other posts see previous issues of *Triple Helix* and recent issues of *HealthServe*.

Contact *HealthServe* at Barker House, First Floor, 106-110 Watney Street, London, E1W 2BR. Tel: 020 7790 1336 Email: info@mmahealthserve.org.uk Website: www.healthserve.org

Albania

GP mentors needed to work for one to two weeks alongside newly qualified doctors in GP postings in isolated village situations in Albania. Would suit someone recently retired.

Contact PRIME – jgeater@which.net

Cameroon

Physicians urgently needed at Banso or Mbingo Baptist Hospitals for ST/LT ministry. Involved in clinical work and teaching qualified nationals specialty procedures. Newly renovated, 250 bed hospitals that are connected to a number of health centres.

Contact Carol Potratz at nabmissions@nabconf.org.

Kenya

Locum required at St Paul's Theological College Dispensary, Limuru, Kenya from now until January 2003

Ideally suit a GP. The Dispensary primarily serves the staff, students and employees of the College and their families but also the local community. The Dispensary offers 'one stop' diagnostic, laboratory, MCH and Pharmacy services.

Contact: Dr P.M.Chesworth. Email: chesworth@waganchi.com

Nigeria

Physician (FP, GS, IM) urgently needed to serve at Mambilla Baptist Hospital for the furlough leave of missionary doctor. Serving a population of 250,000 in a 40-bed hospital that's connected to a number of health posts. Length of Term: open for negotiation.

Contact: Carol Potratz at: (630) 495 2000 X251 or nabmissions@nabconf.org.

Uganda

Locum doctor(s) needed at the 46 bedded Rugarama Health Centre in SW Uganda to cover for a CMS(MAM) mission partner who will be on furlough for five months from December 2002. Ideally suit a GP who could start in November to allow an overlap and finishing on 20 May 2003. There is a wide spectrum of clinical work with minimal admin. (Protocols and Guidelines on site). Use of house and vehicle offered. The situation is also children friendly.

Contact: Rachelle Sanderson at sanderson@infocom.co.ug Tel: (256) 77 787891

Uzbekistan

Operation Mercy in Khiva, has a need for a **doctor** for a week in November 2002. Needed to assist the current Op Mercy staff carry out basic medical testing on school-children and their mums (500 people in total). This will provide useful data to inform those involved in the health project and enable the health team to identify key health problems, which they can address within the local community.

The doctor is needed from either the 3-10 or the 10-17 November 2002. (These dates are somewhat flexible from our end.). Must be able to pay own airfare and visa costs but in-country costs will be provided (ie. accommodation and travel). The testing should be completed within a week but could stay on longer at own expense to travel and visit some of the famous Silk Road cities of Uzbekistan, such as Samarkand and Bukhara.

Contact: Catriona Macdonald: Catriona@asia.com or Sietske Bolt: sietskebolt@post.com

Zimbabwe

Bonda Mission Hospital is looking for a third **doctor** to work in this rural hospital in the picturesque Eastern Highlands of Zimbabwe. It is the only Anglican hospital in the country. It has 150 beds, 50 nurses and two doctors. The ideal candidate would have at least four years experience including medicine, surgery, obstetrics and paediatrics. The job offers a demanding but rewarding experience as part of a small team responsible for all aspects of health care in the hospital and surrounding district.

For more information please **contact** the medical superintendent, Bonda Hospital, Box 3896 Bonda, Zimbabwe. Email: mmcnally@healthnet.zw

EVENTS

A Conference for returned missionary couples 3-8 November 2002 is to be held at Burrswood Christian Centre aiming to help missionary couples re-adjust to life in the UK. It offers an opportunity to 'come aside and rest awhile' and a chance to take stock and recharge the batteries. The course will include training workshops, group work, personal interview, worship and recreation.

For more details, **contact**: Fiona Lloyd-Williams, The Conference Centre, Burrswood, Groombridge, Tunbridge Wells, Kent TN3 9PY. Tel: 01892 863637

The Residential Refresher Course 2003 is booked from 7-18 July 2003 at Oak Hill College in North London. It is hoped to add various practical workshops and round table discussion to the usual lecture format of previous years.

ITEMS NEEDED

Dr Anne Merriman of Hospice Uganda is thankful for the recent editions of the BNF she has received for her students undertaking a Distance Learning Diploma in Palliative Care but is still on the look out for more and for an ongoing source of supply. If you are able to help, please send to

Dr Anne Merriman, Hospice Uganda, PO Box 7757, Kampala

A number or items of medical equipment are still needed by a member in Zimbabwe. These include: glucometers and standard BM strips, non mercury sphygmomanometers, automatic BP monitors, infusion drip counters, pulse oximeter, sonicaid fetal heart detectors, CTG monitor, suction pumps and a simple ECG monitor and an infant resuscitation trolley. If anyone knows of any of these items going spare, please **contact** Peter Armon at the CMF Office.

BOOKS

Jesus the Healer – Paradigm or Unique Phenomenon?

Keith Warrington
Paternoster Press 2000
£19.99 Pb 208 pp
ISBN 0 85364 822 0

This book is a paradox. It has an intensely relevant message that broadly states that we should not equate the healing ministry of Jesus with our own Christian healing ministry; his was unique. Jesus' healings were unique bacause they were more than just healings, indeed, they were even more than a signpost to the Kingdom. His healings actually demonstrated the initiation of the Kingdom. Even those who choose to disagree with his perspectives, which he backs up with closely reasoned argument from scripture, are challenged to examine whether our 'success rate' remotely compares with Jesus'. Moreover, he warns that scripture does not support those who claim that the problem today is lack of faith in those pray for healing. There is, in chapter 2, analysis of many relevant scriptural passages about healing, and the major themes of each passage are highlighted.

So far, so good, but what is the paradox? It is the style of the writing. I do not believe that this book was intended to be an easy read, but it does not need to be so obscure. The third sentence in chapter 1 is an example of the style Keith Warrington adopts: 'Claims today that, because Jesus healed, it is to be expected of believers that they emulate him, are to be critiqued in the light of this pedagogical dimension of the healings.' Another sentence: 'Nevertheless, the healings had valuable potential to stimulate a more developed faith in Jesus than to simply recognise in him a therapeutic agency of significant power'. I can grasp the overall meanings but I am not even sure that the second sentence makes sense.

So should one buy this book? I think it is a volume of great importance. But I do hope that Keith Warrington teams up with somebody from the Plain English Lobby and rewrites it. Then it will be even better.

Michael Harper is Medical Director of Burrswood Hospital, Kent

What are you feeling, Doctor?

John Salinsky & Paul Sakin
Radcliffe 2000
Pb 174pp
ISBN 1 85775 407 7

If you find practising medicine easy then this book is not for you. For the rest of us it is a thoughtful and at times embarrassingly relevant read. The book is the result of a Balint group recording and analysing their work together, and then being brave enough to share it with the world.

Michael Balint was a Psychotherapist who worked with groups of GPs from the 1950s onwards. He is gone but not forgotten. Many 'Balint Groups' live on, seeking to enable doctors to use psychotherapeutic insights and techniques in the context of an ordinary consultation. His seminal book 'The Doctor, His Patient and the Illness' was published in 1957. It opened the floodgates of current GP literature by importing psychological concepts into the medical model.

But I have to confess that Balint groups make me think of brown suits and horn-rimmed glasses. Surely we've moved on? I brought my prejudices along as I picked up the book. But they were soon replaced by a recognition that this is a superbly honest, reflective and intelligent work. It gazes mercilessly at the experience and frustrations of being a flawed human being put into a demanding, pressurised and intimate professional role.

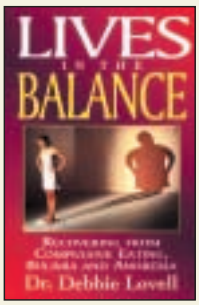
This book came at an interesting time for me. Recently I have been reflecting much on what it is to be a disciple of Jesus in the consulting room. In line with the old adage, when I was young I wanted to change the world and now I am a bit older I realise that it is I who must change. This book is a real stimulus to honest self-examination, and offers genuine insights into the person behind the professional mask. As Christians what will we do with this? Can this area of professional life come more fully under the saving grace and the lordship of Jesus?

All grace is God's grace. Yet again the GP educational world brings questions and challenges which we as Christians should see as our home turf. Any book that makes me want to join a Balint group must be powerful stuff. I recommend it.

David Misselbrook is a General Practitioner in London

Lives In The Balance

Dr Debbie Lovell
Eagle Publishing 2000
£7.99 Pb 260 pp
ISBN 0 86347 392 X



This little book seeks to bring a message of hope to those people who are suffering from a broad range of eating disorders including binge eating disorder (compulsive eating), bulimia nervosa and anorexia nervosa. In addition, there is a section on eating disorders in men, which are much rarer, plus a section for carers from the perspectives of a mother and a husband. The book closes with an afterword and an appendix of addresses, websites and books.

There is a strong Christian emphasis throughout the text. Using the powerful tool of personal testimony on a chapter by chapter basis, the book follows themes that lead to each person's recovery from their particular disorder. There are three testimonies under each category, each one making the very important point that recovery was only achieved through partnership with God. The book does not purport that recovery is easy. In most cases it was a lengthy voyage of personal discovery, leading to greater honesty in

dealings with others and God, through commitment to change, forgiveness and challenging unhelpful thoughts. There is an implicit message that people with eating disorders are individuals with individual reasons for developing their illness, and so there is no blanket solution. Accordingly, some individuals receive help from a variety of sources over time to reach that place of healing.

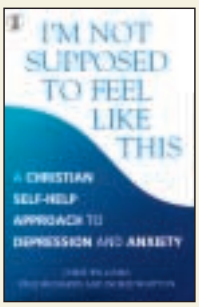
I would thoroughly recommend this book for any Christian who seeks to have a deeper understanding of eating disorders. It is a sound and helpful text that covers a large amount of ground in seeking to embrace a message of hope for both men and women suffering from all forms of eating disorders. This means that it has a broad appeal and perhaps could be most usefully employed as a source of encouragement for everyone who has been touched, either personally or indirectly, by the shame and tragedy of an eating disorder.

For the professional working in a more secular setting, it would be an ideal book to use in the pre-contemplative phase of therapy ie in those people who are struggling for a motivation to change. Because of its strong Christian emphasis, care would need to be taken in checking that, at the very least, the client has Christian sympathies.

Angus Bell is Associate Medical Director of Teesside Psychiatric Services

I'm Not Supposed to Feel Like This

Chris Williams, Paul Richards and Ingrid Whitton
Hodder & Stoughton 2002
£6.99 Pb 280 pp
ISBN 0 340 78639 6



This is an excellent book, written by a Senior Lecturer in Psychiatry, the pastor of a Baptist Church and a Consultant Psychiatrist in Leeds. It provides a Christian view on anxiety and depression, and is written for sufferers and their carers as well as providing practical help for church leaders. Because of its multiple authorship and wide appeal, it is a book that could probably be dipped into at different times by readers from the differing constituencies. It is accepted that a depressed person may well find it difficult to read through the book at one go, yet it is written in such a way as to make reading and reflection easy. There are invitations to 'stop, think and reflect'. Various parts of the text are highlighted. There are spaces to make one's own notes. Key points are recorded at the end of many sections and prayers are suggested.

The book is quite clear that depression and anxiety are not due to a lack of faith in God - they are illnesses and should be treated as such. Whilst most people have an idea about treatments for physical illnesses, many are not so well informed about the treatments that are available for depression and anxiety. Along with the stigma of mental illness, there are often preconceived ideas about mental health treatments with stereotyped fears that are inaccurate. There is an excellent chapter on psychiatry and health services that should allay the majority of these fears. The section on 'overcoming your problems' is written from a cognitive behaviour therapy viewpoint and is very full in its treatment.

The book well recognises that as Christians we are all different, with varying personalities and experiences of church life. Some prefer a more emotional experience and others are more intellectual. For church leaders there is a similarly excellent chapter emphasising the integration of spiritual and medical approaches as helpful aspects of whole person care. The development of a *Religion and Spirituality Special Interest Group* in the Royal College of Psychiatrists is further evidence of the positive working relationships that are developing between professionals working in the Health Service and within churches to the benefit of our patients.

Richard Turner is a Consultant Psychiatrist and Medical Director of Nottinghamshire Healthcare NHS Trust

Health, Healing and God's Kingdom

Meredith Long
Paternoster Publishing 2000
£9.99 Pb 260 pp
ISBN 1 870345 36 3

'Compassion is the immune response of the body of Christ. ...What sets (the church) apart is not that its members suffer, but that the whole body responds to that suffering by sharing it'. Writing from personal experience, Meredith Long nevertheless draws upon an eclectic variety of African resources. This is a well researched and cogently argued book that addresses the paradigm shift from western models of health and disease to an alternative world-view.

We begin to understand the chasm in outlook between the scientific mind of a western-trained physician and the fundamental beliefs and expectations ingrained in a diversity of African cultures. Moreover, our attention is drawn to parallels in cultural norms of biblical society, thereby promoting a broader understanding of scripture.

There is much that is challenging but there are also attitudes to question. 'The doctor treats my disease. The nganga heals me', is a striking yet simplistic statement, particularly for those who have seen some of the repercussions, both physical and spiritual, of the ministrations of traditional healers. Fear and spiritual 'dis-ease' cannot be glossed over, nor can the fundamental need of men and women to be redeemed from the powers of darkness into knowledge of salvation through Christ be overstated. The power of traditional African religion is undoubtedly real, and Meredith Long recognises that this is essentially demonic. On the other hand, in a constructive analysis of healing in the context of Christian gifts, the author comments, 'The Holy Spirit does not intend to establish a branch of alternative medicine'!

This book deals with complex issues, but in an accessible style. It is richly

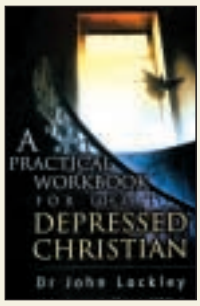
BOOKS

illustrated from African experience with stories, proverbs and metaphor, whilst constantly bringing us back to a biblical perspective. Meredith Long's insights into traditional African views of disease and healing, and her constructive comments on how an understanding of this world-view can be brought into a distinctively Christian model of healing, make this book an invaluable resource for everyone involved in cross- cultural healing ministries. *'In our practice, we communicate that God's realm begins where the reign of science ends. Our challenge is to understand - and practically communicate - God as king of a healing kingdom, that embraces and integrates faith and science.'*

Ian Pitt is a General Practitioner in Southampton and Medical Advisor to Africa Inland Mission

A Practical Workbook for the Depressed Christian

John Lockley
Authentic Publishing, 2nd Edition 2002
£12.99 pb 478 pp
ISBN 1 86024 226 X



I welcome this book, as I did the first edition in 1991. The author has been a GP since 1976 and is described as a writer of three novels and Christian music. Dr Lockley writes out of a wide factual knowledge of depression as well as experience in his work as a family doctor. He thanks 'all those who helped me through my own depression'.

His style is usually chatty, which will help many, and annoy some. He covers the field well. He attacks vigorously the teaching that depression is always due to sin, failure or other spiritual causes. Great good would come if ignorance and prejudice were replaced with facts and sympathy; this book does that well. His own very firm views, however, sometimes jostle unhappily with the consensus views. The book seems to aim to be encyclopaedic and includes exercises for Christians.

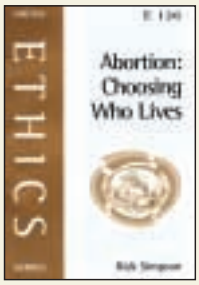
There are some areas that could be improved. The bibliography is limited: I would like to see added well known names of those who have written in this area like Roger Hurding (Senior Lecturer in Pastoral Studies) and Prof Andrew Sims (Former president of the Royal College of Psychiatrists). I hope the author will revise some sections, for example, adequate explanations of CBT (cognitive behavioural therapy) are missing from this book, and I believe it might be improved by CBT input for the exercises.

The result of covering both the medical views and the biblical issues is a large and heavy book, yet one that is eminently worthwhile to own, especially as a resource for churches and those involved in supporting its sick members. I hope this book will be used widely and although the severely depressed person cannot read anything properly, after recovery he may do so.

Gaius Davies is a Consultant Psychiatrist at King's College Hospital, London.

Abortion: Choosing Who Lives

Rick Simpson
Grove Books Limited, Ridley Hall, Cambridge 2002
£2.50 pb 30 pp
ISBN 1 85174 503 3



Rick Simpson, a parish priest, has written this booklet in the Grove Books series as 'a Christian ethical reflection on the process by which abortions are authorised in England and Wales'. He intentionally discusses neither Christian ethical arguments about abortion nor other important questions within the abortion debate, such as when life begins and the rights of the unborn.

The first important issue he raises is that the process by which consultation regarding abortion occurs places Christian doctors opposed to abortion in an impossible position. 'They feel there is no good method of handling requests, which allows them to balance their ethics with good patient care'. In addition, in my experience, some fellow Christians have strong views on what the unfortunate Christian doctor should or should not do and express these with great insensitivity.

Chapter 2, 'Abortion on Demand', contains an excellent analysis of the interpretation of the current law and the criteria allowing abortion, particularly in relation to the unjust and discriminatory Clause E. This allows abortion even when the fetus is fully mature on the grounds of 'substantial risk of the child being seriously handicapped'. As he says, the resulting 'devaluation of life because of handicap in the unborn is hugely, staggeringly at odds with our political and social morality with respect to handicapped members of society'. This concern is widely shared by disabled people.

The third chapter is a telling analysis of what we, as a society, are saying about ourselves by embracing, however tacitly, our current abortion laws. Finally in chapter 4 the author challenges us all to four practical ways forward in which we, as Christians, proclaim the truth about ourselves, and about our loving God. This booklet is a 'must' for all those deeply concerned about the immorality, injustice and ethical illogicality of the abortion law in this country.

Gordon Stirrat is Emeritus Professor of Obstetrics & Gynaecology, the University of Bristol

Photo: Wellcome

Clare Cooper thinks about the doctor-patient relationship

Service with authority

'Well, I don't know. You're the doctor!' I've heard this response from time to time in the consulting room. Efforts to involve the patient in decision making are not always understood or appreciated. At times patients want to leave everything in the doctor's hands. At other times it seems that they are customers demanding a shopkeeper's attention: 'I know what I want and I want it now!' so what is the doctor's role? Clearly we cannot accede to every request. Neither can we impose treatment without consent. Between these two extremes lies a role with two components: to deliver a professional opinion and to be a servant of each patient.

Christian doctors may feel more comfortable with the servant role than their secular colleagues. After all, we follow the example of the Lord Jesus who came to serve and not to lord it over the people, even though he is the Son of God. We are accustomed to seeking – if not attaining – a servant attitude in all areas of our Christian life: at home, at work, in our church and community. We live amongst other believers who also endeavor to follow Christ's example of servanthood and whether we realise it or not this encourages us to 'walk humbly with our God' (Micah 6:8).

What of the doctor – patient relationship? Some patients irritate the best of us, making it even more difficult to approach them with a servant attitude. Yet we also have to fulfil our roles as professional opinion givers. There is both challenge and satisfaction in balancing these two aspects. The doctor cannot be merely a servant. The doctor must also be the professional who makes decisions, guides and informs, counsels and comforts.

Jesus taught us to go the extra mile to meet a need and to treat others with respect. Yet, as he demonstrated the servant role, the authority of his presence astonished people. Jesus had a heart of service and spoke with a voice of authority. We can do no better than to follow his example.

Clare Cooper is a former associate specialist in dermatology, now working for CMF

CHRISTIAN MEDICAL FELLOWSHIP

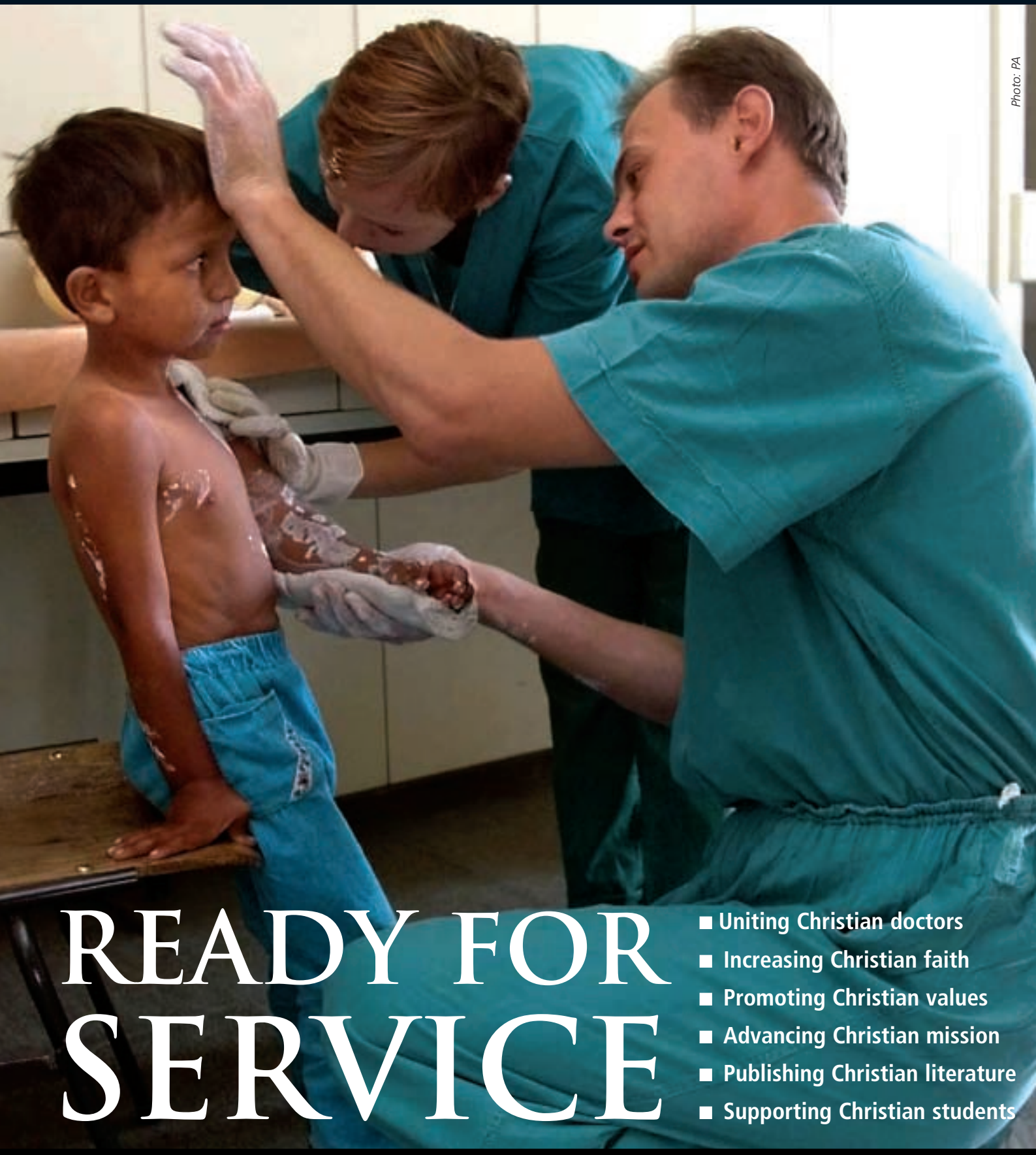


Photo: PA

READY FOR SERVICE

- Uniting Christian doctors
- Increasing Christian faith
- Promoting Christian values
- Advancing Christian mission
- Publishing Christian literature
- Supporting Christian students

To find out more...telephone, email or visit our website or send off the enclosed coupon today

CMF, Partnership House, 157 Waterloo Road, London SE1 8XN
Tel: 020 7928 4694 Fax: 020 7620 2453
Email: info@cmf.org.uk Website: www.cmf.org.uk