TRIPLE HELIX

Spring 2001

For today's Christian doctor

MORNING AFTER PILL

NEW MENTAL HEALTH ACT

ALDER HEY
What lessons?

THERAPEUTIC CLONING

MMR VACCINE

MEDICINE AS A VOCATION
Outmoded concept?

RESEARCH FRAUD

TRANSPLANTS

OVERSEAS OPPORTUNITIES

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EDITORIALS

Euthanasia in the Netherlands

An escalating downward slide

In 1989, euthanasia was decriminalised in the Netherlands and in 2000 it was legalised. The headline in the *British Medical Journal's* news pages (*BMJ* 2000; 321:1433, 9 December) proclaims 'Netherlands gives more protection to doctors in euthanasia cases'. One is tempted to wonder about protection for patients.

Euthanasia has been increasingly accepted in the Netherlands since 1973, when a doctor put an end to her mother's life and received a seven day suspended sentence. It comes as no surprise, then, to anyone who has followed the story, that tolerance of the practice has brought it now to the status of law. Its progression has proved to have a momentum of its own.

Some of the milestones along that road should be noted. In 1982, a State Committee set the criteria under which euthanasia could be practised and in September 1993, Dutch Paediatricians drew up guidelines for euthanasia in children. The new law requires that 'parental consent will now be required before incurably sick minors aged 12-16 can request euthanasia'.

In December 1993 the standard questionnaire for doctors was amended to include a section related to 'Active Termination of Life without Express Request'. The non-prosecution of doctors in the Netherlands applying euthanasia under the specific regulations, led to an increase in its use, in many cases without reference to the regulations. It is estimated that the lives of some 950 to 1000 people are ended every year in the Netherlands without any request for euthanasia. In June 1994 the psychiatrist Boudewijn Chabot was found guilty of unlawful killing of a depressed patient who was not suffering from terminal illness but in his case no criminal sanction was applied.

Despite the assurances of 'doctors acting within strict criteria', some of the figures coming out of the Netherlands suggest that, in fact, anything goes. One paper refers to the 'dark numbers', unreported cases, which may be variably estimated between 30% and 70%, neither figure having any possibility of confirmation. Even the lower figure is very disturbing.

Christian ethical thinking has always given importance to the intrinsic value and equal worth of every human life, regardless of age, health, or any other extrinsic factor. Caring for the sick and disabled is a high social priority which characterises a compassionate society. This has been and remains the basis for much of our law and social policy.

It is also the basis for safe and responsible medical practice and any erosion of such a core value weakens the foundations, not only of medical practice, but of society itself. The Netherlands may see itself as leading the way in this field, but we need to ask very clearly, 'where they are going?', before we even consider following that lead.

George Chalmers
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The MMR dilemma

Be informed, inform others and act on the evidence

Vaccination programmes pose a dilemma; individuals face remote but sometimes catastrophic risks to ensure that the community presents no risk to them of the disease. If individuals fail to take that risk however, both they and the community will suffer. We cannot isolate ourselves from the community of which we are part. As similar pertussis 'scares' in the 1970's showed, everyone suffers if we try.

In MMR vaccination a very effective multiple vaccine protects against measles, mumps and rubella. The risks of non-vaccination are incomparably greater than those of vaccination as large long term studies in other countries and increasing experience in the UK fully confirm. High take up levels are necessary to achieve the benefits of the programme. One largely discredited article has claimed that the triple vaccine is associated with a greater risk of autism and possibly Crohn's disease. The media raise doubts; vaccination rates fall; and the risk of a measles epidemic is real. Parents are frightened and seek single injections instead.

The injection of foreign protein can never be a risk free procedure. In infrequent cases, local and/or systemic complications of varying severity occur. Single injections multiply that admittedly low risk. We may concede much to modern autonomy but doctors are not morally or legally required to act against their better judgement when choosing vaccines however 'paternalistic' their actions are judged by others to be. Doctors must use their own rigorous standards in reaching this 'better judgement' and not simply adopt the opinions of others. Wakefield and Montgomery (*Adverse Drug React Toxicol Review* 2000; 19:265-283) imply that the 'Establishment' has failed to undertake all necessary research and ignored some that has been done. We need to satisfy ourselves that this is not true and to warn parents of the real dangers and choices. The public is well aware that 'Establishment' views have been wrong in the past and is unlikely to be convinced by slick advertising campaigns. Whilst the media like to present contrasting views as equally valid, doctors must be clear that, in this case, one view is overwhelming and the other tenuous.

Doctors who have read professional reviews and who are prepared to expose their own close relatives to vaccination can be reasonably satisfied that their own 'better judgement' is indeed ethical. We need to be honest about vaccination risks confirmed by reliable evidence and to change our practice if new findings justify it. We must ensure that all those who actually give the vaccine know and observe any contraindications however rare. Audit procedures will need to be in place. If parents reject our advice that is their legal right but our moral responsibility remains to ensure that such a decision is as 'informed' as possible.

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Research Fraud

The search for truth must be the prime motivation

Research is essential to advance medical knowledge and ultimately improve patient care. All doctors in training should be taught research techniques, have an opportunity to spend time in research under supervision and be able to interpret published data. Fraud impedes the advancement of both medicine and patient care (*BMJ* 2000; 321:1429).

Recent cases have come before the General Medical Council. It is planned to set up a national panel to address this issue but some perceive the advisory nature of the panel as a weakness. The Committee on Publications Ethics (COPE) set up three years ago, has already had over 100 cases submitted to it (*BMJ* 2000; 321:1487).

Why do individuals falsify data or even communicate results ambiguously to disguise weakness in the research? There is enormous pressure to publish to gain career advancement, greater personal or institutional prestige, or just further funding. In the United States, 20% of applicants for gastroenterology fellowships and 7% of those for emergency medicine residency programmes are said to have misrepresented publications (*Ann Int Med*1993; 123:38-41, *Ann Emerg* 1996; 27:327-330). Those who have been involved in research, whether Christian or not, will know the temptation, so 'casting stones' is not appropriate. 'If we say we have no sin we deceive ourselves…' (John 8:7, 1 John 1:8).

As Christians, we must stand for integrity in every aspect of medicine not just in research. Those in positions of influence in institutions, training and research must set an example but also be supportive. The creation of a 'cut throat' atmosphere in which failure is unacceptable, sets a bad example. Good role models introduce their trainees to the concept of a search for Truth rather than a Nobel Prize. They encourage the concept of research that is valuable whether the results are positive or negative. A manufactured, dramatic finding may bring temporary success but if the foundations of the research are not honest, like any house built on sand - it will eventually fall (Matthew 7:24-27). Ultimately only research conducted with scrupulous integrity is worthwhile.

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The National Clinical Assessment Authority

Should not influence Christians' enthusiasm

'….a rapid response unit for investigating doubts about doctors performance' was *The Times*' description of the new 'National Clinical Assessment Authority'(NCAA)(15 Feburary, p8). John Denham, Health Minister, described it as a 'new approach to the problem of poorly performing doctors'.[1] Formed as part of the implementation of 'Supporting doctors, protecting patients' (*Dept of Health*, November 1999) the NCAA is a new Special Health Authority. Its purpose is to 'operate a new performance assessment and support service to which a doctor can be rapidly referred, where the concern about their practice will be promptly assessed, and an appropriate solution devised'.[2]

How do we respond to news of the new Authority? Enthusiasm? Resignation? Anger? *The Times*' front page headline for the same day as the above was 'Doctors in crisis as complaints soar' and there can be little doubt that the confidence and morale of British doctors has been battered by a series of damning inquiry reports (Bristol and Alder Hey) and an increasingly hostile media interest in highlighting medical errors. The previous week's *Sunday Times* majored on the 'Arrogance' (11 February, p1) of the NHS and of doctors in particular. But it is despair rather than arrogance that pervades many of our colleagues at present.

For many doctors medicine has been the most important thing in their life and seeing it tarnished and brought into disrepute has overwhelmed them. As Christian doctors we know that we work for the glory of God (1 Corinthians 10:31), but our work, even medicine, should never become our God (Exodus 20:3-4). It will be important in the months ahead that Christian doctors are not overwhelmed by cynicism and despair but continue to show an enthusiasm for their work, an enthusiasm which, as Paul writes, is driven by serving the Lord Jesus, not by the fear of the NCAA! (Colossians 3:22-24)

If the NCAA can reassure the public and press that doctors are serious about wanting to ensure a good standard of service for all patients then it will have a valuable role to play.

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1 Assuring the Quality of Medical Practice, January 2001, p2 www.doh.gov.uk/assuringquality
2 Ibid: 6

Anal Sex

We need to be honest about the health risks

On 30 November 2000 the Government voted to lower the age for consent for anal sex from 18 to 16, by invoking the Parliament Act to overrule the House of Lords and pass the 'Sexual Offences (Amendment) Bill'. Less than a month later, research released at a British Psychological Society conference suggested that many homosexuals are tired of constant warnings about their sex lives and feel empowered by rebelling against them (*The Times*, 20 December 2000). An earlier survey of 10,000 UK homosexuals showed that 45% had had unprotected anal sex; two thirds of these did not know the HIV status of their partners. This February it was announced that new HIV infections had hit a record UK high in the year 2000 (*BMJ* 2001; 322:260).

The health risks of anal sex are well documented but poorly publicised. The delicate columnar epithelium of the rectum makes it highly susceptible to syphilis, gonorrhoea, HIV and other viral infections predisposing to anal cancer. Anal squamous epithelial lesions are now found in 36% of HIV positive gay men (*Sex Trans Dis* 1997; 24:14). Furthermore breakage and slippage rates for condom use in anal sex are 32% and 21% (respectively six and three times higher than for vaginal sex)(*AIDS* 1998; 12(5): 495-503).

But whilst doctors would consider it negligent not to warn their patients of the health dangers of smoking, excessive alcohol, poor diet and lack of exercise; most are reluctant to highlight the dangers of anal sex. Nor does the health of its homosexual citizens appear to be a leading priority for government.

The Bible is clear that homosexual acts are wrong and their associated high health risks should come as no surprise. No one is saying that as Christian doctors we should judge our homosexual patients or deny them good medical care. But, as well as being vehicles of God's mercy and compassion, Christian witness also involves being informed in an atmosphere of ignorance and misinformation and speaking the truth about risks to health. Even at the cost of incurring the wrath of the politically incorrect. If we remain silent, we share the blame.

Peter Saunders
CMF General Secretary and Managing Editor of Triple Helix

Preventative Detention

Dominic Beer asks whether a controversial aspect of the New Mental Health Act is really fair.

In the last decade, mental health services have received much adverse publicity, particularly over homicides committed by psychiatric patients. This has given rise to the mistaken public perception, especially in the print media, that many psychiatric patients pose an increasing danger to other people. In fact the number of homicides committed by the mentally ill has remained both small and constant since the 1950's.[1] However, in the litigation-culture in which we now live, it seems that someone must be blamed for these rare events.

The 125-page New Mental Health Act[2] White Paper is an attempt to restore the public's faith in the mental health services, and is as much about public protection as mental health: 'Concerns of risk will always take precedence'. Both the Secretary of State for Health and the Home Secretary have signed it. There is a widening of the definition of 'mental disorder'. People with 'dangerous and severe personality disorders' can be detained if there is a 'significant risk of serious harm to others'. There is no need any more to show that treatment will help. Hence, preventative detention is envisaged. This may be difficult to square with the Human Rights Act 1998, which says that detention may only occur for recognised disorders on 'objective medical evidence' rather than for 'behaviour deviating from the norms prevailing in a particular society'.[3] So, in practice, we may ask who will actually be detained? The estimate is about 2,200 such people, possibly more, three-quarters of whom are currently detained in prisons or in maximum secure hospitals. Who will manage them? What will the treatment/management be? Where will they be detained? For how long? What will the criteria for release be? These are questions for which there is little evidence or research base to provide clear answers.[4,5,6]

The question of preventative detention is the most controversial part of the proposed legislation, but there are other issues, which may provoke discussion. After the 1983 Mental Health Act, mental health professionals in Europe will have found it strange that their counterparts in the UK allowed themselves increasingly to be put in the position of being considered accountable for the anti-social actions of their mentally ill patients. The proposed legislation seems to accentuate this.[7]

What then of the Christian angle? The ethical principles in question here are truth, justice, mercy, personal responsibility and public welfare. If there are indeed people who pose a danger to society, then society needs to be protected from them as far as possible. However, there is no accurate way of identifying such people reliably. As a consequence, many people may be detained who would not have gone on to do anything anti-social. There is injustice in that. Scrutiny by tribunals may well redress some of the justice issues and will assist in seeking out the truth as it pertains to risk factors for violence in individual patients. However, improving public welfare by a small amount is likely to be at the expense of justice for many individuals and possibly also of justice for society in the long term. How does the principle of mercy apply to those suffering from mental illness who have committed an offence? Under these proposals they have the opportunity to benefit from treatment rather than imprisonment. The emphasis in the White Paper of providing more assertive treatment in the community for those who do not wish to have it appears to lessen the emphasis on personal responsibility. However, the written care plan must address issues not just of mental health but also those relating to the patient's physical health, accommodation, employment, faith and financial needs. By focusing resources on the social, personal and medical needs of this group of patients, some patients may become more willing to comply with their overall care, thus improving their mental health and ability to take more complete responsibility for their actions. But for those with 'dangerous and severe personality disorder', preventative detention may result in a diminution of personal responsibility by trying to make mental health professionals 'responsible', or accountable, for the anti-social actions of their patients.

In summary, for the mentally ill, these proposals may lead to better care if resources are forthcoming. For those with 'dangerous and severe personality disorders' the proposed legislation enters unknown waters. It is unjust if there is an emphasis on detention when no crime has been committed and no effective treatment is given. But if detention can be therapeutic, thus enabling change, this group may end up benefiting.

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KEY POINTS

Distorted media coverage of homicides committed by psychiatric patients has created the perception that dangers to the public are increasing and that 'the system' has somehow failed. It is therefore no surprise that the New Mental Health Act White Paper is as much about public protection as mental health. The proposal to detain those with severe personality disorders is particularly controversial. Whilst the safety of society is important there is currently little evidence or research base to provide clear answers about the 'who', 'where', 'how' and 'how long' questions of detention. Public welfare must therefore be balanced with justice and mercy and treatment must be aimed at promoting a sense of responsibility in the patients themselves.

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Sebastian Lucas and Richard Cook reflect on a public scandal.

Alder Hey


Photo: PA photos

Alder Hey is the latest in a series of high-profile 'scandals' involving the NHS in general and doctors in particular. The stockpiling of organs without consent highlighted in the 600-page Redfern Report, and especially Health Secretary Alan Milburn's criticisms of the NHS, which followed, have provoked a huge variety of reactions. *Triple Helix* invited comment from a pathologist and a paediatric surgeon on the practical and spiritual lessons we should learn.

Lessons need learning, but autopsies remain fundamental

'Arrogant' and 'paternalistic' pathologists, deeply wounded parents angry because they did not bury the entire bodies of their dead fetuses and children and a no-regrets, foreign professor to demonise. Images of baby hearts and other organs stacked in cellars, a 1961 Human Tissue Act that is woefully outdated and a health secretary promising radical changes in medical practice and law – all wrapped up in a media frenzy. The Royal Liverpool Children's Inquiry was the latest defining episode in the relationship between the public, hospitals and autopsy pathologists. The problems arose because what went on in the autopsy room was, by tradition of sparing unpleasant details, not described to relatives when permission for autopsy was being sought or being ordered by a Coroner.

Since 1970, according to the Chief Medical Officer's census of organ retention, over 50,000 organs of adults, fetuses and children have been retained; mostly without fully informed consent from relatives. A small proportion were held technically unlawfully in that they came from Coronial autopsies where material is only retained in order to make a diagnosis and for inquest. The fetal/paediatric organ collection at Alder Hey is the largest, but by no means the only such, in the UK.

No one disputes the value of retaining material from autopsies - for getting the diagnosis right, undergraduate and post-graduate education, and research. The management of congenital heart disease has improved greatly, in part through having archived sets of heart-lungs for surgical review. Our knowledge of dementia depends on having well catalogued brains (for Alzheimer's, not just the hopefully rare vCJD). The parents of the children whose organs were kept reinforce that, had they been asked properly, they would usually have consented. But the process of obtaining consent for autopsy takes place at the worst possible time emotionally both for them and for doctors; and the standard consent forms did not necessarily distinguish 'tissue samples' (for histopathology) from whole 'organs' such as heart, brain and lung.

We move forward, but pathology has taken a large knock in morale; with few exceptions the tissue retention was done with the best of medical intentions. We need to apologise where distress has resulted and draw a line to say that what was done is history. The autopsy consent process now involves full participation by the next of kin. I worry that rapid drafting of laws and amendments leads to unmanageable outcomes, and prefer guidelines that can be modified with practice. We need a Human Tissue Authority to oversee research and ethical aspects of tissue archives (and that includes material from surgical operations – another area of historical ignorance). But the autopsy will continue to be a fundamental part of clinical governance and medical education.

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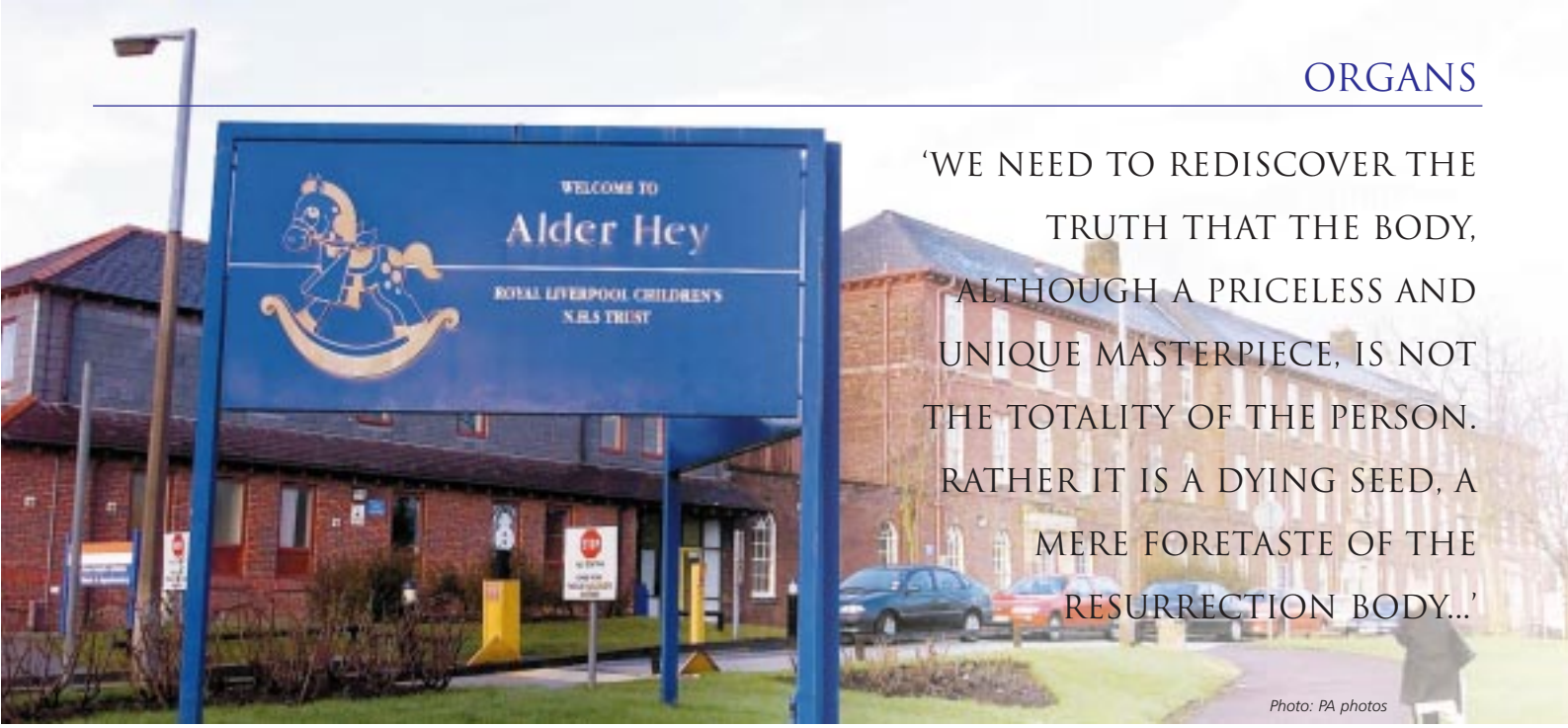
1 *www.rlcinquiry.org.uk* (published 30 January 2001)
2 The CMO's report and census on organ retention are on *www.doh.gov.uk* (published 30 January 2001)

We need a Christian perspective on death and the body

'Great Organ Scandal' may sound like the title of a Roald Dahl children's story. Yet this has been the language of press and parliament, often intemperate and extravagant, and, even if not trivialising the problems, has diverted thought and action from the fundamental issue of how we treat our dead. One doctor's excesses have brought to light the widespread and long-standing practice of collecting and preserving human organs and tissues. Is this now seen as a 'scandal' because of a shift in society's attitude to death and to our bodies?

The Bible says less than we might expect about the human body. It is material - made from 'the dust of the ground', but made a living being by 'the breath of God'.[1] It is a 'tent', or 'clothes',[2] allowing expression of the real person who is 'at home' in the body, then absent from it after death.[3] It is mortal and will decay. However, there are examples of careful and loving treatment of the body after death (the burial of Sarah, Abraham, and other Patriarchs), and even of embalming (Jacob and Joseph - and this, of course, would have involved removal of the viscera). Jesus healed physical diseases, and his own body was treated with care and respect by two secret disciples.

The overall picture is one where both the limitations of the physical body (mortality, decay and disintegration) and also its uniqueness and value are recognised. Above all else it is clear that after death, the body is only a shell. The destiny of the person is elsewhere; either to be with Christ, clothed with a resurrected body like his or to face eternal separation from God.[5] Thomas Sydenham's advice to his students, as



'WE NEED TO REDISCOVER THE TRUTH THAT THE BODY, ALTHOUGH A PRICELESS AND UNIQUE MASTERPIECE, IS NOT THE TOTALITY OF THE PERSON. RATHER IT IS A DYING SEED, A MERE FORETASTE OF THE RESURRECTION BODY...'

Photo: PA photos

published in 'Medical observations concerning the History and Cure of Acute Diseases' in 1688, crystallises what should be our attitude:

'Whoever applies himself to medicine should seriously weigh the following considerations…he must remember that it is no mean or ignoble creature that he deals with. We may ascertain the worth of the human race since for its sake God's only begotten Son became man and thereby ennobled the nature that he took upon him.'

All of us, as doctors, learnt from, were taught on and even examined on, dead bodies and preserved specimens. Much essential morphological research was dependent on the study of whole organs or parts, and much current microscopic and genetic research depends on 'tissues', using biopsies, aspirates and blood - but still human tissue. Obtaining, handling and examining this is never pleasant, and where the material has come from is never far from the consciousness of most of us who are involved. The great successes of much of today's medicine rest to a considerable extent on the careful examination of yesterday's failures - and we have heard little of the huge improvements achieved in recent years. This method of working has been controlled (perhaps not tightly enough) by the law, and by the mores of society - in so far as society at large has wanted to know or to be involved. Our public mores, and especially the religious philosophy of most, has changed. Consequently the perception of the nature of death, and the significance of the body, and the rites and rituals that help have also changed.

The doctor has two, often conflicting, duties. Clearly there is a duty of care for the bereaved. Attention to this usually led me, for one, to limit the information offered when asking for an autopsy. Yes, I was paternalistic - in a desire to protect relatives (and especially parents) from explicit and unpleasant details. I was perhaps failing to recognise their autonomy, but my motive was not to aggravate their grief, rather to bear some of it for them. I wonder if I would have the courage (or the callousness) to get 'fully informed' consent for an autopsy. Yet it is also caring (as well as a legal obligation) to be accurate in certifying the cause of death. Shirking the duty of obtaining an autopsy easily leads to dishonesty, and to a failure to advance medical science for the sake of future patients.

Other aspects of pastoral care have been sadly mismanaged in the current affair. Parents claim to have been told of their children's retained organs sometimes callously and occasionally erroneously, and with little help to understand why they were kept, or how they should be decently disposed of. They are understandably aggrieved as well as still grieving.

But doctors too are hurt, not only by the deaths of their patients, but also by the misunderstandings fostered by inept publicity and by misinterpretations of motives. It cannot be denied that the wholesale and, as far as is known, fruitless accumulation of organs by one academic pathologist was indeed a scandal. If the public (and press and parliament) are indeed 'scandalised' by usually respectful, valuable and life saving studies by the medical profession as a whole, what is required is not ill considered and draconian changes in the law, nor a witch hunt to identify culprits. What we all need is to rediscover the truth that the body (whether our own or that of our nearest and dearest), although a priceless and unique masterpiece, is not the totality of the person. Rather it is a dying seed, a mere foretaste of the resurrected body the person could enjoy for eternity through the grace and power of God.[6]

Richard Cook is CMF President and Emeritus Paediatric Surgeon at the Royal Liverpool Children's Hospital, Alder Hey.

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1 Genesis 2:7
2 2 Corinthians 5:1-5
3 Philippians 1:22-24
4 1 Corinthians 15:12-58; 2 Corinthians 5:1-10; Philippians 3:20-21
5 Matthew 25:41; Revelation 21:7,8
6 Matthew 10:28; Revelation 20:14, 21:1-4

KEY POINTS

The stockpiling of children's organs at Alder Hey without parental consent or apparent purpose was wrong. While insisting that autopsies must remain an essential part of medical practice, for diagnosis, audit, teaching and research, we also need to hear the cry for more honesty and sensitivity when seeking permission to perform them. But the public reaction to this issue is also a symptom that society has lost its way. The increasingly accepted materialist worldview, which equates the person with the physical body, is inadequate. What is really needed is a rediscovery of Christian beliefs about the body, death and eternity.

Peter Saunders' letter to MPs and Peers.

Therapeutic cloning

The cloning of human embryos for research is now legal in the UK. New regulations under the 1990 Human Fertilisation and Embryology Act will allow 'therapeutic cloning' to produce stem cells for use in treating degenerative diseases.

The legislation was passed, by a 366-174 majority in the House of Commons in December, and by a 212-92 vote in the House of Lords on 22 January. Although a committee is to be set up later to look further at the issues, Parliament have effectively rubber-stamped the recommendations in the Chief Medical Officer's 'Donaldson Report' tabled last summer.The new law makes the UK the first country formally to legalise the practice.[1]

The decision followed tough opposition from a powerful alliance of pro-life campaigners and religious leaders. The European Parliament also had earlier called on the British government to shelve its plans and leaders of several other European countries had expressed disapproval.

The implementation of the new law has since been delayed through an appeal by the Prolife Alliance who believe that the Parliamentary votes are invalid because cloned embryos do not fit the definition of 'embryo' as defined in the HFE Act (ie. Produced by fertilisation). The hearing has been delayed until June (after the election), so an embargo on research will meanwhile remain.[2]

CMF General Secretary, Peter Saunders, wrote to MPs and Peers prior to the debate, urging them to vote against the measure and enclosing a copy of the latest CMF File *on Therapeutic Cloning (circulated with the January* Triple Helix*). The main substance of this letter is published below along with its appendix on adult stem cells (slightly abridged), based on research by Phil Jones of the CMF Study Group.*

KEY POINTS

The Government's decision to legalise embryonic stem cell cloning before Christmas without primary legislation or proper debate was irresponsible and unnecessary. Embryo stem cell cloning is unethical because it uses embryos as a means to an end. It is unnecessary because there is a viable ethical alternative in adult stem cell cloning, and dangerous because it creates a slippery slope to reproductive cloning.

The Donaldson Report's recommendations, now rubber-stamped, were based on an overly pessimistic belief in the capacity of adult stem cells to produce new treatments for debilitating degenerative diseases like Parkinson's and diabetes.

Medical Background

In serious degenerative diseases (such as Parkinson's, Alzheimer's and muscular dystrophy) some or all of the cells that are needed for an organ to function are lost. The dream of researchers in tissue repair is that by replacing cells that have been lost through disease, sufferers from such otherwise incurable disorders could be restored to full health. Two approaches have been proposed. The first is to use cloned human embryos, genetically identical to the patient, made by fusing the patient's DNA with an egg emptied of its own DNA. These cloned embryos would then generate stem cells of the required type, which would not be destroyed by the patient's immune system, to repair the damaged organ. But this would result in the embryos being destroyed. The alternative is to use adult stem cells from the patient themselves. (The enclosed *CMF File* explains the technology and options in simpler language)

I am opposed to embryonic stem cell cloning for three main reasons:

1.Embryonic stem cell cloning is unethical because it uses human embryos as a means to an end.

The Judaeo-Christian ethic on which UK Statute Law was originally based affirms that human life at all stages of development deserves the utmost respect. Historical medical ethical codes based on the Hippocratic Oath enshrine a similar view, recognising the power and strength of doctors. The Declaration of Geneva (1948) stipulates that doctors must 'maintain the utmost respect for human life from the time of conception'.

The Declaration of Helsinki (1975) says that in biomedical research 'the interest of science and society should never take precedence over considerations related to the well-being of the subject'.

Whilst allowing embryo research in some circumstances, The Human Fertilisation and Embryology (HFE) Act itself recognises that human embryos have special status and deserve legal protection. Furthermore, the HFE Authority has an obligation to determine that any proposal for research using embryos is necessary and desirable, and that all alternative pathways have been fully explored through prior research or work with animals. This has not been done.

2.There is a viable ethical alternative to embryonic stem cell cloning in adult stem cell technology.

There is now good evidence, growing all the time, that adult stem cells may be a simpler alternative to using embryonic stem cells without the practical and ethical problems inherent in the cloning of human embryos. Very recent research (see below), has demonstrated that adult stem cells have much more flexibility to replace damaged cells than was previously thought. Much of this recent research post-dates

the Donaldson Report, which recommended the use of embryonic stem cells and was accepted by the government last summer.

3. Therapeutic cloning will lead inevitably to reproductive cloning.

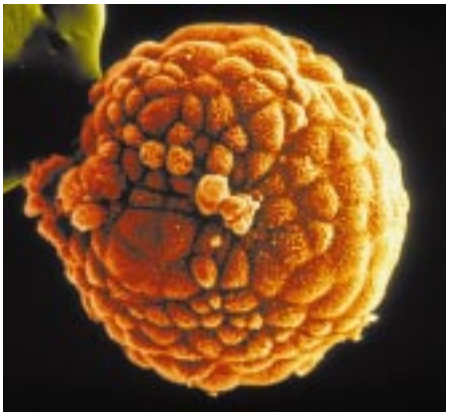
Once cloned embryos have been produced, theoretically all that is necessary for reproductive cloning to take place is for them to be implanted in a womb. This process is technically straightforward and would be impossible to police. Therapeutic cloning of embryos therefore constitutes a very slippery slope to reproductive cloning.

The case for the use of Adult stem cells in Tissue Repair

Adult stem cells are cells that replace cells lost from a tissue throughout life. A single blood stem cell can replace the entire blood system in an animal whose bone marrow has been destroyed.[3] Until very recently the accepted dogma was that in adults stem cells were programmed to generate cells of a single tissue type. For example, blood stem cells[4] could generate blood cells, but not brain or muscle cells. Only embryonic stem cells were thought to have the ability to produce different tissue types. It is now clear that this is not the case.[5]

In papers in *Science* published in December 2000, two research groups (from Stanford University and the US National Institute of Neurological Disorders and Stroke) showed that blood stem cells could generate nerve cells in the brain, when transplanted into mice. [6,7] The blood cells, which had been genetically engineered to fluoresce green, did not need to be injected into the brains of the animals, but migrated into the brain after intravenous injection. The authors of both papers stressed that these observations offered the hope of brain repair from adult blood stem cells.

Similar research reported in 1999 demonstrated the potential of blood stem cells to repair damaged muscle in muscular dystrophy.[8] Mice with a similar disorder to human muscular dystrophy were treated with a bone marrow transplant. The donor blood stem cells were found to have generated muscle cells, repairing the muscle defect in the recipient of the transplant. In November 2000 Canadian researchers at the McGill University Health Centre showed that adult blood stem cells could be used to build up damaged heart muscle; again in research involving rats.



Scanning electron micrograph of a five day old human embyro on the tip of a pin.
Photo: Yorgos Nikas, Wellcome Photo Library

'RATHER THAN AMENDING THE HFE ACT PREMATURELY, PARLIAMENT SHOULD HAVE ADOPTED THE MORE CAUTIOUS AND HUMANE APPROACH OF ENCOURAGING ADULT STEM CELL RESEARCH'

Both embryonic and adult stem cell technologies share some of the same potential pitfalls. In a genetic disease like muscular dystrophy, all the cells in the patient carry the same abnormal gene, and adult stem cells from the patient would need to be genetically modified. Extensive research to achieve successful modification of blood stem cells is ongoing - with some encouraging results.[9] The adult stem cell approach has major advantages. There is very extensive clinical experience with obtaining, purifying and transplanting adult blood stem cells, for example in the treatment of leukaemia, and there are none of the technical problems of developing the new technologies of human embryonic stem cell culture and cloning.

In reality, tissue repair by either route will require extensive further research. But given the remarkable properties of adult stem cells and the experience we already have in their clinical use, it would seem both ethical and scientific arguments favour the allocation of resources to this approach over embryonic stem cell cloning. Rather than amending the HFE Act prematurely, Parliament should adopt this more cautious and humane approach.

Peter Saunders
CMF General Secretary and Managing Editor of Triple Helix

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Self Harm

We are accountable to God in all we do and therefore, we shall… give effective service to those seeking our medical care irrespective of age, race, creed, politics, social status or the circumstances which may have contributed to their illness.

Thus states the affirmation in the *CMF Handbook*,[1] sentiments with which we are all likely to agree. Yet, how many of us as doctors have groaned at 'not another over-dose', or become annoyed with the drunken driver or the familiar abusive alcoholic. If our conscience catches us, we can readily think of excuses - we're over-tired or hungry or we can't be expected to care for those who are dirty, drunk, or whom we cannot understand.

As a junior doctor I was guilty of these thoughts, even if I would have denied it when I was well rested. Recently, however, I have been forced to think about this again, but from the other side.

We are made in God's image. We all know that we should care for our bodies. Some might think that no Christian could deliberately harm their body, but this is what I did. During a long spell of depression, which led to the loss of both my job and career, I deliberately harmed myself, cut myself.

Once, I made a mistake and went further than I had intended, beyond the point where I could steristrip myself back together. I summoned up my courage and went to casualty. Actually, if I'm honest, it wasn't a mistake. I wanted to go to casualty. I was desperate. I had spoken to my Key Worker only days before and again she had reinforced the fact the services were so stretched that there was no one in the Mental Health Team I could contact between appointments. I already felt I had a season ticket with the Samaritans. I didn't know what else to do.

Imagine yourself working in casualty on a Friday lunchtime. You are dreaming of your weekend off, or maybe dreading your weekend on call. Another patient walks in, this time with a relatively minor but self-inflicted wound. The wound on the outside seems small to you, but inside there is a confused, hurting and desperate person. There is someone who used to enjoy life and who worked hard like you do. There is someone who knows that God loves her even if she finds that difficult to believe at times. There is someone who, only a few months ago, would have never believed that she could do this to herself.

I learnt a lot that Friday lunchtime. I learnt about non-verbal communication. I had to, for the nurse ignored me as she stuck me back together with steristrips.

'We don't stitch people who cut themselves', she said, although she later denied this. I learnt that how we treat our patients affects them for the rest of that day, that week or longer. I hated myself. I wasn't helped by other people showing that they resented me being there.

There was one positive experience in that casualty department. One nurse held my hand, listened for a while and made me feel that I mattered, at least to her. I wonder whether she realizes how important that was. Professionally, I have probably learnt a lesson too late. I am unlikely ever to return to clinical medicine and treat my patients as I would like to have been treated.

Commenting on patients whose illnesses are self-induced, the *Doctor's Life Support* for 10th July states:[2] 'Stern warning may be needed but a loving word or deed accompanying professional advice may make all the difference to their lives... If we care, he cares far more and can even bring great good from great tragedy.'

We all need to remember that the patient who calls us as we sit down to a meal, disrupts our social plans, the drunk, the overdose and the self-harmer are someone's friend or relative, possibly even our friend or relative. And may I suggest, 'they' may be 'us' one day.

Anonymous

Useful Contacts

(This list is by no means exhaustive but includes some organisations I have found helpful)

The Samaritans
Tel: 08457 909090
24 hour telephone helpline with offices in many towns where you can call in and talk to volunteers if this is more helpful than talking on the telephone (hours for calling in are usually restricted).

Church Campaign Against Depression
CCAD, 47 Astil Street, Stapenhill
Burton on Trent, Staffs DE15 9DL
Tel: 01283 741115
An organisation whose aim is:
To raise awareness of depressive illness, particularly within the Christian Churches; to promote understanding of it as a treatable clinical condition, rather than a weakness on the part of the person concerned; and to pray for all those affected by depression.

This is a relatively new organisation doing valuable work (many of us can testify about understanding and/or support from the church during our illness) and I am sure they would welcome support from any doctor keen to further the aims of the organisation.

Depression Alliance
35 Westminster Bridge Road, London SEI 7JB
Tel: 020 7633 0557
National self-help Organisation with quarterly newsletter and local groups in many regions.

Doctors Support Network
Tel: 07071 223372
A self-help group for doctors with mental health problems. Monthly meetings (currently in London, but with sufficient support there is scope for organising meetings in other areas as well), together with a monthly newsletter.

National Self Harm Network
PO Box 16190, London NWI 3WW
A national organisation campaigning for the rights and understanding of people who self-harm. As well as their campaigning they also produce literature and provide a list of other helpful organisations.

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Nursing is an important barometer for how our society is embracing post-modernism. **Peter Swift** reports.

In search of identity

Imagine the scene. It is a busy ward in a large teaching hospital. A patient has collapsed, is unresponsive, there is no pulse. A 'Crash Call' goes out. The nurses start cardiac massage. The resus trolley is wheeled up, the de-fib fetched. The 'Crash Team' come running up the corridor. Cannula inserted, nervous fingers snap open ampoules. Adrenaline, Calcium, DC shock. No output. As the drama unfolds a nurse steps forward and commences massage - not cardiac massage but foot massage.

In the ensuing exchange of conversation with the Senior Registrar, the nurse asserts that as a practitioner in Reflexology she alone is treating the patient's underlying disease, all the rest were merely treating symptoms. Sounds far-fetched? I'm reliably informed that this very scenario was played out in a London hospital recently. It invites the question, 'What's going on in society in general and nursing in particular?'

There is a sea-change at work in our culture. For three centuries or more the prevailing philosophy within western culture has been modernism. This emphasised the human intellect and the scientific, technological, rational approach to life. It is a materialist philosophy, rejecting any notion of the spiritual. Such a world-view questions existence of a Creator and asserts that everything can be explained in secular and reductionistic terms.

Most of us will have had contact with some institution of higher education. Within these academic circles, modernism is the over-arching belief system. Until recently this has been the influence that has helped shape Medicine and Nursing as we have known them, particularly as they move away from their earlier Christian roots. But now we are witnessing a sea-change. So while once-upon-a-time the general public showed great respect and deference to scientific experts, now attitudes are changing. People are more likely to question, probe and doubt the words of scientists. Indeed, whereas once science was viewed as mankind's hope for a better future, now people are more likely to blame it and the technology it has spawned for causing more problems than it has solved. The belief in inevitable progress is defunct.

This tendency occurring in society as a whole is magnified within Nursing. Nursing as a profession is currently seeking to discover an identity of its own, one that will make it distinctive from Medicine. In my view nurses will inevitably turn to alternative forms of medicine simply because they are alternative. The emerging 'post-modernist' nurse will emphasise the emotional, the intuitive and the holistic, as opposed to the rational, objective, quantifiable and material. As a thorough-going pluralist, the new nurse will accept that there are many different points of view about everything, all of which are equally valid. Indeed, any 'truth claim' is by definition coercive and domineering, aimed at forcing others to conform to someone else's version of the truth. In this context it is not surprising that an article in the *Nursing Times* last year urges nurses to avoid making moral judgments if one is asked to obtain the services of a prostitute for a client.

Although Christians have never felt entirely comfortable within modernist professions which denied the spiritual, Christians could at least work within Nursing and Medicine, appreciating the benefits of science but recognising that it did not present a complete picture of what it is to be human. Now, however, we are increasingly being faced not with a denial of spirituality, but with alternative spiritualities often dressed up as complementary therapy. It is easy to feel threatened and over-whelmed by the challenge that faces us at the start of the twenty-first century. I suspect that within Nursing, we will continue to see an on-going tussle between two opposing schools of thought, the post-modernist and a reactive modernist rear-guard action.

These are not easy times for Christians. And yet this situation presents Christians with an opportunity. 'Spirituality' is on the agenda, and as Christian nurses we will need prayerfully to consider how best to use these new opportunities. Like the modernist, we too believe in objective truth and that it is knowable. But at the same time we appreciate the limitations of human knowledge and that to be human cannot be fully explained in purely material terms. The spirituality we would profess is one of dependence upon God, rather than one which depends on us manipulating real or supposed spiritual forces.

Peter Swift is a Senior Staff Nurse on the Paediatric Intensive Care Unit at Guy's Hospital in London and on the organising committee of Christian Nurses and Midwives (formerly the Fellowship of Christian Nurses-FCN).

Western worldview changes

Two hundred years ago in Britain most people had a Christian worldview; but with the publication of Darwin's *Origin of the Species* and the rise of biblical criticism, this theistic worldview gave way to an atheistic one. Man came to be seen simply as a clever monkey, the product of matter, chance and time in a directionless and purposeless universe. Morality became relative ('what's right for me') rather than absolute.

Now we are seeing another worldview shift from atheism into pantheism. Pantheism is the ideology which lies behind Eastern religions like Hinduism and also the New Age Movement. God is an impersonal force of which we are all simply a part. Death leads to reincarnation, and morality simply means being in harmony with nature. All is one and all is God. This has meant an increasing openness to all sorts of non-Christian spiritual belief along with a scepticism and suspicion about science. Much of alternative medicine has its roots in the New Age Movement, which in turn is rooted in Astrology. Exponents believe that for the last 2,000 years we have been in the age of Pisces (the fishes), but that now we are moving into the age of Aquarius (the water-carrier). The Age of Pisces was characterised by rationality, logic, objectivity and black and white analytical 'left brain' thinking. By contrast the Age of Aquarius is characterised by intuitional, subjective, grey 'right brain' thinking.

Sociologically the New Age Movement spawned the counterculture of the 1960s with 'flower-power', peace protests, drug experimentation and the Hippie movement. Spiritually it paved the way for a wide acceptance of Eastern religious ideology, Astrology and the Occult. Medically the New Age Movement has meant an increasing disillusionment with and scepticism about scientific medicine.

Source: Saunders P. Alternative Medicine. Nucleus 1999; April:15-25 www.cmf.org.uk/pubs/nucleus/nucapr99/altern.htm

Professor **David Short** on the Christian view of medicine as a vocation.

More than just a job

The idea that a profession, such as medicine, might be a calling from God has little resonance these days. When not used in the traditional sense as a divine call to a religious life, the word 'vocation' is generally applied, in a dumbed down sense, to a regular occupation or profession for which one is specially suited.

Few, even in the medical profession, think of their appointment as a call to the service of God. Most think in terms of engaging in a challenging and satisfying craft, following a prestigious career, making a good living, and having a secure job. Nevertheless, the Christian understanding is that we are where we are by God's appointment. If we find ourselves in possession of a medical training, it is safe to presume that God intends us to use it for his honour, rather than our own, and for the benefit of society.

The concept of vocation

We belong to God because he not only created us but also redeemed us - and did so at infinite cost; nothing less than the death of his Son. As the Apostle Paul put it to the Corinthian believers: 'You are not your own; you were bought at a price. Therefore honour God in your body.'[1] This belief that we are indebted to God for all that we have, coupled with the recognition that the Christian is a servant of Christ, lies at the heart of the concept of an occupation or profession being a vocation. Cardinal John Henry Newman spoke not merely for those in holy orders but for all thoughtful Christians when he said: 'God has created me to do him some definite service; he has committed some work to me which he has not committed to another. I have my mission...' If this is true, it has profound practical implications. It means that we must be able to justify all that we do on the basis of our primary allegiance to Jesus Christ, our Saviour and Lord. This thought should guide our plans and actions in everyday life. It should inspire our attitude to our work, however humdrum and routine. As Paul put it to the Colossian Christians: 'Don't just do the minimum that will get you by. Do your best. Work from the heart for your real Master, for God, confident that you'll get paid in full when you come into your inheritance. Keep in mind always that the ultimate Master you're serving is Christ.'[2] This attitude imparts dignity to every task, and reminds us that shoddy work has no place in Christian service.

Working it out in practice

The way we 'work from the heart' should draw attention to our Master, not to ourselves. The essential difference between a Christian life-style and that of a good pagan is unselfish love - a deep concern for the welfare of those with whom we come into contact. In saying this, it has to be acknowledged that some non-Christians are amazingly kind and unselfish: the image of God shines through them. Unbelievers tend to think of Christians as 'good' people, or at least people who claim to be good and set a high standard for their actions. This is a major misunderstanding. We are very ordinary, sinful people who are amazingly fortunate to be the recipients of God's mercy and grace. Conscious of that, we try to please our Benefactor. We need somehow to get that across: the secret of our life is our privileged position, not our intrinsic goodness.

If we are challenged regarding our lifestyle, we should be able to justify it. As the Apostle Peter enjoined his readers, 'always be prepared to give an answer to everyone who asks you to give the reason for the hope that you have.'[3] He adds: but do this with 'gentleness and respect, keeping a clean conscience'. Ideally, our reaction should be spontaneous. So it is worth thinking out responses to the common, predictable questions. The Christian doctor must be as fully informed and as conscientious and skilful as possible. Once he has applied his medical skill to the problem in hand, then he should be available to meet spiritual need; or, more precisely, to direct the patient to where such need can be met.

Most of us feel totally inadequate for such a life. But it is to this that we are called. It is comforting to recall that this is how God's servants down the ages have felt when they heard his call. Jeremiah's reaction was: 'I do not know how to speak; I am only a child.'[4] Moses, likewise, when called to lead Israel, said: 'O Lord, I have never been eloquent.'[5] God's answer in both cases was to the effect: 'I will be with you. I will give you the needed wisdom and strength. I will help you speak.'That is what he says to us. We can say, with the Apostle Paul: 'I have the strength to face all conditions by the power that Christ gives me.'[6]

Double appointment

The Christian doctor thus has a double appointment - sacred and secular. We have an

KEY POINTS

As Christian doctors we both belong to God, and are called to serve him, and our service of others should be motivated, not by consideration or security or satisfaction, but by gratitude for what he has done for us in Christ. Our lifestyles and words will then communicate that we are privileged sinners who are reliant on God's grace for our skills, knowledge and achievements. But whilst we should serve our earthly masters and patients as if serving Christ himself, part of that vocation involves maintaining a healthy balance between activity and rest, work and family – all underpinned by regular prayer and Bible reading.

earthly master and we have a heavenly Master, who is Jesus Christ. We have good models of individuals with double appointments in the Old Testament. Just think of the prime ministers, Joseph and Daniel, and of brave Queen Esther. This sense of a double appointment has never been better expressed than by Sir Thomas More, King Henry VIII's Lord Chancellor, when he declared himself to be 'the King's good servant - but God's first'. As doctors, whatever our secular appointment, we should be the best servants of the NHS and of our patients; and all the better for being God's servant first.

It is important to appreciate that having a dual appointment doesn't mean carrying a double work-load. The Christian is someone who has accepted Jesus' invitation to come to me 'and take my yoke upon you', with the promise: 'I will give you rest'.[7] The Christian is offered Christ's inner peace, whatever the strength of the storm raging outside. We should determine to avoid the 'clocking on and clocking off' mentality, and all insistence on 'rights'. We should be prepared to do more than we are strictly obliged to do – 'going the second mile' as the Master commended. Having said that, some work-loads are so crazy that the only sensible solution, if relief is not forthcoming, is to cut down on the load and accept a corresponding cut in salary. This may not be possible for those in training positions, but it can be negotiated in many senior appointments, provided there is the necessary determination and patience. Temporary pressures cannot be avoided, but persistent over-work can.

THE CHRISTIAN DOCTOR ... HAS A DOUBLE APPOINTMENT - SACRED AND SECULAR ... AN EARTHLY MASTER AND A HEAVENLY MASTER

The budgeting of time

The budgeting of time, essential for all doctors, is absolutely crucial for the Christian who is determined to glorify God at work. Time must be allocated for recreation, for spouse and family, and for communion with God. All are vital, particularly the last. Professor Drummond of Edinburgh spoke from experience when he said: 'Ten minutes spent in Christ's society every day; aye two minutes, if it be face to face and heart to heart, will make the whole of life different.' It is essential to make a habit of reading a part of the Bible daily, followed by meditation and prayer - ideally at the beginning of the day. To make the best use of time, we must be prepared to say 'No' to demands outside the main objective of our life. We need to challenge ourselves with the question: 'Whose agenda am I following, God's or my own?'

Our infinite resources

In the present difficult circumstances which prevail in the medical profession, particularly with increasing loads and shortage of staff at all levels, the Christian doctor needs to look to God for wisdom and strength and grace in everyday life. And the resources are there. I often lay hold of the promise in the Epistle of James (1:5): 'If any of you lacks wisdom, he should ask God, who gives generously to all without finding fault, and it will be given to him.' Our resources are adequate for any situation we can ever face because, as believers, God himself lives in us (by his Holy Spirit), with all that that implies. So let us enter upon each day with its unknown demands, putting our hand firmly and confidently into the hand of God. As I go to work, I often repeat the words of Charles Wesley:

'Forth in thy name, O Lord, I go, my daily labour to pursue,

Thee, only Thee, resolved to know, in all I think or speak or do.'

David Short is Emeritus Professor of Medicine in Aberdeen.

References

1 1 Corinthians 6:20
2 Colossians 3:22-24 (*The Message*)
3 1 Peter 3:15
4 Jeremiah 1:6
5 Exodus 4:10
6 Philippians 4:13 (TEV)
7 Matthew 11:28-29

Pam Sims gives guidance in the light of the recent government decision.

The Morning After Pill

The Morning After Pill (MAP) was first publicly debated in the mid-eighties. It was judged not to cause early abortion under the terms of the 1967 Abortion Act by the then Attorney General in 1983.[1] The view now held by the medical establishment at large is that pregnancy starts after implantation of the embryo.[2]

The method licensed for use since 1984 (marketed as PC4 by Schering) has been the Yuzpe regimen. Two pills each containing 50 mcg of ethinyloestradiol plus 250 mcg levonorgestrel (or its equivalent 500 mcg norgestrel) are given 12 hours apart, starting within 72 hours of unprotected intercourse.

The treatment has been remarkably safe though a common side effect was nausea and vomiting. There were also theoretical, but unfounded, concerns over possible thrombotic side effects of the oestrogen component.[3]

Age	1975	1999	%rise
Under 15	2.3	3.3	43%
15	7.5	8.2	9%
16-19	17.5	26.0	49%

Rates of abortions per 1,000 women per year, Residents of England and Wales.
Source: Abortion Statistics Series AB nos. 24 and 26, ONS

KEY POINTS

The MAP levonelle-2 has recently become available over the counter in pharmacies without prescription to girls above 16. The view of the legal and medical establishment is that pregnancy begins after implantation; so the morning after pill, although it acts, at last in part, by preventing implantation is widely viewed as a contraceptive rather than an abortifacient. Teenage pregnancy, sexually transmitted disease and abortion rates have risen despite wider availability of the MAP. The key underlying ethical issues centre around the status of the embryo, the context of sexual intercourse and the lesser of two evils debate.

How it works

The precise mechanism of action of MAP is uncertain.[4] Ovulation is delayed if it is taken early in the cycle, fertilisation is probably not affected neither is the function of the corpus luteum. Early trials[5] of high dose oestrogen showed impairment of tubal transport with a consequent increased risk of ectopic pregnancy, more recent data on the risk of ectopic shows no increase in risk. There has been no evidence of teratogenicity in the event of an ongoing pregnancy. There is conflicting evidence on the endometrial effects of MAP. However a recent review of published literature confirms that 'The Yuzpe regimen could not be as effective as it appears to be if it worked only by preventing or delaying ovulation.'[6]

Not every act of intercourse results in pregnancy. The risk of pregnancy after a single act of intercourse at any stage of the menstrual cycle is 2 – 4%. In the days around ovulation it rises to 20 – 30%. In clinical trials there are two ways of expressing results. One gives the overall failure rate and includes the women who would never have become pregnant anyway. The other expresses the ratio of observed to expected pregnancies and an estimate of the probability of pregnancy occurring at that particular stage of the cycle is made.[7]

Recent Developments

A multicentre international trial was set up by WHO to compare the Yuzpe regimen with progestogen alone in the form of levonorgestrel. The dosage was 750 mcg also taken twice within 72 hours and 12 hours apart. The results were reported in the *Lancet* in 1998.[8]

- Levonorgestrel alone was significantly more effective in preventing ongoing pregnancy after a single act of unprotected intercourse than the combined oestrogen-progestogen preparation.
- Both methods were more effective the earlier the first dose was given after intercourse.
- Results of an earlier study showing significantly less nausea and vomiting were confirmed.

Levonorgestrel (as Levonelle-2, also marketed by Schering) is now fast becoming the drug of choice. It prevents 85% of expected pregnancies from continuing, rising to 95% if started within 24 hours of coitus. The overall failure rate is 1.1% when expressed as a percentage of all those treated. Levonelle is more expensive than PC4 (cost price £5 per pack) although the price may possibly come down.

Social Background

In spite of the rapid rise in use of MAP abortion rates have not changed significantly. There are over 150,000 per year in England and Wales. Of particular concern is the sexual activity of teenagers; conception rates have steadily increased with teenage abortion more dramatically rising (see figure). We now have the highest rates in Europe.

In the White Paper on Teenage Pregnancy[9] the Government aims to halve the rate of teenage conceptions amongst the under 18s by 2010. Sex education and availability of contraception are supposedly the answer.

Prescribing

Contraception, including MAP has always been available by NHS prescription free of charge through GP's, family planning clinics and increasingly A and E departments. Since the Gillick ruling in 1985 girls under 16 have been able to receive contraception without parental knowledge, though this is not encouraged. There have been two recent developments:

- As of 1 January 2001 MAP was made available over-the-counter (OTC) to women over 16. The Ministerial Order was introduced in December 2000 and confirmed in the House of Lords on 29 January 2001.
- Extension of Patient Group Directions. PGD's have long enabled non-medics to prescribe certain, usually basic, drugs. A Ministerial Order passed in August 2000 greatly expanded the scope for such prescribing.

Drugs have to fulfil safety requirements for OTC sale and pharmacists should be trained to give appropriate advice. Not all countries have pharmacy status. In the US, for example, drugs are either on prescription or on general sale. In certain European countries, such as France, MAP is available from pharmacists without prescription.

Concerns in this country of OTC provision include the following: the young girl may falsify her age, there should be a private place for discussion, there is no access to her medical records and finally the price may be prohibitive. The present charge to the public is £19.99 OTC though some clinics are selling it for £10.

Pharmacists may also dispense MAP under a PGD. This too is the mechanism by which school, and other nurses give the drug. In these instances there is no charge and legally the girl may be under 16. Setting up a PGD involves establishing strict guidelines for use of a drug and regular review.

Christian Response

There are several ethical questions involved in a consideration of MAP:

- Status of the embryo - when does life begin?
- Sexual intercourse – does it have any meaning?
- Sexual health of teenagers in particular – what are the messages being sent to them these days?
- Individual prescribing habits of doctors – should we give MAP?
- Church's response – is it of any relevance?

Doctors holding the absolutist position, believing that individual human life starts at fertilisation, would not be able to prescribe MAP. By the same token they would have problems with IVF, cloning of embryos, certain IUD's or any other type of postcoital contraception. If we believe that life is a developing continuum from fusion of the gametes onwards then we will have problems with anything that hinders this process. The fact remains that MAP does not always work in this manner – but unless used very early in the cycle (up to day eight) it must do so some of the time.

'THE NEED FOR MAP IS AN INDICATION FOR FURTHER CONTRACEPTIVE ADVICE.'

As we have already seen, use of MAP is very often in women who would not have conceived anyway. From the point of view of a possible embryo no harm is done. However from the point of the culture being encouraged many would argue that great harm is being done and that promiscuity is being promoted.[10] Teenage sexual activity has continued to rise in spite of sex education and availability of contraception. MAP is simply one end of this spectrum.

The question of whether we, as Christian doctors, should prescribe MAP is becoming increasingly academic. As we have seen women are increasingly receiving it from sources other than their doctor. Undoubtedly the progestogen-only drug is very safe indeed, with virtually no contraindications.

Many doctors feel that MAP is the lesser of two evils and better than the abortion request that might follow. However not every woman would become pregnant. And not every woman once definitely pregnant would necessarily want it terminated (though MAP, not being teratogenic, does not in the least remove her option of continuing to term).

GP's, family planning specialists and school nurses may feel they are in better position to provide ongoing counselling and support than a pharmacist in a one off visit. Follow up is very important. The need for MAP is an indication for further contraceptive advice. It should also be seen in the context of sexual health in general with screening for and possible treatment of STI.

The response of Christians and perhaps the Church in general to MAP has largely been condemnatory. Pro-lifers have genuine concerns over the mechanism of action of these pills. The rest of Christendom agonises over the morality of young people as they indulge in sexual activity at an ever younger age. The ideal of sex within marriage and children (including 'accidents') being accepted as a gift from God seems to be very far removed from the reality of life at the beginning of the 21st century.

Steve Chalke in a recent magazine article[11] has argued the case for the Church to put more effort into providing practical support for youngsters caught in the trap of low self esteem, poverty and early sexual activity. He accepts that we should make a moral stand, but that this should be non-judgmental – 'Jesus called us to be salt not pepper!'

Pamela Sims is a Consultant in Obstetrics and Gynaecology in Hexham.

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1. Reference was made to the Offences Against the Persons Act 1861, which made causing miscarriage a crime. In fact literature of that time seems to indicate that the law applied at all stages of embryonic development. See Gerard Wright QC. *The Legal Implications of IVF, chapter in Test Tube Babies – a Christian View*. Order of Christian Unity, 1984: 42
2. See for example Guillebaud J. *The Lancet* 1998; 352: 416-417
3. Vasilakis C, Jick SS, Jick H. *Contraception* 1999; 59: 79-83
4. Glasier A. Review article. Emergency postcoital contraception. *New England Journal of Medicine*. 1997; 337: 1058-64
5. Morris JM, Van Wagenen G. *Am J Obstet Gynecol* 1973; 115:101-6
6. Trussell J, Raymond EG. *Obstet Gynecol* 1999; 93:872-6
7. Figures quoted from Faculty of Family Planning and Reproductive Health Care of the RCOG. Recommendations for clinical practice: emergency contraception. Interim Guidance October 1999.
8. Task Force on Postovulatory Methods of Fertility Regulation, WHO. *The Lancet* 1998: 352: 428-33
9. *Teenage Pregnancy*. A White Paper (Cm 4342). The Social Exclusion Unit. June 1999
10. The Morning After Pill. *Promoting Promiscuity*. The Christian Institute: January 2001. *www.christian.org*
11. Chalke S. What might Jesus say to The Church about the Morning After Pill. *Christianity & Renewal* 2001: 47-8 (March)

EUTYCHUS

Misplaced faith

President George Bush's decision to set up a federal bureau for faith based social services has refuelled fears about children's lives being put at risk. A 1998 study in *Paediatrics* (101:625-9) has already documented the deaths of 172 children whose parents belonged to faith healing sects that forbid traditional medical care for illnesses. The US Supreme Court has twice - both in 1944 and 1990 - affirmed a child's constitutional right to medical treatment; with the earlier judgement declaring that parents are not free 'to make martyrs of their children'. But congress subsequently ruled in its 1996 Child Abuse Prevention and Treatment Act that there was no federal requirement for a child to receive 'any medical service or treatment against the religious beliefs of the parent or legal guardian'. (*BMJ* 2001; 322:512, 3 March)

Misplaced embryos?

A Rotherham woman who conceived triplets, after having given permission for only two embryos to be implanted during IVF, has successfully sued a Sheffield infertility clinic. Patricia Thompson, agreed to accept £20,000 in damages. (*BMJ* 2001; 322:508, 3 March)

Superior genes

Down's syndrome children possess three copies of the gene USP25, which is often lacking from the cancer cells of people who develop lung cancer. Down's syndrome children are resistant to many forms of cancer, and the gene may hold the key for gene therapy for those who are less genetically resilient in the face of neoplastic disease. (*The Times* 2001;11, 23 January).

Pharmacists in revolt

A survey of doctors and pharmacists in London has indicated significant opposition to the reclassification of the abortifacient morning-after pill as a drug available from pharmacists without prescription. The research, published in the *Journal of the Royal Pharmaceutical Society,* indicated that 45% of family doctors and nearly a quarter of pharmacists were against the reclassification. 57% of pharmacists and more than a third of doctors believed that the reclassification would lead to reduced use of routine birth control methods. (*Daily Mail*, 5 March – Reported in *SPUC Digest*)

Furious with Philistines

Samson may be the first case of antisocial personality disorder according to three Californian psychologists. A positive diagnosis of the condition requires only three of seven recognised behaviours catalogued in the American Psychiatric Association's 900-page *DSM-IV*. Samson has six, including impulsiveness, recklessness and fighting. The leader of the San Diego Research Team told *New Scientist*: 'It's almost as if the writer of the story has the DSM criteria tacked to the wall and he is writing a sketch. But this was 3,000 years before the DSM.' (*The Times* 2001;10, 15 February)

Serial polygamy

A 'large minority' of young people choose to live with a variety of partners rather than marry, according to a report by the Institute for Social and Economic Research. Based on the 1998 British Household Survey of over 10,000 adults across Britain, the report, *Personal Relationships and Marriage Expectations*, shows that the rate of marriage has sharply declined. In 1988 57.5 and 95.6 per 1,000 of single men and women respectively got married. The equivalent figures for 1998 were 20.2 and 39.6. Only 36% of children born to parents living together will live with both parents until they are 16. (*The Times* 2001; 8, 14 February)

Leading by example?

Rich countries have a moral obligation to tackle poverty according to Clare Short, Secretary for International Development. Her new white paper on globalisation and poverty pledges to raise UK aid budget to 0.33% of gross domestic product (GDP) by 2003-4; the UN target is 0.7%. The World Bank has shown that the most important intervention to promote development is to ensure that children, especially girls, complete primary education. *Eliminating World Poverty: Making Globalisation work for the Poor* is accessible at the Department of International Development's website at *www.dfid.gov.uk*. (*BMJ* 2000; 321:1492, 16 December)

Wade in the balance?

Henry Wade, the former attorney in Dallas county, Texas, who was named as the defendant in the Roe v Wade case, has died at the age of 86. Lawyers filed a lawsuit in Dallas county on behalf of 'Jane Roe' in 1969, claiming that state restrictions on abortion were unconstitutional. Henry Wade eventually lost the case in the US Supreme Court in 1973 when the justices declared a constitutional right to abortion. Norma McCorvey, the actual 'Jane Roe' in the case, went through with her pregnancy and gave birth to the unborn child at the centre of the case. She is now a pro-life campaigner. (*Dallas Morning Metro*, 5 March – Reported in *SPUC Digest*)

Royal approval

£1.6 billion is spent on complementary and alternative therapies in Britain each year according to a House of Lords Report. About 15 million people use herbal medicines and one in three have tried other therapies such as aromatherapy and acupuncture.
There are now 40,000 alternative therapists, and 36,000 family doctors. Currently, only osteopathy and chiropractic are regulated by law. The British Medical Association backs tougher regulation. In a secret 90-minute meeting with Health Secretary Alan Milburn, Prince Charles, a well-known long-time advocate of alternative medicine, pushed for at least £10 million to be allocated for research into the treatments. For every £100 spent on orthodox medicine research only 8p is spent on complementary therapies. (*The Times* 2000; 1,4, 29 November)

RevieWWWs with Cyberdoc

Cyberdoc reviews vocation, the MMR vaccine, Alder Hey and the New Mental Health Act – the words in bold correspond to links on Cyberdoc's website at xtn.org/cyberdoc/vocation

Vocation

The internet remains a rather strange place. Weeks and even months can go by when you become so used to it that you almost start to think that it is like the 'normal' world. Then all of a sudden you are confronted with how different it really is. Take the subject of one of this issue's articles, 'medicine as a vocation'. I started by searching for the word 'vocation' on more than ten of the top internet search engines and was astonished to return less than 90 pages on the whole internet. 90 pages is a grain of internet salt for a single word search. What's more, almost all of even these few pages came from the same handful of sites advertising the vocation of being a catholic priest or monk. There literally was no mention of the word anywhere else. With such a high percentage of junior doctors working outrageous hours, maybe celibacy and separation from the outside world are staging a comeback in a different guise! But is the concept of vocation being lost forever from our language and culture?

Cyberdoc reports total failure in searching for useful pages on the subject of vocation in this twilight world where anything that isn't modern often doesn't seem to get a look in (unless we are talking about ancient copyright expired books, many excellent Christian examples of which are found at **www.ccel.org!**)

MMR Vaccine

Perhaps more surprising still was the relatively small number of pages on the MMR vaccine. Most of these were news pages, but one alerted me to what must be a relatively new web service. **Findarticles.com** is a compilation of more than 300 'reputable magazines and journals' including the *BMJ* and *Lancet*. As a result, searching for MMR on this site returned a very useful collection of articles. But other than the news sites, which report what has been seen in the news recently, there is remarkably little else on the web on the MMR vaccine.

Alder Hey

The Alder Hey scandal also seems to have made little impact on the web. The **Alder Hey Hospital** news page lists links to the inquiry report and other online resources. **Findarticles.com** again was very useful, returning many journal articles on the subject.

The New Mental Health Act

On the subject of the reform of the Mental Health Act there is somewhat more to find. The **hyperguide** to the Mental Health Act is an excellent introduction to the existing legislation. It has a copy of the government's white paper, but little discussion of its implications. The **BBC** has a short but clear explanation of the Mental Health Act and a good description of the politics of the subject. The **Department of Health** has a page with the white paper, a summary of responses to this, research about the Act and papers from Europe on the subject. **Mind** has a number of documents available online which portray a user's view of both the act and its reform.

We seem to have chosen a collection of subjects in this issue of *Triple Helix* with remarkably little coverage on the web. This is presumably because none of them have caught the imagination of the collection of amateur web masters who create so much of the internet we all know and love.

This article and links to previous Cyberdoc reviews can be found at *xtn.org/cyberdoc/*

Cyberdoc is Adrian Warnock, SpR in Child and Adolescent Psychiatry in London, and a previous editor of Nucleus.

A Unique Gift


Catriona and Gerry

A remarkable story of how tragedy and transplantation brought together two families from either side of the religious divide.

Two and a half years ago, in August 1998, we held a small thanksgiving service for our Ruby fortieth wedding anniversary. Leading the singing in our family music group was our son-in-law Richard with his guitar. He was just back from the church camp and many remarked that he was radiant that afternoon.

Richard had been baptised in our church, Morningside Baptist in Glasgow, and he as a student in the early 1980s had become very involved. With our daughter, Catriona, he had been in the music group, and they were married in 1985.

Later that day, in August 1998, we set off for a family holiday in Perthshire, four children, four spouses and nine grandchildren. Just three days later our holiday came to a sad and abrupt end. Richard was knocked off his cycle, having been hit from behind by an 18 year old, inexperienced driver. Before the family could reach him he was airlifted to the Neurosurgical unit at the Southern General Hospital in Glasgow and he died the next day of irreversible brain damage.

Our daughter Catriona's fortitude and faith have been amazing from the start of the tragedy. Within minutes of hearing the sad news about the seriousness of his head injury, she made it clear that she wanted Richard's organs donated for transplantation. The Transplant Co-ordinator worked hard, but timing was tricky. Although we knew that the pressure within Richard's skull would continue to rise, no one could predict when he could be declared brain dead. Catriona wanted their four children, aged six to twelve, to come and say goodbye to Daddy, and she also wanted to be with him until he went back to theatre. Eventually the longest day came to an end and we made our sad way back to pack up our truncated holiday.

Exactly one year later, a man called Gerry from Northern Ireland, wrote to Catriona. He expressed his deep thanks for one of Richard's lungs that had been given to him, transplanted on the day Richard died. Although still in his mid-fifties and in the prime of his productive professional life, a fatal lung disease, alveolar fibrosis, had reduced him to a pulmonary cripple.

He wrote that before the operation he was so breathless he could not even bend down to tie up his own shoelaces and he needed extra oxygen 24 hours a day. After the transplant he has resumed a full active life. On the day he wrote he was putting on his trainers and was about to go out on his cycle. He said that he thanks God every day for his renewed life, and he daily remembers Richard's family in his prayers.

Gerry and Catriona exchanged letters and family photographs. Then in August 2000, Catriona, her four children, my wife Margot and I went over to Derry in Northern Ireland to meet Gerry and his family. Both families were nervous but excited. Because the central characters, Gerry and Catriona, were so enthusiastic, the time together was a great success. Gerry is now 57, and he has a large and close grown up family. Their hospitality was overwhelming.

FAMILIES GROW BY THE JOY OF A MARRIAGE AND THE MARVEL OF A NEWBORN LIFE, BUT WE HAVE DISCOVERED A THIRD WAY, THE WONDER OF TRANSPLANTATION

We shared the traumatic and stressful experiences of two years before and our hopes for the future. We ate, talked, laughed and walked the beaches of Donegal together. Gerry even kicked a football around the garden with our grandson Timothy.

Families grow by the joy of a marriage and the marvel of a newborn life, but we have discovered a third way, the wonder of transplantation. Our family has been enlarged and enriched by a warm and affectionate family from Ulster. We are united by a living lung that has rich memories of the past, gives vitality for the present and hope for the future.

Gerry is such a positive, and productive Roman Catholic Christian man. From humble origins he established a building business that is now widely respected for the quality and personal nature of its work.

He uses and enthuses trades people from both sides of the divided community, giving jobs and hope. He has been involved in building and rebuilding both protestant and catholic churches. He has a special way of dealing with and encouraging people, and this really shows. He has spent considerable time helping young people from both communities. He told me that he never makes a business decision without asking himself the question 'What would Jesus do?'

Among his plans for Derry and its people is a vision to develop and revitalise the neglected waterfront of the river Foyle. He repeatedly told us that without the gift of Richard's lung he could not have taken on these things, and so, remarkably, we are part of these dreams and developments.

Our impression is that Gerry has always shown a concern for others, but the gift of the healthy lung seems to have given new vision and compassion. Although we miss Richard so much, our loss has its positive side. We are happy that Richard's death was the means of bringing renewed life and hope to others. Richard was such a competent and caring person, he must rejoice that even after his death he has been able to give life and hope to others. It is providential that his personality, energy and enthusiasm seem so well matched to those traits we saw in Gerry.

The motto of one famous Scottish family is 'Saved to serve'. Gerry seems well aware of this privilege and responsibility. But in a sense, this motto is a message for all Christian people. We are all debtors to the love of God and the sacrifice of the Lord Jesus.

William Cutting is Emeritus Consultant Paediatrician in Edinburgh

OPPORTUNITIES ABROAD

Specific Vacancies by Country

For most posts the volunteer is expected to be **UK based**, to have support from his or her **home church** and to raise some or all of the necessary **funding.** If you think you may be able to meet a particular need please contact the mission or institution direct. The Overseas Support Secretary will also be glad to speak with you about specific vacancies or medical mission in general - usually in CMF office Monday pm and all Wednesday and Friday.

AFRICA

Kenya

Chogoria Hospital needs **medical officer in charge** (expat or national) and from July **paediatrician**.

Contact Dr Alison Wilkinson or MO i/c, PCEA Chogoria Hospital, PO Box 35, Chogoria, Kenya.
Tel: +0166 22620. Fax: +0166 22122. Email: chogoria@africaonline.co.ke

ASIA

Pakistan

Bach Christian Hospital URGENT - FEMALE OBSTETRICIAN to cover extended leave from **January 2002** having obtained a visa and done some language study. A 50 bedded mission hospital in the foothills of the Himalayas. Six doctors in post including only one obstetrician.

Contact Dr Elspeth Paterson, Bach Christian Hospital, PO Qalandarabad, Disst Abbottabad, NWFP 22000, Pakistan.
Email: elspeth@brain.net.pk (via this office if you wish)

Bannu Hospital, newly built hospital on the Northwest Frontier needs a **doctor** with GP training and a **nurse midwife** able to speak or willing to learn some Urdu, and prepared to stay for two tours of three years. Must have a sense of call to cross-cultural mission and sensitivity to other faiths. Diocesan school available locally and a secondary Christian boarding school. Those recommended for training at the CMS college at Selly Oak will be linked to UK parishes before leaving for language study in Pakistan.

Contact Stuart Buchanan, Programmes Manager, CMS, Partnership House, 157 Waterloo Road, London SE1 8UU.
Tel: 020 7928 8681. Fax: 020 7401 3215.
Email: stuart.buchanan@cms-uk.org

Thailand

Manoram Hospital. URGENT – SURGEON needed for this well known mission hospital

Information from Dr Alex G Henderson FRACS, 62 Holywell Road, Studham, Dunstable LU6 2PD. Tel: 01582 873 303 or Quintin Bradshaw at the hospital. Email: fionaquintin@bigfoot.com. For a formal offer contact the hospital office
Fax: 056 491084 Mail: Manoram Christian Hospital, Manoram Chainat Thailand 17110

AUSTRALASIA

Papua New Guinea. Christian **doctor** for health service in a remote district in the Highlands. Some experience in obstetrics, surgery, paediatrics, medicine and anaesthesia. Paid on a government contract. Peaceful and friendly community with minimal night work.

Contact Rev Chris Pittendrigh ABMS Melbourne, Australia.
Tel: 0561 (03) 98194944.
Fax: 0561 (03) 98191004.
Email: cpittendrigh@abms.org.au

MIDDLE EAST

Female obstetrician and **midwives** for a new hospital run by a well established team in a small Arab Peninsula city. Up to date skills and a love of people essential. Long-term commitment and a willingness to learn Arabic preferable.
Contact Thanksgiving, PO Box 1134, Clacton on Sea, Essex CO16 8EF

RESOURCES AND REQUESTS

Medical Visits Overseas

PRIME (Partnership in Medical Education previously **Doctors Dilemmas**) are planning teams of **GPs** and **paediatricians** to make small teams for 2-3 week visits to multiple overseas centres (Eastern Europe, N. Africa, Russia) to share skills in child care and family medicine.

Contact Dr John Geater, 25 St Helen's Down, Hastings, Sussex TN34 2BG Tel: 01424 424955. Email: j.geater@which.net

In His Image Medical/Spiritual Conferences, Camps, Retreats, Clinical Outreach to rural areas in Central Asia in 2001. See *Triple Helix* Autumn 1999 in Among All Nations No 9.

Contact Bridget Burritt in the USA for dates and details bburritt@inhisimage.org or enquire at this office.

Jian Hua Foundation

July 2-27 2001 to Quinghai Province of China. Volunteer **health personnel of all fields** needed to provide medical seminars and offer free medical consultations and medicines to local people.

Contact Mr Douglas Noble, UK Medical Representative, Green College, University of Oxford, Woodstock Road, Oxford OX2 6HG. Email: douglas.noble@green.ox.ac.uk. Or outside UK Dr Stephen Wang, Jian Hua Foundation, Director of Medical Services (Xining). Email: jhfmedserve@mail.com

UK

London Replacement CMF Overseas Support Secretary required by July 2001. S(he) will be seconded half the time as Medical Director to MMA HealthServe. Job Descriptions and further details from this office.

Events

Overseas Update the Residential Refresher Course for **Christian Doctors and Nurses and Midwives** working or considering working in mission situations overseas to be held DV at Oak Hill College, Southgate, London N14 4PS,
June 18-29, 2001. Brochure available from this office.

A much larger list of **General Opportunities and Specific Vacancies** for **all Healthcare Disciplines** is available in the new magazine of MMA HealthServe obtainable from First Floor, 106-110 Watney Street, London E1 2QE.
Tel: 020 7790 1336
Email: info@mmahealthserve.org.uk
Website: www.mmahealthserve.org.uk

MMA HealthServe also keeps a small **Christian Health Professional database** of those who may be available for short periods to cover leave or illness – form available.

BOOKS

The Telemedicine Tool Kit: A workbook for NHS doctors, nurses and managers

Roy Lilley and John Navein
Radcliffe Medical Press
£30
ISBN 1 85775 480 8

Telemedicine is here to stay and with the falling costs and increasing capabilities of computers, imaging systems and the internet it holds real promise for missionary doctors in remote areas wanting to seek specialist advice, as well as those working in the NHS.[1]

The NHS Plan[2] states that, 'The NHS will have the most up-to-date information technology systems to deliver services faster and more conveniently for patients'. As a result of this NHS Plan there will be, 'electronic booking of appointments', 'access to electronic personal medical records', 'electronic prescribing of medicines' and 'facilities for telemedicine by 2005'. However, Lilley, Navein and Frank Burns (the author of the foreword) are deeply critical of the NHS' attempts to-date in utilising new technology.

Following the authors advice to 'flip through the pages' (all 185), I was both impressed and confused by the scope of the book. Topics, which are poorly indexed, include buying a computer system, NHS Direct, the history of the Internet, electronic patient records, digital x-ray storage and voice recognition software. In its favour, the book takes a relaxed look at telemedicine while enabling the reader to think through the issues raised. It takes a sensible approach in challenging us to ensure telemedicine projects are well planned (twelve strategic steps are included) and to use them as a stimulus for positive changes in practice. The technical section does provide useful information, which should help the reader to become familiar with the technology.

Assuming they can be found, there are a number of sections which provide an aspiring telemedic with useful discussions of techniques such as Store, Forward and Real Time Data Transmission. Having some experience of running a telemedicine project, however, I was disappointed with the discussion of patient confidentiality and medico-legal issues.

In summary, I would recommend that anyone beginning to think about using telemedicine in clinical practice should browse through a library copy of this book. If you can find the relevant sections, it will inform and challenge your thinking.

1. *British Medical Journal* 2000: 321:465-6 (19 August)
2. The NHS Plan. http://www.nhs.uk/nationalplan/contentspdf.htm

Tim Lyttle is a General Practitioner in Shropshire and Medical Adviser for Operation Mobilisation

Caring for Muslim Patients

Ed. Aziz Sheikh and Abdul Rashid Gatrad
Radcliffe Medial Press Limited 2000
£17.95 Pb 135 pp
ISBN 1 85775 372 0

This is a compendium by ten Muslim authors whose aim is to enlighten non-Muslim health care workers about the religion, customs and world view of Islam, so that they may better understand their Muslim patients and so give more sensitive care. The book contains chapters on the origins of the Muslim communities in Britain, the nature and beliefs of Islam, and a review of the Islamic view of health and disease. There are chapters on the family, birth and death, the fast and the Hajj (the pilgrimage).

The perspective of the writers is that of scholarly Qur'anic Islam tempered by European experience. A Muslim friend admired it greatly and referred to it as 'pure Islam'. Unfortunately, it is this very purity that is the book's greatest drawback. The great majority of Muslims in England originate from rural communities whose Islamic faith is mixed with pre-Islamic occult beliefs and magic practices. While all Muslims will unhesitatingly endorse the contents of this book as being mainline orthodox Islam, these 'folk Islamic' beliefs are not mentioned. This omission is all the more serious where health is concerned. In Muslim communities originating from the Indian sub-continent belief in the evil eye and its effects is endemic, and many have had recourse to it, but of this there is no mention at all.

Doubtless these omissions reflect cultural and religious tensions; theological 'high' Islam has difficulties in reconciling itself with the religion of the majority, often labeling it 'not Islam'. While indeed it may be un-Islamic, it is what the majority of Muslims in Britain believe and live out today.

The chapters on birth, death and the family are full of fascinating and informative detail, but reflect an ideal rather than the reality of Muslim family life today. The major problems facing the new generation of Muslims are not mentioned: the explosive tensions arising out of many arranged marriages; the struggles and frustrations of women who, after four decades in Britain, are just achieving the kind of opportunities and freedom that women in some other Muslim societies take for granted; the confusion of the elderly whose own rote education in Bangladesh or Pakistan has not enabled them to understand why their children have grown up so differently from themselves. Beside these major upheavals, a discussion on the difficulties of obtaining circumcision for boys seems secondary.

The book does have redeeming features – take the case histories, for example. These are set in frames and are far more human, honest and down to earth than the text itself. The section that deals with the devotion and love

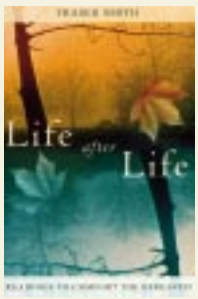
which Muslims have for the Prophet Mohammed is of great importance.

The central weakness of the book is that its historical-theological perspective does not by itself give us an insight into the hearts of people today. Anthropology and sociology are better equipped to do that. There is a real need for literature of this kind but it needs to reflect what is, not what might or ought to be.

Robin Fisher is a General Practitioner in Birmingham

Life after Life: readings to comfort the bereaved

Fraser Smith
SPCK 1993
£6.99 Pb 104pp
ISBN 0 281 04 71 8 9



Fraser Smith is a Methodist minister whose work includes the offer of comfort to those who are dying and bereaved. This anthology of verses and prayers is interspersed with personal comments and poems which, being based on experience, ring true. The deaths touched on range from abortion to accidents to the loss of an elderly partner.

Most of the book is a helpful source of appropriate messages for dying or bereaved patients or friends. Parts of it (especially the selected passages of scripture) could profitably be read to someone who is dying. Other sections come from those useful little cards that are found in church bookshops and can be slipped in with letters of condolence. They are so much more accessible in one volume.

The desolation and despair accompanying all kinds of death are acknowledged. Outrage and anger are wrapped up in some of the 'why' questions. The section on 'Will they be all right?' unreservedly affirms the lively hope of eternal life and final resurrection, with an occasional prayer that the lost loved one might find peace. As the collection is for selective use, any parts which express dubious theology can be left aside as there is so much more to choose from. Those appropriate for the death of a child are, like the event itself, very moving. The writer's analogy of death being comparable to birth should remind us that faith sometimes comes alive at times of loss.

It is obvious that the writer's calling has made him very sensitive to his role as comforter. So should our own. This little book contains much that we will want to keep on both our professional and personal bookshelves, ready to hand in times of need.

Janet Goodall, Emeritus Consultant Paediatrician, Staffordshire

Life and Death in Healthcare Ethics

Helen Watt
Routledge 2000
£7.99 Pb 83pp
ISBN 0 415 21574 9

This attractively produced little book has 72 pages of text and a further 25 pages of notes, bibliography and index. It is written with frequent bold subheadings that help to direct the reader through a rather condensed writing style.
It uses a few classic cases such as Dr Arthur, Tony Bland and Lillian Boyes as a springboard for a discussion of the author's position on the morality of euthanasia, abortion and related issues. In broad terms this perspective would be similar to that which is currently aired in conservative evangelical writings.

The intended readership appears to be various student bodies and others approaching healthcare ethics for the first time, although the brevity of the book and its reliance on philosophical concepts make it heavy going as an introductory text. A student commencing Healthcare Ethics could better use their money purchasing larger and less polemic standard texts. The last chapter was aimed at a different reader, that is, someone needing arguments to justify their non-involvement in immoral clinical procedures, and I believe that they could gain help from the text in this regard.

My main concern about the book was that I gained the impression that the author did not give us her main reasons for holding to her positions. Arguments for the personhood of the foetus revolved around the manifest fact that there is a physical continuity between the conceptus and the adult. Arguments for the importance of not killing innocent human beings arose from the apparently incontrovertible assumption that life was good. Yet throughout, there were hints of a distinctive Roman Catholic doctrine, the importance of life per se, the ethics of virtue, a guardedness towards contraception and some fancy footwork with respect to tubal pregnancies. The real reasons for the positions adopted would therefore appear to be Scripture and Magisterial pronouncements. As the book ignored the presupposition of special revelation the actual arguments given were less than convincing.

Overall, however, this is an interesting book and I will happily look out for the next one the author produces.

Norman Gourlay is a General Practitioner in Argyll.

Letters

We have had a large post-bag this issue, and accordingly most letters have been abridged.

PVS

Emeritus Consultant Anaesthetist, ***David Hill****, questions Andrew Fergusson's terminology.*

In his editorial (*Triple Helix* 2001; Winter:3) regarding the failure of the Human Rights Act to protect patients in the Persistent Vegetative State from being killed by starvation and dehydration, Andrew Fergusson accepts the term 'permanent'.

However, some patients diagnosed with PVS have made varying degrees of recovery after lengthy periods of coma, and some were simply mis-diagnosed. Using 'permanent' implies a certainty and hopelessness, which misled Dame Butler-Sloss about the mentioned patients and contributed to flawed judgement. 'Persistent' is a modifiable diagnosis; 'Permanent' involves guesswork and is essentially unprovable.

Andrew Fergusson *replies.*

A good point. I used the word 'permanent' because that is what the condition is officially called in the UK. Personally, I am more concerned about the prerogative implications of the word 'vegetative'.

Legalisation of Cannabis

William Notcutt*, Consultant Anaesthetist in Norfolk, argues that cannabis' legalisationfor medical use is not the real issue.*

Fergus Law (*Triple Helix* 2001; Winter:6-7) misses the essential debate. If clinical trials demonstrate that cannabis' extracts are safe and effective, then the Medicines' Control Agency will facilitate their availability on prescription. The real question for Christians is whether to support cannabis' legalisation for recreational use. Decisions must be scientific, logical, moral and scripturally-based. The Bible warns against alcoholic intoxication but does not proscribe or condemn it outright. Should the same approach be taken for cannabis?

Abortion and Conscientious Objection

This article (Triple Helix 2001; Winter:5) provoked much correspondence. Several were saddened about discrimination towards those who conscientiously object to clerking patients for abortion but felt Christians need to face up to practical realities. Oxford GP ***Patricia Prosser*** *quoted 2 Corinthians 2:14 in strengthening her point.*

In love, we seek to influence society through our daily contact with patients; opting out totally is … pharisaical.

I could decide not to deal with abortion requests and send patients to colleagues. Alternatively, I could spend time talking through their problems, encouraging them not to rush for the easy option. I can also refer for further counselling to the Life Crisis Centre. As a Christian on the gynaecology ward, I was perhaps the first person they had encountered who encouraged them that it was not too late to rethink.

Bedford GP, ***Jenny Wilson****, agrees.*

Until anaesthetised, the outcome of admission for TOP is not a forgone conclusion. We will not be judged for the lady's final decision to go ahead with TOP, but we will be judged on how we approached the situation and whether we showed God's love.

Manchester GP, ***Sharon Kane****, writes of regret for not getting involved during her training with pre-clerking such patients.*

What I know now that I didn't then, is that a significant minority undergoing abortion do so, not by choice, but because of external pressures over which they feel they have no control. At least 10% suffer serious psychological difficulties afterwards. Some are longing for someone to tell them that there's another way.

She likens her current practice to Obadiah's rescue of 100 prophets from Jezebel (1 Kings 18:1-15).

I refer women for abortions if they are adamant … with a heavy heart, those days are the least favourite … [but] I consider taking part a price worth paying … The radiant joy on the women's faces having made the decision to continue with the pregnancy is a reward worth all the other pain.

Her work has been informed by a specialist counselling course run by IMAGE (contact details below). Over five Saturdays between January to May, it covers: a biblical basis of life, basic counselling skills, teenage sexuality, post-abortion counselling, and how to set up and run an advisory centre.

I've used the lessons learnt on this course with loads of patients … when they present for termination, and also in spotting patients who may, for example, present with depression, with an abortion experience somewhere in the background.

Everett Julyan *responds.*

It is encouraging and challenging to read about those who have been able to show Christian love and concern to women feeling pressurised into abortion. I would gladly counsel anyone requesting an abortion but where I decline to get involved is in clerking women admitted immediately prior to a planned abortion, which has already been agreed upon after counselling with at least two doctors.

As a Christian I am forbidden to help end the life of a human being simply because their existence is perceived as inconvenient.

A minority might change their decision to proceed after counselling at the 11th hour. However, seeking to counsel but then withdrawing when the decision to continue is already confirmed may be very insensitive.

But I agree that making the most of the opportunities God gives us is better than zero involvement.

Abortion counselling courses

- ***IMAGE***, Coverdale Christian Church, Morborne Close, Ardwick, Manchester, M12 4FG Tel: 0161 273 8090 (Price £75)

- ***CARE for Life***, 1 Winton Square, Basingstoke, RG21 8EN Tel: 01256 477300

Creative Suffering

'Since coming here,' said the prisoner, 'I've come much closer to God.'

Opal's quiet words were convincing. In turn, she was touched to learn that opal gemstones owe their beauty to immense pressure, bearing down on fragments of silica in water. This pressure produces their scintillating colours and makes them so precious. The parable appealed to her amidst the constraints of her detention. She could already perceive its creativity.

During the service which followed came two unaccompanied solos, the words particularly poignant when heard in a prison. After four years away from home, still without news of parole, a grieving American mother sang first.

'I am learning to wait on the Lord,' she sang, her voice and face expressing deep longing but also deep trust.

A gifted musician followed, with old words to a new tune, her rich voice unfaltering. I, for one, was moved as never before by the hymn 'Fight the good fight'. In that setting, the words acquired such clear focus;

'Cast care aside, lean on thy Guide;
His boundless mercy will provide;
Lean, and the trusting soul shall prove,
Christ is its life, and Christ its love.

Faint not, nor fear, His arms are near;
He changes not, and thou art dear;
Only believe, and thou shalt see
That Christ is all in all to thee.'

Doubtless, some of those behind bars were victims of someone else's drug dealing, perhaps by carrying a supposed present for a friend. We did not ask. Yet for a few, their relationship with the Lord himself was growing, as other ties were severed. The Easter message was again made plain; the risen Lord overcame evil to set its captives free. As his suffering was creative, so he can transform ours to be creative.

A friend recently reminded me about the nature of our Lord's work at the carpenter's bench. As a master craftsman, he purposefully carved the wood up into fragments which he then shaped. His first public mission statement (as well as his first experience of rejection) was in the synagogue at Nazareth (Luke 4:16-30). Perhaps some of the furniture there was his own handiwork, bearing silent witness to his creative planning.

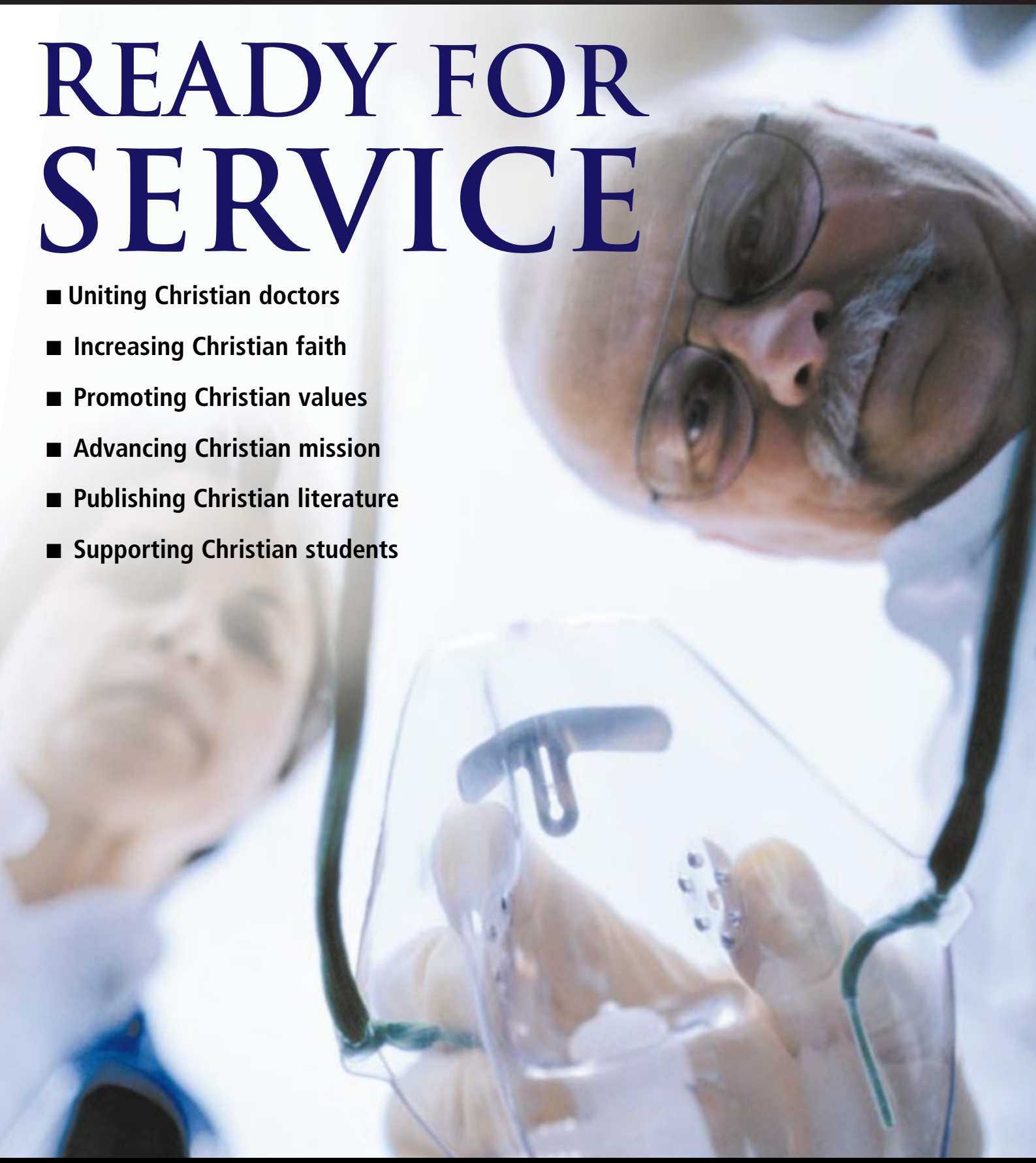
When circumstances imprison us, or events carve us up, it is well to remember how, after painful and prolonged captivity, Joseph (and many another 'trusting soul') made the wonderful discovery that, through it all, 'God has made me…'. (Genesis 45:9)

Janet Goodall
Emeritus Paediatrician in Staffordshire

Photo: Janet Goodall

CHRISTIAN MEDICAL FELLOWSHIP

READY FOR SERVICE



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