readers' letters:

Postcoital 'contraception'

*St Helens GP **Mike Clayton** agrees with John Holden's views in the Summer 1999 edition about the morning after pill:*

I do not prescribe hormonal postcoital contraception (PCC) either for reasons similar to those John Holden outlined. Some take a broad definition of 'conception' as not so much a point in time (ie fertilisation) but rather as a period which extends to include successful implantation. Therefore from this definition, PCC is a method of contraception.

Whilst not the only justification for this position, I have never been swayed by the argument that since there is a high loss rate in nature of fertilised embryos (possibly 60% or so) then this somehow downgrades the value, significance and status of the embryo. The observation that something occurs naturally - even frequently - surely does not in itself justify artificial intervention which brings about the same result.

The official view, often stated, that PCC is not an abortifacient is a semantic one based on the legal interpretation that it is not an attempt to procure a miscarriage since no 'carriage' as such has taken place.

So, how I handle such requests in practice is:

1. Establish the facts (sometimes PCC is not indicated - though this is rare as most advice is that even if the risk is very low, it should be given).

2. I explain that I do not give PCC 'for my own reasons' and will usually ring through to one of my other partners or, if I am doing a locum, to one of the partners in the practice (I have always said before I accept locum work that I do not prescribe PCC as I think it only fair to warn in advance). The amount of counselling I give in addition is variable depending on the circumstances - sometimes it is a matter of the other doctor simply picking up where I left off, or ranging to the other extreme, I explain all that is involved and someone else signs the script. (I'm still not convinced about this one.)

3. The other alternatives available are the same as John Holden outlined.

I would estimate that only 20% or so ask me why I take the position I do.

Usually with the help of a quick sketch I explain how PCC is thought to work. My universal finding is that those who want to use PCC appreciate being better informed - only on a few occasions has someone then decided not to proceed once they appreciate the mechanism of action. Just as doctors vary in their ethical positions, so do our patients.

On a practical note, I do not experience difficulties in general from 'burdening' an extra onto another GP (but perhaps I'm not the one to say). It is only polite though to offer to 'swap' extras or return the favour when inevitably something else crops up (eg when allocating visits etc).

Sometimes I wonder whether it is really worth all the bother, given all the other stresses and demands during an average day but I suppose it achieves two things:

1. It makes people think.

2. I want to keep my conscience clear - and although it means inconvenience and anxiety (for both parties!) I cannot simply bury my intellectual conclusions.

***Mark Houghton** is a GP in Sheffield who also takes the same view. He offers 'more pointers to good practice':*

John Holden's article pointed helpfully to the right road in this matter. May I add some more pointers to good practice:

1. The pressure of the 'emergency' nature of the consultation can be reduced by good patient education. All new patients (men as well as women!) need a joining leaflet explaining:
a. The mode of action of PCC. I get repeated complaints from patients who were not told how PCC and other anti-implantation agents work and who wished they had been.
b. That in some doctors' opinion these drugs are unethical and bad for health, with reasons given briefly. Name the doctors in the practice who hold this opinion and promise a caring ear from all irrespective of race, religion, sex etc.
c. That a second opinion is always on offer. Telephone numbers for difficult times like weekends, giving advice and other opinions, can be added so there is no medicolegal comeback and freedom of choice is there.

2. Sexual health literature can indeed extol the benefits of keeping sex for husbands and wives. God has been saying that from the start though it may be better not to mention him at present. But we are duty-bound to point out the serious health consequences of multiple partners, of cohabitation versus marriage, of early first sex and of divorce just as we do for smoking. (Excellent data on this for your waiting room leaflets are in a paper by public health consultant Dr Ted Williams, *Marriage, Cohabitation, Divorce and Children*, June 1999, available from the Maranatha Community, 102 Irlam Road, Flixton, Manchester M41 6JT.)

Yes, this teaching is 'seldom heard' by our society, because it is seldom publicised. Good practice will ensure patients get all the facts from which to decide their own lifestyle before the 'emergency' comes.

*Leicester consultant anaesthetist **Hugh James** however, thinks John Holden ascribes too much value to the early embryo:*

While I respect John Holden's sincerity in his wish to give full value as a human being to a fetus from conception, I think his logic is weak and the scripture he uses is far from conclusive.

At an early stage of development of the embryo it is uncertain whether it will implant and progress, or even whether it will become one person or two, should it form identical twins. Can one really consider it a living human being? At this stage, God knows the future but we do not. Psalm 139 which John Holden quotes proclaims just that, and it emphasises God's role in creation. It says nothing about the stage at which we become 'people'. Indeed Ephesians 1: 4 tells us that God chose us 'before the foundation of the world'. So why is the womb special? And technically of course, many of the embryos never embed in the womb, anyhow. Is it conceivable that a large proportion of those in heaven are conceptuses who never developed beyond ten days?

An embryo is a creation of God and not to be treated lightly. However, that is not to say that it deserves the protection of a fully formed baby. In reality we all give a differing value to a fetus depending on its gestation. In the rare instance that the life of someone's wife is at threat from a pregnancy, who would not sacrifice the life of the fetus for the mother?

For anyone who would want to consider further the concept of a developing value for the fetus, I would strongly recommend Dr Peter May's recent series of articles in the *Church of England Newspaper*.

(See also the article by Mandi Fry on pages 6-7)

Sexual health

*Manchester GP **Sharon Kane** has further practical advice on disseminating the Christian truth about good sexual health:*

As a Christian GP I so often feel helpless before the tide of increasing teenage sexual activity and the attendant problems of unwanted pregnancies, STIs, and the timebomb of female infertility caused by silent chlamydia infection.

I am heartened therefore by the recent publication of three health promotion leaflets intended to educate teenagers about the risks of early sexual activity and to encourage them to say 'no'. They are not preachy or moralising but contain well-substantiated medical facts. They are produced on glossy colourful paper and have catchy titles:

If you think saying 'no' is tough, just wait till you say 'yes'

How to be a better lover

You didn't get pregnant, you didn't get AIDS, so why do you feel so bad?

These leaflets were originally produced by the US Department of Health and Human Services, and are now being published by IMAGE, a Christian group in Cheshire. They are available from them at IMAGE, PO Box 51, Hyde, Cheshire SK14 1PY. Tel. 0161-368 8875.

IMAGE would like to see these leaflets distributed in mainstream health education, to avoid the appearance that this issue is solely the concern of a moralising religious group operating in a little corner. If you have any ideas about how this might be achieved, or if you have the means or connections to make this a reality, they would love to hear from you!

Finally to those who, like me, feel overwhelmed by the tide of evil that seems to be flooding our land, and who sometimes wonder if it has just gone so far that we might as well give up standing for what is right, may I share an encouraging scripture the Lord showed me recently. Isaiah 28: 6 says 'He will be . . . a source of strength to those who turn back the battle at the gate'. I would emphasise those last three words.

Debt relief - but at what cost?

*Retired Sussex GP and former missionary **John Geater** returns after recent encouragements to the question of relief for developing world debt. He argues there's a long way to go yet*

Many *Triple Helix* readers will have signed the Jubilee 2000 petition calling for debt cancellation for the world's poorest countries. We were pleased debt cancellation was high on the agenda at the G8 Conference in Cologne and recognise the major part played in this by our Chancellor, Gordon Brown. Many will have been delighted that debt cancellation of $100 billion was announced in June (not quite as good as it might seem as $50 billion was due to have been written off anyway but still a major step in the right direction). When placed alongside the total developing world debt of over $2 *trillion* however, there is still a long way to go before the poorest nations get out of their economic slavery to the rich.

What many do not realise is that the mechanism whereby debt is remitted is tied to Structural Adjustment Programmes (SAPs) dictated by the International Monetary Fund. These impose stringent conditions on debtor nations, which may force them:

- to privatise state industries, creating profit for richer investing individuals and financial institutions but depriving thousands of people of employment and their only means of support

- to make drastic cuts in government expenditure to free resources for debt repayment. These have almost always resulted in drastically reduced spending on health and education

- to introduce 'cost recovery' mechanisms which can result in the imposition of of heavy charges upon those who are sick and place education beyond the reach of the very poor

- to 'rationalise' the number of civil servants. This often includes laying off doctors and teachers and has a further negative impact on health and education services, particularly for the poorest citizens who cannot afford the private sector

• to devalue currency, rendering their exports and commodities cheaper to the developed world and pushing up the prices of imported goods including medicines

Details of the complicated workings of SAPs can be obtained from the World Development Movement at www.wdm.org.uk or from Christian Aid or the Jubilee 2000 office. The May 1999 edition of *New Internationalist* is also enlightening reading. IMF policies seem to be having the effect of worsening the poverty of the very poorest in the developing world.

Whilst it is not within the remit of Christian health professional organisations to become involved in the wider economic arguments, I would encourage individual Christian health professionals to align themselves with the world's poorest people by writing to their MP and to the Chancellor congratulating the government for what has been done so far but urging that pressure is brought to bear on the IMF to abandon its harsh right wing monetarist policies in favour of an approach that does not harm the poorest people in the poorest countries.

We should all be concerned by the imposition of unaffordable health charges. For instance, as a result of SAPs, state hospitals in Nicaragua now impose an admission charge of $30 - three weeks' salary for the poorest people, and in Tanzania people have to pay what would be the equivalent for the average Briton of about £100 for a clinic visit. Previously they had free medical attention. Whilst we should welcome restrictions on spending on weapons, we should passionately oppose such drastic restrictions on the availability of health care for the poor. We should take up the matter with Gordon Brown and Development Minister Clare Short to prevent debt relief having the effect of depriving the most vulnerable of health care. International subsidies should be applied to medical imports to offset the extra costs to the developing world from IMF-imposed devaluations.

As Christians we cannot walk away from our obligations to the poor, nor as health professionals from our obligations to the sick. We cannot close our eyes to their plight nor walk past on the other side pretending they're not there. Charitable giving helps a few - but if we can change IMF policy we can help the many.

Transplants: are the donors really *really* dead?

David Hill *replies to those who criticised his views about brainstem death:*

The brainstem tests were introduced in 1976 as prognostic indicators to determine when death will inevitably supervene; it was only in order to obtain organs from beating-heart donors that the 1979 Memorandum regarded the same tests as diagnostic of death. In the first case treatment could be discontinued and the patient allowed to die; in the second treatment is continued and even intensified. David Cranston is correct in writing that ventilators would continue to be switched off even if transplants were not required. The point is that the ventilators are not turned off when organs are required.

His practice is also wrong (as is that of his transplant colleagues) if 'the transplant surgeon has nothing to do with the diagnosis of brainstem death apart from checking the records'. The Code of Practice requires that 'he must have satisfied himself by personal examination of the body that the patient is dead' (Para IX, 35). If death has been determined on the basis of brainstem tests, this can only be by repeating them, which is not done.

John Searle might look again at the Memorandum (II, 7) which justifies the change from prognostic to diagnostic. It claims that 'by then all functions of the brain have permanently and irreversibly ceased'. There is ample evidence, to which Stuart Cunliffe refers, that activity in the cortex, hypothalamus, thalamus, basal ganglia and pituitary may continue, and the permanent irreversibility of other changes is, of course, essentially unprovable. The concept that higher centres of the brain cannot function without the brainstem is long outmoded now that, for example, waking centres have been identified in the higher brain. In addition, the brainstem is incompletely tested.

As a fellow anaesthetist, I cannot agree with him that 'what was then taken to the operating theatre for the removal of organs was a corpse' in any normal use of that word. Both muscle paralysing drugs to prevent movement and some form of anaesthesia to control the hypertension and tachycardia that accompany the trauma of surgery are required - not characteristics of a corpse. Current organ harvesting practice is pragmatic, but neither scientific, logical nor ethical.

Stuart Cunliffe is correct in doubting that this information is ever presented to potential organ donors or their families, thus invalidating their consent.

The Editor welcomes original letters for consideration for publication. They should have both Christian and healthcare content, should not normally exceed 400 words, and if accepted may have to be edited for length.

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