Spring 2006

for today's Christian doctor

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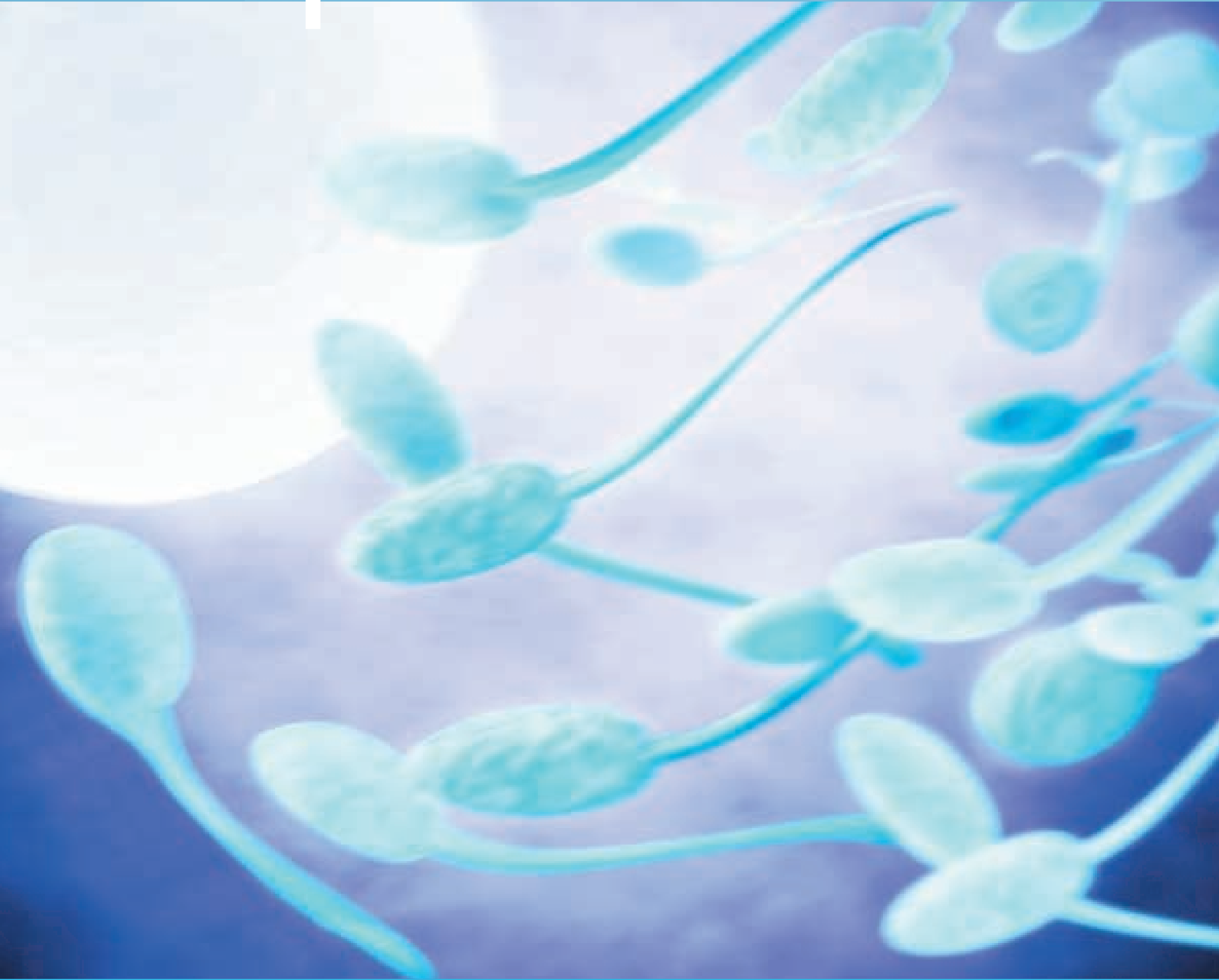

NaPro technology

assisted dying, ru486, medical corruption, conscientious objection, evangelism, abortion, ECT, four hour rule, community health, news from abroad

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contents

Editorial 3
Assisted dying - *Peter Saunders*

News reviews 4
The Joffe Bill - *Peter Saunders*
RU 486 - *Rachael Pickering*

Objecting to conscientious objectors 5
Trevor Stammers

Medical corruption 6
Steve Fouch

Do what only you can do 7
Mike McLaughlin

Empowering communities to care 8
Ted Lankester

Sick soap syndrone 9
Rachael Pickering

Are the majority of UK abortions illegal? 10
Chris Richards

Fit for purpose 12
Dominic Beer

NaPro technology 14
Ann Carus

Four hour target 16
Juniors' forum
Verona Beckles and Stephen Nash

The invitation 18
Jeremy Franklin

Eutychus 19

Reviews 20
Ruth Fowke, Janet Goodall, John Keown, Nick Land

News from abroad 22
Peter Armon

Final thoughts 23
Peter Armon

Assisted dying

Putting Christian arguments in secular language

Diane Pretty sought assisted suicide

we need to use arguments that make sense to non-christians

As Christian doctors we oppose euthanasia and assisted suicide because we believe in the sanctity of human life made in the image of God. Also we recognise that far from being helpful, assisted dying may be the greatest disservice we can offer, by propelling people forward to a judgement for which they are unprepared. Historical ethical codes uphold a similar absolute prohibition on killing; the Hippocratic Oath includes the affirmation, 'I will give no deadly medicine to anyone if asked nor suggest such counsel'.

But although we believe fully in the sanctity of life, to win the debate on assisted dying we need to be using arguments that will make sense to those who do not share our Christian beliefs. The *Care Not Killing Alliance*,[1] launched on 31 January, brings together 28 organisations to promote palliative care and oppose euthanasia, in the lead up to the second reading debate on Lord Joffe's revised *Assisted Dying for the Terminally Ill Bill* on 12 May. CMF has played a key role from the beginning working alongside the Association for Palliative Medicine, leading disability groups like the British Council of Disabled People, Christian church groupings including the Church of England, Catholic Bishops' Conference and Evangelical Alliance and a host of other healthcare providers, human rights groups and faith groups. What are the key arguments that alliance members are employing?

First, we need to recognise, as the European Association for Palliative Care has affirmed, that requests for euthanasia and assisted suicide are extremely rare when patients' physical, social, psychological and spiritual needs are properly met.[2] Just 6% of hospice patients even discuss the matter, and only 3.6% of terminally ill patients in other care settings.[3] The vast majority of people dying in the UK, even from diseases like motor neurone disease (MND), do not want 'assisted dying' and the 1,000 MND patients, who die annually in the UK, do so in the main comfortably with good palliative care.[4] The very small number of high profile cases who push for assisted suicide, are simply well publicised exceptions. In two large series from St Christopher's Hospice, where modern palliative care began, 94% of over 200 MND patients had a peaceful death, and contrary to media hype, no patients choked.[5,6] Paradoxically Diane Pretty, who took her case for assisted dying unsuccessfully to the European Court of Human Rights, had a death that was 'perfectly normal, natural and peaceful', according to Dr Ryszard Bietzk, head of medical services at the Pasque Hospice, Luton, where she was cared for.[7]

Second, therefore, rather than pushing for assisted dying, our key priority should be to build on the excellent tradition of palliative care that we have in this country and make best quality palliative care more readily accessible. Palliative care is still being delivered in a postcode lottery, financed mainly by the charitable sector, and with 56% dying in hospital where palliative care is most poorly resourced, rather than at home, where most would prefer to die, given the choice. Furthermore, while 95% of patients using hospice or palliative care have cancer, 300,000 people with other terminal diseases who might benefit from this care are excluded because of their conditions.[8] This is an intolerable situation. By 2020, the over 50s will comprise half the adult population. It is essential we rethink current service provision and end-of-life care to ensure it can meet the demands an ageing population will make in the next 20 years.

Third, the real question is therefore whether we should change the law for a very small number of people who are strongly determined to end their lives. In 1994 the last House of Lords' Select Committee to report on euthanasia unanimously recommended no change in the law. Its chairman, neurologist Lord Walton of Detchant, later described in Parliament their concerns about such legislation: '*We concluded that it was virtually impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law in the United Kingdom could not be abused. We were also concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death.*' Hard cases make bad laws, and no law allowing assisted dying could ever be controlled.

Christian doctors need to play a key role in this debate; and they will do so most effectively by learning to put what are essentially Christian arguments in secular language.

***Peter Saunders** is CMF General Secretary*

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The Joffe Bill

It's only the beginning

Review by **Peter Saunders**
CMF General Secretary

Lord Joffe's revised *Assisted Dying for the Terminally Ill Bill*[1] has its second reading the House of Lords (debate but no vote) on Friday 12 May. The Bill has taken on only four of the Lords' Select Committee's ten recommendations[2] and seeks to enable 'an adult who has capacity and who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request'; in effect to legalise physician assisted suicide (PAS), but not euthanasia, along the lines of the Oregon *Death with Dignity Act*.[3]

Advocates of the bill have been quick to point out the so-called 'safeguards' within it. It's only assisted suicide, only for adults, only for those with 'six months to live', only for unbearable suffering and only for those who make a 'persistent and considered' request. They further emphasise the option of palliative care, the need for signed consent, assessment of mental competence, the two-week waiting period and the detailed documentation.

They fail to point out however that: assisted suicide is euthanasia by intention and often unsuccessful leading to the need for the doctor to step in with a lethal injection; assessments of 'Gillick competence' will extend the Act to children; prognosis in terminal illness is difficult to define and can be altered dramatically by treatment; suffering has been completely subjectively defined contrary to the advice of the Select Committee; individual cases are not to be reviewed independently until after the key witness (the patient) is dead; the evidence from Oregon and the Netherlands proves that relying on doctors' self-reporting is notoriously unreliable; requests for assisted suicide can be profoundly influenced by fear of being a burden (impossible for those without personal knowledge to assess), depression (no psychiatric referral is necessary) and experience of palliative care (only 'advice about' but not 'experience of' is required).

Furthermore the Bill contains within it the seeds of its own extension. If we are allowing assisted dying for reasons of compassion, then why deny it to patients who are suffering unbearably but not terminally ill? If we are allowing it for reasons of autonomy, then why not grant it to anyone who wants to make the choice? Such inconsistencies will be ripe for challenges under the *Human Rights Act* the minute that assisted suicide is established as a therapeutic option for anyone at all.

Lord Joffe is to be commended at very least for his honesty in giving evidence to his own Select Committee: '*We are starting off, this is a first stage... I believe that this Bill initially should be limited, although I would prefer it to be of much wider application… But I can assure you that I would prefer that the law did apply to patients who were younger and who were not terminally ill but who were suffering unbearably, and if there is a move to insert this into the Bill I would support it.*'[4]

Don't be fooled by the 'it's only' safeguards. It's only the beginning.

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RU486

Moves for abortions at home

Review by **Rachael Pickering**
GP trainee in London

The last twelve months have seen moves to further promote the designer abortion drug RU486 around the world. Otherwise known as the anti-progesterone mifepristone, it was specifically developed as an abortifacient by French pharmaceutical firm Roussel-Uclaf (hence the letters RU) in the 1980s; in Britain it has been licensed for use as such since 1991. By blocking the uterine actions of progesterone, RU486 causes endometrial breakdown and abortion of the embryo or fetus.

But traditionally up to four trips to the abortion clinic have been required to complete an RU486 termination. In addition, it usually has to be given with a vaginal prostaglandin in order to stimulate the uterus into expelling the dead fetus. This often involves considerable pain and distress for the woman. This discomfort (both physical and psychological) is one of the reasons why, in England and Wales, most terminations are not performed medically but surgically, using vacuum aspiration.

Now, perhaps in an effort to make abortion cheaper for the NHS, even easier to obtain and allegedly more convenient for the women concerned, our Government is ploughing ahead with plans to promote abortions *at home* using RU486. A Department of Health study has suggested that this is safe. Supervised by a nurse, 172 women less than nine weeks pregnant took mifepristone and misoprostol at a health centre; they then went home and had medical abortions.[1]

In the USA, there are growing concerns that RU486 predisposes the endometrium to infection. There have been at least five maternal deaths from septic shock after RU486 abortions. The father of one of these young women, Holly Patterson, is campaigning for a review of the drug by the American Food and Drug Administration.[2]

A previous news review in this journal concluded that the history of this drug was a long tale of deception and corruption on several continents that we hadn't heard the last of.[3] According to recent figures, the government's £150 million campaign to reduce pregnancies among young girls has been an embarrassing failure, with ministers under pressure to close the discredited Teenage Pregnancy Unit.[4] This latest move to shift abortion from the operating theatre to the privacy of British homes, without any attempt to address the spiralling rates of unplanned pregnancy, further trivialises a procedure which has ended the lives of six million babies, markedly changed our national demographic profile and brought a legacy of psychological, physical and spiritual trauma for women.

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Trevor Stammers exposes more political correctness

Objecting to conscientious objectors

'What are the editors of a once fine journal of medical knowledge doing, to let such an opinion piece be published?' asks one reader.[1] Another despairs that, 'After 30 years of reading the *BMJ*, Savulescu's article was the first to make me feel physically sick'.[2]

The cause of the avalanche of protest of which these comments were but a small part, was an article by the utilitarian, Oxford philosopher, Julian Savulescu, in which he attempted to deny a place for conscientious objectors in medicine.[3] From his (possibly ironic and certainly incorrectly referenced) starting point of Shakespeare's Richard III's 'Conscience is but a word cowards use, devised at first to keep the strong in awe', he pursues a curiously ill-thought out path of iconoclastic rhetoric which fully deserved the strong reactions it received.

Savulescu contends that 'a doctor's conscience has little place in the delivery of modern medical care'. Conscientious objection is a hangover from the bad old days of paternalistic medicine. Furthermore, in a system where 'less than half of doctors whose primary job it is to deal with TOP would facilitate a termination at 13 weeks if the woman wanted it for career reasons', conscientious objection results in both inefficiency and inequity. Religious values 'corrupt' the delivery of health care and to allow conscientious objection on the basis of them is clearly discriminatory when 'other values can be as closely held and as central to conceptions of the good life as religious values'.

However Savulescu makes several false assumptions including that what is legal is just. The Nazis would have applauded his assertion that we should not 'allow moral values to corrupt the delivery of a just and legal health service'. It was doctors' compliance with a law they saw as just, that facilitated the Holocaust.[4]

Secondly, he appears to conflate conscientious objection with religious belief. There are many doctors today with no religious belief, as well as many with it, who consider euthanasia and abortion to be intentional killing of the innocent and having no place in the delivery of medical care. Several respondents link the desperation of Savulescu's pleas with the desperation expressed by RCOG President, Allan Templeton, recently over the recruitment crisis in England and Wales in O&G.[5] Only about two in every 100 medical graduates are now opting for the specialty, a figure that needs to be trebled if hospitals are to 'keep pace with increasing expectations from patients'. One such graduate (now a dermatologist) relates how, 'Applying for an obstetric SHO post as part of my GP training in the 1980s, I was informed in the job description that "the unit carries out approximately 1,000 terminations a year and the SHO will be expected to participate". I didn't apply, and never did an Obs/gynae job, which affected my career. No doubt I could have found an O&G SHO post somewhere, but rightly or wrongly I didn't, due to the real or perceived pressure to be involved in abortions.'[6] I understand from colleagues in Northern Ireland there is no recruitment crisis there.

This ties in with Savulescu's apparent failure to recognise the irony of his reluctant acceptance of conscientious objection only in situations where there are enough other doctors to do the killing (or whatever else may be objected to). If, as Savulescu suggests, conscientious objectors don't become gynaecologists, then the crisis will just deepen. Furthermore some patients only want to be cared for by obstetricians who will not do abortions. It is surely not paternalism to allow them that choice where possible. Pro-choice lobbyists can be remarkably intolerant in some situations. It is because conscientious objectors share Savulescu's belief that 'the primary goal of a health service is to protect the health of its recipients' that they are objectors. It is difficult to see how the abortionist's curette benefits the recipient fetus.

If values have no place in determining medical care, on what basis does Savulescu attempt to impose his own moral values on conscientious objectors? His own paternalism and his ideal of 'statute-driven medicine' appear more 'idiosyncratic, bigoted and discriminatory' than the moral values he is so intolerant of.

However he is not alone and his editorial appears to be just the most widely-criticised element of a concerted campaign against conscientious objection in medicine. Recent reviews in several GP weeklies of a paper indicating that 15% of doctors would pass a woman requesting an abortion onto a colleague to arrange the referral were universally outraged that this was the case and called for the number of such doctors to be reduced! Sam Rowlands, in an otherwise helpful overview on caring for women seeking abortion, suggests that 'Abortion can no longer be considered an area of medicine where personal beliefs can be expressed'.[7]

Last year *The Times* reported on Prof Wendy Savage's 'campaign to expose pro-life doctors'.[8] A glance at the *Voice for Choice* website will give a good insight into the supporters of the campaign, though very little information as to its plans.[9] It is certain however that, as the number of abortions continues to rise and the number of doctors willing to carry them out falls, the abortion industry will do all in its power to try and prevent doctors' exercising their right of conscientious objection in this area. Vigilance is required both at GMC level and government level to save conscientious objectors from the assault of those who know not that 'conscience is born of love'.[10]

Trevor Stammers *is a General Practitioner in London*

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Steve Fouch highlights a growing medical problem

Photo: Wellcome

MEDICAL CORRUPTION:

A new global health threat?

A recent report suggests that worldwide, some 5% of all spending on healthcare (£850 million a year) is being lost through corruption.[1] This includes:

- Public health budgets being subverted by unethical officials for private use
- Hospitals functioning as self-service stores for illicit enrichment, with unclear procurement of equipment and supplies and ghost employees on the payroll
- Health workers demanding fees for services that should be free. For instance, in **Bulgaria**, as in much of Southeast Europe, doctors frequently accept small informal payments or gifts for medical treatment. This can be anything from between US $10 – $50 and in some cases can rise to US $1,100
- In the **Philippines**, a 10% increase in the extortion of bribes by medical personnel was shown to reduce the rate of child immunisation by up to 20%
- In **Costa Rica**, nearly 20% of a US $40 million international loan for health equipment wandered into private pockets

Furthermore, aggressive marketing techniques used by pharmaceutical companies to 'buy' physicians' support for specific drugs, leads to a high rate of prescriptions that are not always based on patient need. This outlay in marketing direct to doctors (£7,360 a year per doctor in 2005) adds c$20bn a year to pharma budgets, the costs of which are reflected in higher drug prices for 'brand name' medicines versus their generic counterparts.[2] This also helps price many of the world's poor out of the market for essential medicines. 'Poor families face the agonising choice of food or medicine. Feed your child or cure his illness, but not both? No parent should face that awful choice.'[3]

The effects of medical corruption are felt in other ways. 'Corruption in health care costs more than money. When an infant dies during an operation because an adrenaline injection to restart her heart was actually just water – how do you put a price on that?' said Huguette Label, Chair of Transparency International who published the report. 'The price of corruption in health care is paid in human suffering.'[4]

Even in the response to disasters, there is corruption. *The Global Corruption Report 2006* also presents troubling evidence of financial irregularities in post-tsunami relief operations last year. Duplications and misappropriation of funds and resources directed at the survivors of this and other major disasters is of grave concern.[5]

Medical corruption is undermining progress towards the United Nations' Millennium Development Goals, in particular the three related directly to health (reduced child mortality by two-thirds; improved maternal health (reducing mortality by 75%); and the fight against HIV/AIDS and other communicable diseases).[6] With the target date for achieving the goals just nine years away, the global community is already way off target to meet these goals[7] – and corruption is slowly emerging as one of the primary causes. More money than ever may be coming from Western governments and international bodies like the Global Fund to address the health needs of the poor, but much of it is getting lost in a maze of corruption before it ever reaches those it is intended to help.

The Hippocratic oath enjoins doctors to '*come for the benefit of the sick, remaining free of all intentional injustice*', and Scripture enjoins us as God's people again and again to be honest, fair and just in our dealings with one another, and especially with the poor.[8] In standing up for justice in international healthcare, we need to stand up to this kind of corrupt practice. And sadly, even Christian institutions are guilty of it. I have anecdotal reports from elective students, missionary doctors and mission agencies indicating that even in some mission hospitals this kind of corruption goes on. How can we speak out about this kind of injustice unless our own house is in order?

How can this be tackled? Transparency International makes some specific recommendations including:

- Donor and recipient governments making all health budget and policy information open to public scrutiny
- Adopting and enforcing codes of conduct for health workers and private sector companies
- Incorporating conflict-of-interest rules in drug regulation and physician licensing procedures
- Public health policies and projects should be independently and publicly monitored
- Procurement processes should be competitive and transparent
- Rigorous prosecution will send the message that corruption in health care will not be tolerated

But greater transparency and accountability at the national and institutional level must be met with greater honesty and integrity at the individual, professional level, and regulations are not enough to ensure that this happens. Ethical standards need to be integral to medical training throughout the world. Good leadership, care and respect for staff, adequate pay, and above all in Christian hospitals, a strong emphasis on biblical integrity, are all essential. Unless the attitudes and practices of individual doctors and administrators are so transformed, we will see millions left in poverty, ill health and facing an untimely death from all too preventable causes.

Tackling global health problems is an issue of justice as much as it is one of charity and medical intervention. God's people need to make a stand and lead the way in showing how medical corruption can be eliminated.

***Steve Fouch** is CMF Allied Professions Secretary*

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Michael McLaughlin asks us to reconsider how we spend our spare time

Do what ONLY you can do

You sit at work all day, listening to never ending medical problems, and trying to find solutions. Then you go home and different family situations compete for your attention. And then, on top of this, seemingly endless good causes suck up your precious spare time!

Stop and think. Not everything you do at work requires your individual attention; that's why the NHS has multi-disciplinary teams! And similarly, although no doubt you're brilliant at all these things you're doing outside of work, perhaps you should be passing them on to someone else. Perhaps, instead, you should be *doing what only you can do*.

In too deep

Moses is a good example of a gifted man too involved in the minutiae of life. Whilst leading the Israelites in the desert, he received a visit from his father-in-law Jethro. Sitting in on one of Moses' courts, watching him settle petty disputes and small claims, Jethro pointed out that Moses was wasting his time and his particular gifts. This should have been apparent to Moses himself, but he was in too deep and couldn't see the woods for the trees. He was trying to do everything himself! So, after a rethink, Moses enlisted the help of others to settle lesser cases, leaving ample time for him to deal with weightier matters. [1]

Resource allocation

The principle of resource allocation is clearly taught in Scripture. In the early church, the Holy Spirit gave spiritual gifts as he willed, intending that each person put their gift to the best possible use. [2] For example, it doesn't make any sense for a gifted teacher to do church business administration, or perhaps serve meals, when he or she could be teaching. Allow me to paraphrase the Apostles: 'Our time and skills are not best used in organising rotas and soup kitchens, as we have been gifted by God to study and teach the Bible to this growing church. Instead, let's appoint spiritually mature people to organise food distribution for the needy. Then we can get back to the work God wants us to do'. [3]

Doctors have unique giftings. True, many doctors are talented in various ways that are complementary but not specific to medicine – leadership qualities, organisational abilities, and the ability to think clearly – but then many non-medics also possess these in abundance. Usually, when people approach you for help with their good cause or committee, they are looking to use these more generic skills, not your medical talents.

Lateral thinking

So what can we do when people want to harness our talents to projects outside the scope of our specific giftings? Often a bit of lateral thinking is required, as when my pastor asked, '*How am I going to get you to serve on the church board?*'

I was caught on the spot, but managed not to commit myself: 'I don't think that's something I can do presently'

'*You didn't even say you'd pray about it!*'

'I'm not convinced that it's the best investment of my time and gifting. There are many others in the church who can sit on the board. God has entrusted me with other things that only I can do.'

'*But how can we influence our church leaders with your insights and wisdom if you don't sit on the board? There are five or six other key leaders like you in our church who serve in national ministries and I wish that you'd all take your turn!*'

> perhaps you should be passing some things on to someone else

What was my solution? 'Why don't you invite us one at a time to spend an occasional Saturday morning breakfast with the board discussing a critical issue or leadership in general? That way we can still concentrate on the areas only we can do'.

The crucial question

Over the years, I have met with thousands of Christian doctors and dentists. Yet when I ask them to consider using their special skills and gifts to mentor medical students and junior doctors, or perhaps hold the odd session in an inner-city clinic, many have to decline reluctantly as they are too heavily involved in very worthy yet non-medical Christian good causes.

Of course, which ministry each of us gets involved with has to be a personal decision. However, before deciding, I would encourage you first to ask this question, 'Is this something that only I can do?' The answer will help you determine the best investment of the influence, gifts, skills and resources God has entrusted to you.

After I once presented these ideas to a group of doctors, one of them admitted, 'I had intended to resign from discipling medical students. But I guess, after hearing what you've said, I need to continue doing what only I can do'.

Of course, we need to make good on the commitments we've already made. It may take a while to align your gifts and possible ministry involvements more properly. But it will happen sooner, if you keep asking, 'Is this something that only I can do?'

Adapted with permission from an article by ***Michael McLaughlin****, Western Regional Director of Christian Medical and Dental Association, USA.*

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Ted Lankester explains why community based health care is essential

Photo: Empics

Empowering communities to CARE

Community based health care (CBHC) is now a dominant theme in cutting edge literature on global health. Started by the earliest communities on earth, it was modelled by Jesus Christ and formulated in the Alma Ata Charter of 1978. Without CBHC, there will be no effective health services in the poorest communities, which will likely return to subsistence medicine. It is not just a good idea – a neglected part of the health care system in resource poor countries – but the imperative for improving the health of the neediest people on earth, a fifth of the world's population.

A pioneering example of CBHC is based in two remote Himalayan valleys. I was part of an early team working there. Nurse trainers, backed up by weekly doctor visits, trained community health volunteers to see and treat two thirds of all illness episodes through house-to-house visiting. Many more illnesses were prevented. In one village alone, child malnutrition plummeted within two years from over 30 percent to less than two percent.

Supporting a depleted workforce

The developing world isn't training enough health care staff, many of whom are leaving for developed countries.[1] This is a serious issue: 'Money and drugs will fail unless poor countries have enough people to tend the sick…Africa needs a million more health workers'.[2] CBHC is often the only health care available, and with the right management, training and support, it offers an excellent return for investment.[3]

Involving the community

CBHC can empower communities to deal with health problems themselves. The ASHA Christian project, working with half a million Delhi slum-residents, has seen spectacular health improvements through community worker empowerment: 'Thousands of disadvantaged and illiterate slum women are now acting as highly effective pressure groups, and this has resulted in proper housing and a vastly improved environment. As vibrant community groups these women are at the fore-front of resolving social issues and community conflicts'. This approach is especially valuable where HIV/AIDS is prevalent: 'HIV prevention programmes should be planned *with* and not just *for* whom they are meant…[to ensure] participation and ownership of communities'.[4]

But often CBHC programmes are too busy and stretched to document their achievements. Smaller programmes need to be strengthened and linked together for mutual learning. New initiatives such as Community Health Global Network, ICMDA Mission Mobilisation Network and Crossnetwork Journal, and ongoing CMF/HealthServe initiatives are trying to address this enormous need.

The increasing role of faith

The need is never ending, and health workers need huge motivation to remain active, resident and competent. Often religious faith inspires people and programmes to function and local Christian communities are central in this. Even organisations such as UNAIDS, WHO and UNICEF recognise that faith based groups can have a unique role 'not just in delivery of care but in leadership, to address the root causes that have fuelled this epidemic'.[5]

Changing perceptions

We need to erase the idea that CBHC is an optional extra. It should be the central plank of any effective strategy aiming to have lasting impact on the 1.2 million people estimated to be without basic health care. 'The focus of all strategies should be to ensure access by every family to a motivated, skilled and supported health worker…family members, relatives and friends, an invisible workforce consisting mostly of women: they are backed up by diverse informal and traditional healers…by formal community workers; all strategies should seek to promote community engagement in recruiting, retaining and accounting of worker performance.'[6]

> faith based groups can have a unique role

Imagine how this could work in practice. A young child becomes sick in a remote community. The health centre, 30 miles away, has run out of medicine, but the trained community health worker correctly diagnoses malaria and treats the child with medicine from her medical bag. Even better, perhaps the child's mother has been similarly trained, and has been given a supply of malaria medicine to keep at home. The same system could work for acute respiratory infections. This would have a huge impact as these two conditions cause most of the deaths in many resource-poor areas.

Without CBHC, the world's poorest people, especially mothers and children, will continue to die needlessly.[7] 'Access to and affordability of health care in rural and isolated communities provided by well trained and motivated staff who are on hand to deliver it, must be considered immediately so that the diseases of poverty and the factors that strengthen its grip can be tackled at their roots.'[8]

***Dr Ted Lankester** is co-founder of Community Health Global Network and Director of Health Care at InterHealth*

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Rachael Pickering asks whether reality TV has gone too far

Sick soap syndrome

Recently I turned on the television to see a baby dying under a surgeon's knife. It wasn't a horror film, nor a medical soap like *Holby City*. It was a reality TV docu-drama following the separation of conjoined twins.

A live death

In 2004, Egyptian baby Manar Maged was born with craniophagus parasiticus – with a parasitic twin attached by its head to her own head.[1] She was otherwise physically normal, but her twin had only a head and neck stump. Though capable of blinking and smiling, she was entirely dependent on Manar for circulation and nutrition.

The parents were told that Manar stood a good chance of surviving the operation, but that her twin would inevitably die during the surgery. So, in February 2005, with a video link broadcasting every cut of the knife around the world, Manar was separated from her twin, who died live on air.

Although the operation was hailed a huge success, Manar herself died the following month, but not before she had been paraded around the world on a fund-raising roadshow, culminating in the USA on the Oprah Winfrey Show. Her twin was buried in a private ceremony in a Muslim cemetery and at last afforded the dignity and respect given to more 'normal' dead babies, that she was denied during her dying moments. The final grisly BBC headline read, 'Two-head girl dies of infection'.[2]

How did it come to this?

How on earth has our society come to find these trying events entertaining? Maybe it all started with the gritty pseudo-reality of soap operas. But the new millennium saw us embracing *Big Brother* – a live soap opera without the overpaid actors![3] Instead, ordinary people sat at home watching other 'ordinary' people doing everyday things. Strangely it was a massive hit, though a huge waste of the nation's leisure time! Then the floodgates opened, countless other reality programmes followed, and it's now possible to spend 24 hours a day, seven days a week, immersed in so-called 'reality'. Lately the concept has evolved still further: reality TV has merged with the seedy world of chat shows and given birth to so-called reality docu-dramas. Now ordinary people get to divulge intimate details of their problems to the rest of the world: their gross obesity which requires us to watch their bariatric surgery; their children's physical and mental disabilities and how other people react to them; even the finer points of their emotional turmoils, sexual deviances and relationship breakdowns. And in the background of every programme, another kind of Big Brother keeps up a running commentary, to make sure we really engage with these troubled souls.

What are we learning?

Programmes like *Big Brother* are simply huge tabloid gossip machines. So, as Scripture warns us away from gossip, it's easy to make a case for avoiding watching them.[4] But what about so-called docu-dramas? After all, many of them are billed as educational! Doesn't each one tell the story of a person affected by a specific medical, emotional or mental illness? Well, yes, but that doesn't mean that society learns anything useful from them. What did we learn by watching Manar's twin die live on air? What do we gain by observing the gory details of a grossly obese person's gastric bypass? And how much do we benefit from witnessing the breakdown of a person's marriage?

In this day and age, there are huge resources for the general public to obtain objective medical knowledge and opinion. Gleaning subjective information on rare diseases from distressed individuals is neither necessary nor advisable. Moreover, our recent national obsession with docu-dramas is feeding our emotions and making it appear 'normal' to put private issues out on public display.

Consent

Back to Manar. Of course, neither twin was capable of giving any kind of consent. Moreover, it could be argued that their parents were not in a position to make a truly informed decision about filming either. However, the surgical team most certainly were in a position to ponder the rights and wrongs of the proposal, and I wonder how on earth they justify their decision.

But what about the plethora of individuals who agree to have their distress and illnesses broadcast across the world? Are they truly receiving informed consent counselling beforehand? Moreover, are the doctors involved really acting in the best interests of their patients? Despite the fact that most participants in reality docu-dramas are adults, by no means all of them could be said to be of sound mind. And what about the children? How many parents are sitting in front of cameras, telling the nation about their child's ailments, when the child is too young really to appreciate the potential consequences of their parents' actions.

Our response

Should we be concerned that society now feels the need to know and discuss everyone's intimate secrets? Well, yes we should. The Genesis account of Shem and Japheth's concern to protect their drunken father's dignity, in contrast with their brother Ham's voyeurism, is a sober reminder to us that some things are best left unseen and unreported.[5] As doctors we are granted access to the most intimate details of our patients' lives, but *only* with a view to helping them overcome or cope better with their problems. In so doing we should grant them the same respect of privacy that we would wish for ourselves. Condoning the broadcast of distressing personal situations is simply pandering to the morbid fascination of our channel-flicking entertainment culture, and a serious abuse of professional privilege.

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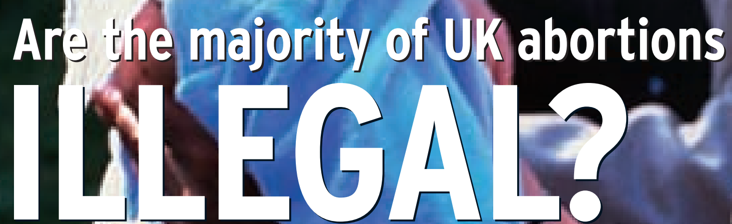
Chris Richards questions the status quo



Are the majority of UK abortions ILLEGAL?

Photo: Wellcome

key points

95% of abortions are authorised under Ground C of the 1967 Abortion Act; which requires the risk to a mother's mental or physical health from abortion to be less than that from normal pregnancy.

However maternal death from suicide, murder, accidents and natural causes is higher following abortion than normal childbirth; and the risks from haemorrhage, infection and for subsequent pregnancy problems are also appreciable.

Furthermore, several recent major studies have confirmed that abortion seriously threatens a woman's mental health whilst undisturbed pregnancy often improves it.

Women seeking abortion, the public at large, and the medical and legal professions need to be made more aware of these facts.

Unless a pregnant woman's circumstances fulfil one of seven grounds set out by the Abortion Act 1967, induced abortion remains an illegal act in this country. 95% of abortions are performed on Ground C,[1] which exempts a doctor from prosecution for performing an abortion (before the 24th week) if:

'*…continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman… (account may be taken of the pregnant woman's actual or reasonably foreseeable environment…)*'[2]

Since the inception of the Abortion Act, doctors have often made the assumption that the clause could be fulfilled for any woman who did not want to keep her pregnancy, because the emotional consequences of giving birth to an unwanted baby or the physical consequences of delivering a baby were greater than that of induced abortion.

Over forty years of the Act and after six million abortions, there is accumulating evidence of the serious and long-lasting consequences of abortion. Could 95% of UK abortions be illegal because of inaccurate assessment of the risks?

Physical Health

Is there evidence that the physical health of a woman is worse following an induced abortion than if she keeps her pregnancy? When considering Ground C one needs to assess the risk of death and other irreversible consequences.

Mortality

The UK maternal mortality rate is estimated to be 13.1 in 100,000.[3] In the 2000-2 confidential enquiry, there were only five abortion-associated deaths from a total of 261 maternal deaths suggesting that abortion is a significantly safer procedure than giving birth.[4] However there are at least two important reasons why these statistics vastly underestimate the mortality associated with abortion. Many deaths go unrecognised because the procedure is often performed in clinics that don't provide on-going care for the woman. The causal association with subsequent illness is not then recognised. But even when it is, it may still not be included on the certificate. The report on maternal deaths acknowledges these shortcomings in ascertainment even for pregnancy.[5]

However an in-depth Finnish study of deaths within a year of delivery, miscarriage or abortion from 1987-94 gives a more complete and disturbing picture. Compared to women who gave birth, women who aborted were 3.5 times more likely to die within the year.[6,7] The risk of death from suicide was seven times higher than the risk of suicide within a year of childbirth. Women who aborted were also four times as likely to experience a fatal accident, 13 times more likely to be murdered and 1.6 times more likely to die of natural causes than women who gave birth.

Morbidity

A recent Scottish study estimated the severe morbidity rate from undisturbed pregnancy to be 3.8 per 1,000 but almost all events, including haemorrhage (incidence 1.9 per 1,000), were treatable with a good long-term outcome.[8]

The serious, but usually treatable, acute complications of surgical abortion are haemorrhage (incidence 0.1%) and uterine perforation (incidence 0.4-2%). The risk of infection[9] (incidence 10%) is greatly increased

when Chlamydia or Neisseria are present - up to 23% developing pelvic inflammatory disease (PID) within four weeks.[10] With rapidly rising Chlamydia rates this will be an increasingly common complication o f abortion.

Induced abortions may have important effects on future pregnancies. PID can cause infertility and future pregnancies have a greater risk of placenta praevia (increased by 7-15 times), and pre-term labour (twice as likely).[11] The latter is an important cause of chronic lung disease and cerebral palsy in the child.

Finally there is growing evidence (though still disputed by some) that abortion - but interestingly not miscarriage - increases the risk of breast cancer (relative risk of 1.3-2).[12,13] In addition term pregnancy acts as a clear protection against the development of breast cancer.

Mental Health

Is there evidence that the mental health of a woman is worse following an induced abortion than if she keeps her pregnancy?[14]

Countless harrowing testimonies[15] following induced abortions bear witness to the prolonged and profound psychological effects for some woman. But is there any epidemiological evidence to support these individual accounts?

Both sides of the debate have quoted studies to support their views. One reason for this is the demanding methodological criteria for an effective study. It needs to establish whether abortion causes mental illness or mental illness predisposes to abortion, and to adjust for the spurious influence of confounding factors such as income and education. Many women are reluctant to admit their abortion (concealment) leading to an underestimate of any adverse effects from abortion. Finally, to test Ground C the ideal comparison categories of 'abortion performed' verses 'abortion refused' are not available in a society where there is effectively abortion on demand. Sometimes 'unplanned and kept' or 'unplanned and aborted' categories are studied as lesser alternatives.

Bearing these issues in mind what conclusions can we draw from the best published studies? A recent New Zealand study looked at the mental health and pregnancy/abortion history of a cohort of 15-25 year olds by interview.[16] With low concealment rates and adjusting for confounding factors, they found that those keeping their pregnancy had mental illness rates 60% of those who had an abortion. The findings remained significant even when pre-pregnancy mental health was taken into account. This study took no account of the 'plannedness' of the pregnancy but a similar type[17] of study showed a comparable effect when the pregnancy was unintended, though this could not be shown to be statistically significant in unmarried women. In another study the detrimental effect of abortion on mental health was still present eight years later.[18]

Other studies avoid the subjectivity of psychological interviews by using the harder indices of psychiatric admission or suicide rates. Reardon and others looked at psychiatric admissions from the medical records of low income women in Canada (thereby taking into account social background and avoiding problems with concealment).[19] Such admissions were commoner at 90 days (2.6 times) and 4 years (1.5 times) in those women who had abortions than those who delivered their baby.

As already mentioned women who have abortions are much more likely to commit suicide within a year of the event than those who give birth.[4,5] It is noteworthy that the suicide risk following birth was half that of the general population. Though pre-pregnancy mental state may contribute to some of the difference, the most obvious conclusion is that abortion seriously threatens a woman's mental health whilst undisturbed pregnancy often improves it.

In addition one can reasonably anticipate the adverse mental effects of the physical consequences of abortion on the women including pelvic inflammatory disease, pre-term labour in future pregnancies and breast cancer.

Conclusion

Francis Schaeffer wrote, 'Abortion does not end all the problems; it often just exchanges one set for another'.[20] These words from a passionate anti-abortionist without the observations of the last forty years, contain a hint of balance that might suggest that Ground C could sometimes be fulfilled. We now know differently.

Much pain and grief will never be adequately recorded in scientific studies and there are many reasons why studies tend to underestimate the damage of abortion on the woman.[21] Nevertheless, our increasing insight into the true consequences of abortion shows that abortion is never an easy way out. A decision for the life of her foetus generally brings health for the mother, whilst a decision against life often brings a toll of physical destruction and grief that has far-reaching consequences for the woman as well as the foetus.

There are a number of important implications of these findings.

- It may no longer be professionally credible for a practitioner to sign the form that acknowledges legitimate grounds for abortion under Ground C.[22]
- All woman requesting abortions should be warned of these sequelae. How many would change their mind if they were fully informed?
- Without such warning, we can expect women to bring legal action against practitioners and abortion clinics for the damaging consequences.
- We need to warn young people about one of the huge potential costs of pre-marital sex (the majority of abortions are performed on unmarried teenagers).

Finally, as this truth dawns, should we be surprised that pro-abortionists are proposing revision of the 1967 Abortion Act to introduce a clause that more clearly legalizes abortion on demand?

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Dominic Beer examines a controversial therapy

Fit for purpose

is ECT useful or should it be banned?

Photo: Wellcome

key points

Electro-convulsive therapy (ECT) has received adverse publicity in film, the media and from the anti-psychiatry movement. However, randomised controlled trials and the National Institute of Clinical Excellence (NICE) support its use in depression, catatonia and for severe manic episodes. Most patients support its use, side effects (headache and transient confusion and memory loss) are minimal, it has no dubious 'spiritual roots' and although its mechanism of action is not fully understood, it remains well supported amongst psychiatrists. Without an adequate alternative, and as long as there are safeguards and strict monitoring of ECT, it is right that very ill psychiatric patients should be able to receive this effective yet controversial treatment.

Mary is 72, has stopped eating and drinking, is profoundly depressed and believes she deserves to die. You consider giving her antidepressants but you know they may take a few weeks to work. She might die unless you intervene within a few days. A colleague suggests ECT (electro-convulsive therapy). What should you do?

A controversial treatment

'ECT is one the most controversial treatments in medicine' says a *BMJ* leader.[1] Why is this? It has received much adverse publicity from portrayals in films such as Ken Kesey's 'One Flew over the Cuckoo's Nest' in which patients were shown as being given ECT without general anaesthetic or muscle relaxant (a procedure which can lead to vertebral fractures). This may have led to the perception that ECT is used as a means of behavioural control or even punishment. Some patient groups such as the charity MIND, which does much valuable work for the mentally ill, have advocated the outlawing of ECT unless the patient consents to it voluntarily.

The anti-psychiatry movement writes articles entitled 'Psychiatry's Electro-convulsive Shock Treatment: a Crime against Humanity'. In so doing they appear to try to make the link between ECT and torture. They also claim 'Psychiatrists who use ECT are violating their Hippocratic oath not to not harm patients and are guilty of a form of health care quackery'.[2]

What is ECT?

ECT involves the passage of a small current of electricity across the brain for about two seconds via electrodes attached to the scalp, inducing a generalised tonic-clonic seizure for up to one minute. The patient is under general anaesthetic and will have been given a muscle relaxant to reduce the risk of body spasms and hypoxia. The procedure takes place, usually twice a week, in an ECT suite with an anaesthetist, psychiatrist and nurse. Electrodes are either attached to both sides of the head (bilateral) or to just one side (unilateral), usually the non-dominant, in order to reduce the risk of cognitive side-effects. It was first used as long ago as 1938 by two Italian psychiatrists Cerletti and Bini.

It is thought that ECT works by increasing the amount of certain neurotransmitters which have a mood regulatory and antipsychotic effect. The exact mechanism is not fully known. Some would say that it should be outlawed on that basis – that it is 'quackery'. The problem is that we don't fully understand how some common drugs, such as the mood stabiliser/ antidepressant lithium, exert their therapeutic effects either. Should they be banned on that basis? Surely not - these drugs are rightly used before all is known about them.

Is ECT evidence-based?

Randomised controlled trials (RCTs) show that in depressive illness ECT is an effective treatment in the short term. 'Real' ECT is more effective than 'sham' or simulated ECT (where no electric current is applied). Bilateral ECT is more effective than unilateral ECT. RCTs show that ECT may be of benefit in the rapid control of mania and catatonic schizophrenia.

There are now official guidelines on when ECT can be used in the United Kingdom. NICE (the National Institute for Health and Clinical Excellence) allows its use in three illnesses: 'severe depressive illness'; 'catatonia'; and 'a prolonged or severe manic episode'.[3]

What do patients think of ECT? 11,000 patients per year have ECT in England; what do they think about the treatment? They find it helpful and would have it again.[4] This is borne out by a systematic review,[5] which also identified the need for more research: patients interviewed by a doctor are more likely to answer in the affirmative than those asked by a fellow patient whether they like the treatment. Another area for research is memory loss - about a third of patients report loss of autobiographical memory (retrograde loss). The Royal College of Psychiatrists reports that there is no problem with the formation of new memories (anterograde memory).[6]

Hasn't modern science come up with any alternative to ECT after over 60 years? Well, maybe there is now a possible successor to ECT called repetitive Transcranial Magnetic Stimulation (rTMS), but it is by no means sure that it is an effective treatment in depression. It is very much in the research stage.[7] It involves the application of a magnetic stimulus to the brain and the effect on neurones is similar to that of ECT (depolarising) but without causing a seizure. If it does become part of routine clinical practice it will mean that patients don't have to be anaesthetised or have a muscle relaxant. They can have the treatment in the outpatient department and the main side effect is only a mild headache.

From a Christian point of view what are the issues?

Using George Smith's criteria:[8]

1. Can ECT be recommended with integrity?

ECT is an effective treatment, although its exact mode of action remains not fully understood. However, it cannot be regarded as 'quackery' given the presence of all the research studies that show its efficacy and its life-saving effects. It is clearly not torture, and even though some may see it as such, it is an effective treatment when used for the right reasons.

2. What are its roots?

They lie within the psychiatric profession, a profession based on the scientific approach, which can be seen as morally neutral, although like anything, it can be subverted for evil ends.

3. Is ECT harmful?

Nowadays it is a very safe procedure - the mortality is 4.5 per 100,000 patients, about the same as for any minor operation under general anaesthesia. Any life-threatening complications relate to general anaesthesia; less serious side-effects are headache, neckache, short-term confusion and memory disturbance.

For many patients like Mary the mortality of the untreated illness is greater than the mortality of the procedure. ECT may also be safer than the side effects of medication; postural hypotension and cardiac side effects may be especially damaging. This makes ECT a fully justified treatment in severe illness. But ECT may still be harmful in other ways. More research is needed to see if there is indeed any permanent retrograde memory loss.

What safeguards are there?

Psychiatrists are more cautious in their use of ECT. This is in part due to the development of better and safer antidepressants. NICE Guidelines set audit standards for facilities and practice. Consent from the patient prior to ECT is sought. If informed consent is impossible because of severe mental illness, there has to be a Second Opinion Doctor appointed by the Mental Health Act Commission to sanction treatment.

If ECT could not be given without informed consent, some of the most ill patients like Mary would be denied the opportunity of one of the most effective treatments. This would not be just - those who are least advantaged and least able to choose should be treated to the same standard as those who can.

What happened to Mary?

Mary had two applications of ECT and was eating and drinking again within five days. After twelve treatments her depressed mood and delusions had significantly improved; her progress was then maintained by the antidepressants that had been started earlier.

Conclusion

ECT is a safe procedure. It is unclear whether it produces long-term memory loss. Some want it to be banned; others only want it to be used when the patient gives informed consent. However, given the severity of illnesses like psychotic depression, patients may not be able to give informed consent. Where possible medication can and should be used. Sometimes psychiatrists cannot wait for a response to medication. Or there may be circumstances when medication is ineffective or produces too many side effects. Without an adequate alternative, and as long as there are safeguards and strict monitoring of ECT, it is right that very ill psychiatric patients should be able to receive this effective yet controversial treatment.

I am grateful to Dr Adrian Treloar (Consultant Psychiatrist for Older Adults, Oxleas NHS Trust) for his helpful suggestions and comments on this article.

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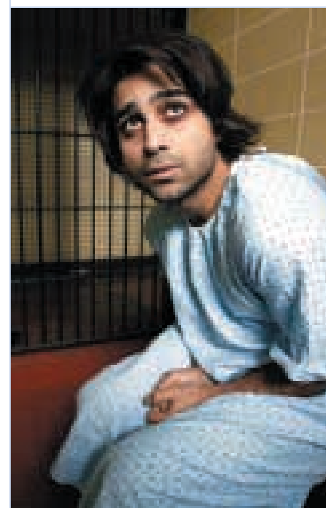

ECT is an effective treatment when used for the right reasons

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Anne Carus introduces an ethical, less invasive approach to fertility support

NaPro TECHNOLOGY

key points

NaPro Technology is a new women's health science that works co-operatively with individual women's ovarian cycles, with the aim of enhancing fertility. Blood tests and documentation of a woman's ovulation signs are the main stays of the technology, along with appropriately timed intercourse. Drugs – such as hCG and clomifene – are sometimes employed to enhance deficient phases of the ovarian cycle.

Originally devised from the science behind modern-day natural family planning, NaPro technology is particularly suitable for couples who find IVF unacceptable. Its strength lies in maximising a couple's chance of conceiving a viable pregnancy without recourse to procedures that are ethically unacceptable (such as embryo wastage) or that some believe violate the marriage bond (such as gamete donation).

Many subfertile couples have reservations about IVF. Some have concerns about the creation, manipulation, selection and disposal of early human life. Others worry about the strain that IVF could produce in their relationship, and dislike the idea of separating the unitive and procreative aspects of sex. Still others are concerned that using donor gametes violates the marriage bond. Ideally, these couples would like an approach that respects the status of the embryo whilst supporting the integrity of both the emotional and physical aspects of marriage. For some of these couples, Natural Procreative Technology could be an acceptable option.

Family planning to infertility treatments

Natural Procreative Technology (NaProTechnology) evolved from a Catholic gynaecologist's efforts to adapt Natural Family Planning (NFP) to 'difficult' groups of women – those who are breastfeeding, have long cycles or are peri-menopausal. Using the Billings Ovulation Method (where a woman detects her own fertility pattern by noticing changes in her cervical mucus) as a baseline, standardizing those observations and documenting other fertility biomarkers such as menstrual flow on a chart, the Fertility*Care* system for NFP was devised.[1,2]

But on reviewing the charts of couples who had subsequently failed to conceive when they wished, significant differences were noted compared with charts of normally fertile couples. Further research on these subfertile couples illustrated statistically significant differences of oestradiol and progesterone levels.

This system of accurate cycle charting provides the basis for NaProTechnology: 'A new women's health science which has as its main principle the ability to work co-operatively with a woman's menstrual and fertility cycles'.[3]

Starting out

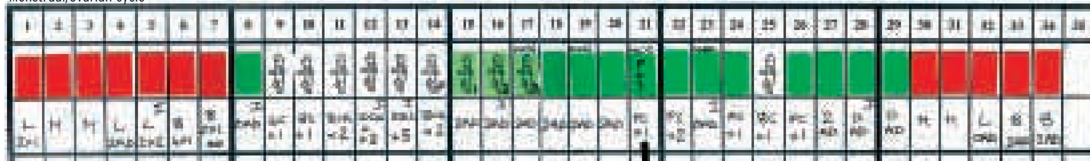
Couples come from various reproductive backgrounds, with regular or irregular cycles. Minimum conditions for natural conception must exist: one patent fallopian tube, an acceptable seminal fluid analysis, and regular intercourse. Baseline investigations include day three FSH, LH and prolactin. If pelvic pathology is suspected, GPs are often willing to refer to NHS gynaecologists who are supportive of our approach.

Charting

Charting is taught in a supportive environment to build confidence and accuracy, and husbands are encouraged to be actively involved. Couples are taught a standardised method of observing all cycle markers and recording cervical mucus.[4] This information is not gathered in standard approaches to infertility investigation. The variations between women in cycle observations and the comparison in the same woman between cycles hold valuable clues in assisting diagnosis and monitoring response to treatment.

Advice about strategies to improve mucus, such as hydration and stress management, is given. Sometimes charting is all that is needed: some

Menstrual/ovarian cycle



FertilityCare Chart
The adjacent chart shows a 29 day cycle, menses and cervical mucus quality, luteal phase length of 15 days, timing of HCG luteal support and timed luteal phase oestradiol and progesterone levels to monitor medication response. Charts can also be used to time follicular tracking.

couples on the programme conceive after interpreting their individual subfertility record and using potentially fertile days for regular intercourse, a process termed Fertility Focused Intercourse (FFI).[5]

Hormonal support

If a couple's chart and tests suggest that ovarian follicles aren't developing or rupturing well, clomifene can be employed to improve follicular function. Better mucus quality can accompany improved ovulatory function. Hormonal deficiencies following ovulation, in the luteal phase, are improved with hCG injections or natural progesterone. Crucially all medication is timed to the charted events of each cycle to optimise function.

Reassessment

Once hormonally effective cycles are established, a couple's chart is reassessed.

Timescales

Couples are advised to utilise a minimum of twelve effective cycles. Treating beyond 18 cycles is unlikely to be successful. Couples are reviewed regularly and have monthly contact with their teacher, which also assists them in developing relationship skills as many are under great stress. Obtaining spiritual support from church and prayer groups is encouraged.

British programme

A British NaProTechnology programme is run from Liverpool. Forty percent of couples are Catholics, and the rest are of other faiths or none. A small percentage has previously had unsuccessful IVF.

The cost for twelve effective treatment cycles is around £1,500. This practically takes 18 to 24 months. Although expensive in terms of the required commitment, it is more cost-effective than IVF.

In Britain, over seven years, 164 couples (average age 36) with medically defined infertility (two thirds primary) have gone on to complete up to a year of treatment. Despite a miscarriage rate of around 20 percent, a take home baby rate of around 25 percent (all singletons) per programme has been achieved.

Farther afield

The Republic of Ireland programme has a twin pregnancy rate of 3.4% with no higher order pregnancies.[6] And a large international prospective study is currently investigating NaProTechnology outcomes in detail.

At the end of the day

Every infertility programme should consider its impact on couples who, at the end of the day, do not conceive. In addition to an improved understanding of the issues contributing to their failure to conceive, some couples have identified other benefits.

Follicular and luteal variations

Progesterone and oestrogen levels are taken mid-luteal phase, seven days after last peak-type cervical mucus (the Peak day) *rather than* conventionally seven days before next predicted period. Hormonal and ultrasound studies confirm a close correlation between the Peak day and ovulation.[6,7] A 'window of fertility' surrounds this day.[8] Further hormonal investigations may be performed: pre-ovulatory oestradiols, luteal phase oestradiol, and progesterone profiles taken three, five, seven, nine and eleven days after the Peak day. Differentiation is made between early and late luteal phase deficiency, or sub-optimal oestradiol and progesterone production across the luteal phase. Some follicles don't rupture but do luteinize; others persist as follicular cysts. They may be small or have poor hormonal function, with subsequent poor corpus luteal function, resulting in reduced fertility and increased miscarriage risk.

Luteal support

Poor luteogenesis may respond to timed low dose hCG, to support each suboptimal corpus luteum. Subsequent assessment of adequate response is undertaken. Combining this approach with FFI, couples have conceived who have previously tried clomifene ovarian stimulation without success.

Follicular stimulation

Theoretically, poor luteogenesis may exist alone or may follow poor folliculogenesis. If luteal support alone does not produce hormonally effective cycles, then follicular phase support is added, usually with low doses of clomifene with the aim of achieving monofollicular, hormonally effective cycles. Couples are regularly reminded of this both before and during treatment as this is substantially different to other fertility treatments. Even in couples who have been through unsuccessful IVF, successful conception has followed mild ovarian stimulation, luteal phase support and regular FFI.[9]

...helped us move from a point of frustration and confusion to a point of acceptance we could not have reached alone. (Couple with secondary infertility for six years)

Assisted reproductive technologies will continue to develop and be available for couples who feel them appropriate. However, the medical profession could be accused of not providing for the smaller group of subfertile couples for whom an ethical route is paramount. NaProTechnology could fill that void and indeed provide a possible cost-effective option for any sub-fertile couple.

***Anne Carus** is a physician in NaProTechnology in Liverpool*

Photo: Wellcome

A new women's health science which has as its main principle the ability to work co-operatively with a woman's menstrual and fertility cycles

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Four-hour **target**

The government target, that patients should not wait more than four hours in the Accident and Emergency Department before admission or discharge, has created great controversy. Does the four-hour rule just create extra stress and a distortion of clinical priorities or is it actually improving patient care? **Verona Beckles** and **Stephen Nash** give two different views on a divisive issue.

About to breach

Verona Beckles advocates prayer, planning, prioritising and, if necessary, politics

'It's just that she's about to breach!' How many times have you heard that line down the phone? Recently, during a week of days on call, I planned to count the number of times this familiar phrase came my way; after a couple of days, I lost count and gave up.

How do you respond when someone says that to you? Perhaps, like me, you almost bite your tongue off rather than sound annoyed. Or maybe you sulk and go round muttering like Muttley from Wacky Races! Should you protest? After all it's not your fault that she was referred three and three quarter hours after she arrived in A&E. Or are you resigned to the fact that four hours is the government's target and none of us would want our granny lying on a trolley for a minute longer than necessary? Perhaps you drop everything, dash down to A&E and see the patient.

She doesn't need admitting. What next? Do you join in the white lies by discharging her off the computer before she's got her clothes on, or before you've finished her GP letter? Or maybe you get down there, only to find that the admission decision has been taken out of your hands – the A&E registrar has fast-tracked to the ward! It can be really frustrating!

As Christian juniors, how should we manage this aspect of the day-to-day grind at the coalface?

Prayer

Ask God for help at the beginning of every day and throughout the day. He knows exactly what we

The other side of the coin

Stephen Nash argues for patience, constructive criticism and grasping the big picture

Back in 1993, I returned from the mission field and became an A&E consultant in a London teaching hospital. I was utterly appalled: daily press scandals, huge waits for beds and unbelievable A&E overcrowding with patients littered everywhere. Staff morale was rock bottom, patients weren't receiving good care, relatives were frustrated, and managers were impotent.

Why waits went up and care went down

- Reducing numbers of hospital beds
- More A&E patients but no more staff
- Poor A&E and hospital management
- Culturally accepted norm of long waits
- Out-of-date patient processing systems
- Slow access to investigations

A large plan

In the year 2000 *The NHS Plan*, with its promise of a maximum four hours' wait in A&E, was a central part of Labour's election manifesto.[6] So, having won a second term on the strength of it, they needed to deliver the goods. The public were getting impatient: drastic action was necessary or they would not get a third term in office.

Many things were tried and a stressful time followed for everyone concerned. 'Data sanitisation' occurred in many hospitals and Trusts got creative in order to get round the definition of a breach. Beds replaced trolleys, areas of A&E were relabelled 'wards', and decision to admit times were deliberately delayed to buy time. It was a scandal.

If you can do it once...

In March 2003 there was a two-week period when every Trust had to demonstrate the effectiveness of all the investments and efforts made so far. Although so many Trusts said it was impossible, most did achieve the target of 95 percent of patients seen and discharged or admitted within four hours! So how did the government respond? Predictably: if you can do it for two weeks, then you can do it all the time! This four-hour target became the government's top priority, and this was forced down to chief executives and onto managers, doctors and nurses. There was a lot of complaining but finally A&E waits were taken seriously.

All this worked very much to the advantage of A&E departments but there was much bullying, harassment and unreasonable pressure. However, after five years or more of sustained effort, I think the

need, and what our patients' real problems are. He is our provider God who carries us through the day.[1] Jesus too only had a few moments with his patients but still, divinely, he managed to get straight to the root of their problems.[2] And what about those in authority over us? We should pray for them and, when possible, obey them.[3]

Planning and prioritising

We all vary in how well organised we are at work. Have a long, hard think. Are you as organised as possible? Do you delegate whenever appropriate, for example using the emergency department technicians and anyone else who's around? Are you a team player and do your on-call team truly operate as a team?

How do you prioritise your patients? My tip is to find out what time each referred patient arrived in A&E and to ask where they will be. This way I can strike a balance between those who are sickest and those I must aim to see within the target. And when you are tied up with these more urgent patients, do get someone else to answer your bleep, and keep your team in the loop.

More senior juniors need to learn how to reallocate resources: follow Christ's example and ensure that everyone takes a break and has a meal.[4] It will certainly mark you out from other registrars!

Politics

It's so tempting to tap into and feed the continual moaning and groaning that prevails in the Mess Room. But we are urged to do everything without complaining.[5] So instead, why not repent of our apathy and turn our valid criticisms of the system into positive steps for change? There are many ways of helping to make Christian values an integral part of your hospital's ethos. Yes, a lot of Christian juniors do suffer from that deadly disease of busyness, but medical politics is a great way of getting your voice valued and heard. Pass on your concerns to your hospital juniors, BMA rep. Go one step further and get yourself elected onto a local policy making committee. Or dive in at the deep end by getting involved with the BMA yourself!

Verona Beckles *is Senior trauma and orthopaedic SHO in Barnet*

government just lost patience and decided enough was enough: 'Stop complaining! Just do it! We will help but you must do it!'

Whilst I do not applaud or approve of such behaviour, I do believe that there was no other way. The resistance to change was just too enormous. And as in war, drastic situations call for drastic solutions.

Every Trust had to participate in a programme that focused on minors, majors and the specialities. All our processes were reviewed. Good ideas were shared. A huge focus was made on A&E itself but a whole system approach was adopted. There just isn't enough space to describe all the changes.

Success at last?

I will never forget arriving at work one morning in May 2003. For several weeks we hadn't had any overnighters (that is, patients waiting overnight on a trolley for a bed the following day). The nurses were laughing and joking. It was a delight to come to work. The sun had finally come out.

It had worked. Yes, new problems were created but at last the problems in A&E became everyone's problem. Yes there were financial incentives but I don't believe they were the main reason for departments achieving the target. Rather I think it was the fear of not achieving and the consequences that would follow. Chief executives were under so much strain and this pressure was transmitted vertically downwards directly onto A&E and the various specialities.

Constructive not destructive criticism

Yes there are mistakes but I would emphasise that these are exceptions to the rule. The odd patient is admitted unstabilised and incompletely evaluated. Usually this causes uproar and is used as an excuse to rubbish the four-hour target. But what about all the correctly admitted patients? Without the target, most of these patients would still be on A&E trolleys, and the post-take ward round team would still be seeing patients in the A&E corridors. Such response to mistakes is not healthy. Instead we should be asking more constructive questions. Why wasn't this particular patient stabilised prior to transfer? Why wasn't the speciality doctor able to get down to A&E? Why were the investigations incomplete? And why did A&E refer so late? We should address problems regarding individual patients fairly and squarely, rather than using these incidents as excuses to rubbish the target.

Moving on

Now in 2006, there has been so much focus for so long on the four-hour target that I believe we have been neglecting the patient. We must move on and focus on providing excellent quality in four hours.

Stephen Nash *is a Consultant in Emergency Medicine in Kent, Executive Member of the British Association for Emergency Medicine and Chair of Clinical Effectiveness Committee*

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testimony

Jeremy Franklin looks back on a memorable patient

The invitation

One of the best things about working in the same practice for many years is the fact that some of your patients become your friends. Conversely, people you originally knew as fellow neighbours and churchgoers eventually turn up in your consulting room. This presents interesting challenges to the traditional doctor-patient professional-personal boundary line.

William, who was both my patient and a fiercely competitive squash partner, asked me to have a look at a skin lesion. I was able to reassure him: 'Nothing to worry about!' I decided to take the plunge: 'But while you are here, William, would you like to come to a dinner next Monday? There will be at least two people sharing how putting their faith in Christ has changed their lives for the better'.

What would he say? William was director of our local greyhound stadium. He and his family lived a completely secular life. Still, although he looked a bit shocked and surprised, William accepted my invitation!

Unseen difficulties

What I did not know then was that his marriage was in severe difficulties. His wife Pauline was very depressed and had also developed agoraphobia. A few months before, to make matters worse, she had become convinced that her home was haunted. She had found others prepared to agree with her on this and the family had only recently moved in order to escape the ghosts. But, Pauline had decided that this new home was haunted as well!

Although Pauline was seeing a psychiatrist and taking anti-depressants, anxiolytics and hypnotics, life for the couple was unbearable and their marriage was breaking down. At the time of my invitation, William had decided to give up his job, sell up his home and move away in an attempt to save his marriage.

Pauline was not pleased by my invitation. She thought it was a ploy for William to avoid spending time with her; certainly she wasn't going to attend. And on the morning of the dinner, she broke down in tears and decided to pack her bags and leave.

Dramatic turnaround

When William arrived at the dinner, he was shocked to find Pauline there! Moreover, she'd driven 40 miles to attend, more than she'd managed for months. They both listened attentively to the speaker, whose message spoke to Pauline's heart: 'There is someone present here who is at the end of their tether, but not to worry, as this is not the end, rather that Jesus will provide a new beginning'. Pauline grasped at this hope that she might have a future after all.

A lady sitting next to her explained the Gospel to her in more detail and that night Pauline committed her life to Christ. A miracle occurred, and within a few days William recalls that a person he had not seen for over two years returned. Pauline was able to stop all her medication. Although shocked and surprised, her psychiatrist said that these 'cures' sometimes happened and not to be too disappointed when the inevitable relapse into depression occurred.

William was struck with awe. From facing total disaster in his marriage, he had quite suddenly found new hope. 'What has happened?' Quite simply, he had been confronted with the power of the living Lord. He too humbled himself and knelt down to receive the Saviour who had so wonderfully demonstrated his love for him, by changing his wife and saving his marriage.

Together they both joined a church and began serving the Lord with joy. As for their family: their sons, mothers, and several other family members subsequently came to faith, as did William's secretary.

Twenty years on

Today their marriage is going strong and Pauline's depression has yet to return! William still works at the greyhound stadium and is continually confronted with the commercial, ethical and moral problems of business life. But the difference is that the Lord is with him.

***Jeremy Franklin** is CMF Pastoral Secretary and a retired GP in London*

A firm foundation

The Bible is clear: our Lord requires us to be ready to explain our faith to anyone who asks us.[1] And, going one step further, we should sometimes consider taking the initiative ourselves. For the Apostle Paul asks, 'How can they believe in the one of whom they have not heard?'[2] As Christian GPs, we need to be prepared to explain the Gospel to all non-believers, whether they are friends, patients or, like William, both.

But when it comes to the view taken by our professional ruling body, are we standing on shaky ground?

*The Council has hitherto taken the view that the **profession of personal opinions or faith is not of itself improper** and that the Council could intervene only where there was evidence that a doctor had failed to provide an adequate standard of care. The Committee supported that policy and concluded that **it would not be right to try to prevent doctors from expressing their personal religious, political or other views to patients.** It was agreed, however, that doctors who caused patients distress by the **inappropriate or insensitive expression** of their religious, political or other personal views would not be providing the considerate care which patients are entitled to expect.*[3] *(emphasis ours)*

Clearly we need to be avoid such inappropriate or insensitive expressions of our faith, but we should be reassured that it is permissible to share Christ with our patients.

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Legal challenge on Christ's existence

An Italian court has decided, after a long drawn out legal battle, that Catholic priest Enrico Righi will not have to prove in court Christ's historical existence. The priest was taken to court in September 2002 after he criticised Luido Cascioli's atheist book *The Fable of Christ* in a local Catholic paper. (*Brussels Journal* 2006; February)

US Supreme Court to review 'partial birth abortion' law

The US Supreme Court has agreed to hear the government's appeal of lower court rulings that prevented enforcement of a federal law banning 'partial birth abortion'. The court will hear arguments on the appeal in October. Abortion became legal in the US with the Supreme Court's Roe v Wade decision in 1973. Congress passed the law banning partial birth abortion in November 2003, and it was signed by President George Bush (*BMJ* 2003;327:1009). It has never come into effect because three lower federal courts ruled the law unconstitutional and unenforceable because it does not include an exception to protect the health of the woman. Meanwhile the state of South Dakota has voted to ban all abortion other than to save the life of the mother. (*BBC News* 2006; 7 March)

Hewitt opposes abortion changes

Health Secretary Patricia Hewitt has said she is not in favour of introducing tougher UK abortion laws. She said she was against reducing the 24-week limit, but wanted to try to cut the number of late terminations. Her comments came after a survey in the *Observer* suggested that 47% of UK women wanted tougher abortion laws. Pro-life campaigners welcomed the results of the survey of 1,790 adults, but pro-abortion groups say women need access to late abortions. (*BBC News* 2006; 29 January)

Medics keep the faith

Some 61 per cent of GPs and more than half of consultants believe in God, a survey for *Doctor* (10 January) has revealed. But it seems the message is not getting through to NHS Trust managers. *The Times* notes that *Nursing Standard* reports the laying-off or shortened hours of hospital chaplains in NHS cost-cutting measures. Carol English, a professional officer for the Amicus union, says trusts see chaplains as a 'soft touch'. (*The Times* 2006; 17 January)

Euthanasia 'extremely rare in UK'

Euthanasia is extremely rare in the UK and few doctors want to see it legalised, a study says. Pro-euthanasia campaigners have long argued terminally-ill patients are helped to die in secret. But fewer than 1% of deaths were by euthanasia in 2004 and few doctors want to see the law change, the Brunel University survey of 857 doctors found. (*BBC News* 2006; 17 January)

Racial and Religious Hatred Bill

The Government's defeat (by one vote!) over key amendments to the Racial and Religious Hatred Bill ensures that the offence of inciting religious hatred has to be intentional and specifies that proselytising, discussion, criticism, insult, abuse and ridicule of religious belief or religious practice will not be an offence. Without Christians' protests and God's provision the vote would have been lost. (*Evangelical Alliance* 2006; February)

Britons choose assisted suicide

Retired Bath doctor Anne Turner, 66, is the latest in a line of Britons choosing to end their life with the assistance of the Dignitas clinic in Switzerland. The controversial charity says it has now helped more than 40 people from the UK to commit suicide. The first, in January 2003, was Reginald Crew. (*BBC News* 2006; 24 January)

Calling a spade a spade

The *Daily Telegraph* has given a frosty welcome to the Voluntary Euthanasia Society (VES) rebranding itself as 'Dignity in Dying'. In a short editorial titled 'Euthanasia's euphemism' it states, 'It tells you something when an organisation has to refer to itself by a euphemism. Who among us does not want to die with dignity? Every hospital, hospice and care home does its best to ease our transit to that undiscovered country from whose bourn no traveller returns. Many campaigning groups play these silly verbal games, of course: Friends of the Earth, Women Against Rape, Liberty. There is even a unilateralist group called the Movement for the Preservation of Life on Earth (which the rest of us, by implication, are against). In this case, though, it is hard to shake off the suspicion that euthanasiasts are shy of spelling out what they are really about, viz killing people.' (*Daily Telegraph* 2006; 23 January)

Making babies

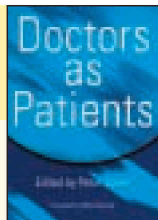
'The choices for couples having children – or for those who are concerned about the possible genetic consequences if they do – have increased dramatically in recent years – but these advances need to be carefully monitored. The possibility of deliberately creating 'designer babies' – children genetically engineered for their good looks, intelligence or sporting abilities are not on the horizon – and may never be because of the complex nature of our genetic make-up.' These are two of the conclusions of the Human Genetics Commission's report 'Making Babies: reproductive decisions and genetic technologies' published on 31 January following a national consultation exercise. (*BBC News* 2006; 31 January; HGC, *www.hgc.gov.uk*)

New powers over death considered

Government ministers are considering plans to let adults appoint someone who could block life-sustaining treatment if they were too ill to do so themselves. The *Mental Capacity Act*, which comes into force in Spring 2007, gives people the chance to appoint someone who can instruct a doctor on their behalf. Under plans to implement the Act, they would need to indicate if this included powers to refuse life-sustaining care. But critics have said the proposals amount to 'back-door euthanasia'. (*BBC News* 2006; 30 January; DCA, *www.dca.gov.uk*)

Therapy for fatal nerve disease

A simple ventilator and facemask could extend the life of motor neurone disease patients, research suggests. A team from the University of Newcastle-upon-Tyne found quality of life was improved, and life expectancy boosted, in some cases by years. MND, an incurable disease of the nervous system, is fatal within 14 months of diagnosis in 50% of cases. Details are published in the journal *Lancet Neurology*. (*BBC News* 2006; 23 January)



Doctors as Patients

Petre Jones

- Radcliffe 2005
- £24.95 Pb 216pp
- ISBN 1 85775 8870

This is a courageous and overdue book written by doctors with mental illness. All look back over their illnesses and describe their experiences with remarkable honesty and clarity. Following diagnosis and treatment, most of them continue to practice, some with knowledge of the cyclical nature of the illness with which they have to contend.

Jones, a major contributor himself, has done an excellent job of making a coherent whole from twenty-four contributors. All are members of the *Doctors Support Network*, a secular self-help group for doctors with mental health problems (*www.dsn.org.uk*). Thirteen of them have bravely written under their own names and revealed their field of work.

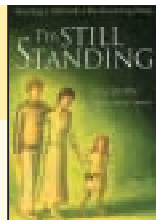
In Part One, they tell their own stories, out of which Part Two 'What It's Like' is culled. Unsurprisingly, the first chapter in this section discusses stigma and discrimination. I suspect it will make uncomfortable reading for those of us prepared to recognise our lingering, deeply ingrained prejudices. The relevant chapters of this section should certainly be read by everyone who comes into contact with, or has to make career and financial decisions affecting, doctors who are also patients. This chapter should be read by every member of the General Medical Council (GMC), especially as its function is under scrutiny for other reasons. The NHS might improve if managers and politicians also took on board some of the experiences and reflections recounted in this useful book.

uncomfortable reading for those of us prepared to recognise our lingering, deeply ingrained prejudices

Part Three 'Dealing with It' has practical advice on dealing with sick doctors for doctors as patients, for medical staff treating them, for colleagues, Occupational Health Services, and the GMC. The final chapter on resources is well set out and likely to be useful for sick doctors, and for those helping them in any capacity. An unusual feature of this book is the inclusion of poetry; sometimes nothing else adequately describes the largely indescribable.

The book can be read straight through, for it is well thought out, or parts can be cherry-picked from the contents, index, or the clearly boxed summaries at the end of many chapters. These boxed summaries, which also occur elsewhere, would be a good place to start for those simply wanting an overview of this neglected subject.

***Ruth Fowke** is a Retired Consultant Psychiatrist*



I'm Still Standing

Parenting a child with a life threatening illness

Jan Burn

- Bible Reading Fellowship 2005
- £5.99 Pb 95 pp
- ISBN: 1 84101 3498

This book offers unusual insights into what it means to have a child whose life-threatening illness has abated but has not necessarily gone for good. In this it is an unexpected addition to the many other books available that deal with terminal illness in childhood, or the long term care of a child with congenital disabilities. It is more a book to help in the ongoing haul of coping with the relapses and remissions of disease rather than one to read at the time of onset, although some parents could find that the emotions described are comparable to their own, or be grateful for a little forewarning.

Jan and James Burn, both pastors, have three children. This is the inside story of their painful progress since 1993 when family life became dominated by the management of seven-year-old David's malignant renal tumour. They embarked on a switchback of remission and relapse, relief and dread, plans unfulfilled and side effects unforeseen. Remarks by Christian friends were not always helpful.

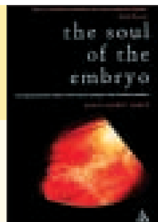
As she watched David's suffering, Jan often felt powerless, exhausted and isolated in her own pain. Emotionally drained, it was a struggle to support all three children and to maintain some normality. An abnormal blood count might put a stop to a long anticipated treat. Exhaustion made it easy to skimp time or explanation for the other children, or to excuse the sick child's unacceptable behaviour but not theirs. David's father once had to remind him that the doctors had taken his kidney, not his manners, and he needed to apologise - which he did, strangely comforted by familiar rules in a world otherwise out of control. Marriage partners, too, need hard-to-find time to stay tuned, perhaps with differences of attitude to resolve as they support each other.

Jan Burn tells us honestly how awful all this has been. Aware that medical care saved David's life, she also saw his confidence and cooperation rocked when staff failed to treat him respectfully and truthfully. She emphasises the need for attentive listening by all concerned. There are other helpful passages on learning to be flexible, to forgive, to be freed from the guilt of feeling responsible for the illness and coping with all the related uncertainties. One of the hardest things still is to avoid overprotection of all three children, and to overlook their emerging independence in the twelve years since diagnosis.

The shadow remains, as recurrence is still not ruled out, but it is clear that the whole experience has been a journey into deeper faith and trust in God. Strategically placed and highly relevant Bible verses reveal where strength can be found to enable other affected families to stand up to all these stresses.

This little book fills a niche not adequately filled before, and is a must not only for parents in similar circumstances but for their medical and pastoral caregivers.

***Janet Goodall** is an Emeritus Paediatrician in Stoke on Trent*



The Soul of the Embryo
David Albert Jones

- London: Continuum 2004
- £16.99 256 pb
- ISBN 0 8264 62960

The Soul of the Embryo begins by considering the account of creation in the Hebrew Scriptures. It then considers the largely mistaken but nevertheless influential foundations of Western thinking about embryology as laid down by Hippocrates and Aristotle. The widespread and approved practices of abortion and infanticide in ancient Greek and Roman societies are contrasted with their condemnation by rabbinic Judaism.

The book analyses the development of Christian reflection on the nature of the soul. Despite the fact that St Augustine was influenced by Plato and St Thomas Aquinas by Aristotle, both of these Christian thinkers agreed that the soul was naturally related to the body as the principle of life and that in the separated state the soul was incomplete until bodily resurrection. As for the origin of the soul, the dominant view of Catholic Christians from the fifth century has been that the soul is immediately created by God and is infused into the new human being. And as for the timing of ensoulment, although the earliest Christians appeared to have dated it from conception, in the Middle Ages the view that ensoulment took place at formation was dominant.

Two later developments led to a questioning of the belief that the soul was infused by God at formation. The first was the theological revolution of the Reformation, not least its questioning of medieval Aristotelianism. The second was the scientific revolution in the seventeenth century, which reshaped embryology as it did the other natural sciences.

The book proceeds to consider the development of the Catholic casuistical tradition concerning abortion, which focused on the question whether abortion to save the life of the mother was ethical. A minority opinion that such abortion was justified before ensoulment did not prevail.

The book later turns to the historical development of the criminal law on abortion. It notes the influence of the notion of delayed ensoulment on the common law's prohibition of abortion only after 'quickening'; of improved embryological knowledge on the tightening of the law in the nineteenth century to protect life from conception; and of the recharacterisation of abortion by many (including some Christians) as an act of compassion for the mother which helped account for the relaxation of the law by the Abortion Act 1967.

The final chapter of the book pulls together conclusions from the various disciplines that inform the book's examination of the status of the embryo: theology, philosophy, ethics, science and law. Jones concludes that the tradition's 'enduring desire to protect the human embryo' has been extraordinarily constant through two millennia of Christian thought and practice.

Archbishop Rowan Williams describes the book as 'a valuable contribution to a most important debate'. Quite so. It is to be highly recommended.

Adapted with permission from a Tablet review by ***John Keown****, Rose Kennedy Professor of Christian Ethics at Georgetown University*

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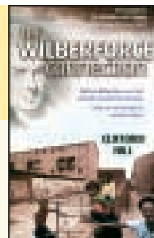

The Wilberforce Connection
Clifford Hill

- Lion Hudson 2004
- £9.99 380 pages Pb
- ISBN 1 85424 6712

A culture of gross drunkenness and violence, a civic life with rising crime and corruption, a society marred by social dislocation and sexual immorality, a church confused, divided and ineffectual – this is 21st century Britain – but also a picture of late 18th century Georgian England, where a small group of Christian men and women succeeded in transforming their society.

Hill opens his book with pen pictures of the main characters within an effective, campaigning, Christian community that was to be known as the 'Clapham Sect'. They worked not only to abolish slavery but also in Wilberforce's words 'to make goodness fashionable'. They succeeded in catalysing major social reform and in establishing the modern missionary movement. He outlines how their deep evangelical Christian faith impelled them both to seek the spiritual salvation of their fellow men and to work for their social and physical well-being.

This is a wide-ranging book, which looks at the social, economic, and religious roots of a deeply divided eighteenth century society and details how the Clapham group achieved massive change in the face of considerable political and social opposition. More disturbingly Hill outlines how Britain has frittered away the spiritual and social capital of the last two hundred years to reach our current morally and spiritually destitute society. His chapters on church history, which help explain the churches' weakness in rising to the challenge of secular humanism in the eighteenth century and to the challenge of post-modernism in the 21st, are particularly enlightening. He pulls no punches –you will be challenged to consider which aspects of your church history and church culture undermine your ability to be salt and light in modern society!

This is a readable, informative and well referenced book which will challenge you to reflect on how your life can make a difference.

The Clapham Saints were a mixture of scientists, businessmen, lawyers, politicians and churchmen who worked together and worshipped together, dedicating their money, time and talents to build the Kingdom of God. Hill's final challenge is to consider how we can do the same in our institutions (such as hospitals and the NHS) and how the church needs to change to equip us to do so. The book cites CMF as an example of how Christians can work together and encourage each other in bringing the Kingdom of God into the institutional workplace. As Rowan Williams concludes in his preface, 'Hill challenges us to take seriously … how holiness can become compellingly attractive and transforming in a society'.

Buy it, read it, respond to it.

Nick Land *is Deputy Medical Director, Tees and North East Yorkshire NHS Trust*

news from abroad

Well done INF!

A recent article in the magazine of the International Nepal Fellowship (INF) highlights the work being done by their medical camps programme, which has been running since 1993 and has involved a number of CMF members. The camps involve small teams of Nepali staff and expatriate volunteers, Consultants and GPs. They usually run for 1 – 2 weeks. Over 50,000 patients have been seen and 3,800 operations performed between February 2003 and October 2005.

Teams planned for later in 2006 have yet to be confirmed but include the possibilities of:

- September – Plastic Surgery
- October – Gynaecological
- October/November – ENT
- November/December – General Surgery

For further information, contact INF via their website at www.inf.org

CMF Capacity Building Trips - two possible trips in the pipeline

Ian Spillman, Paediatrician and member of our *HealthServe* Committee is exploring the possibility of taking a group on a two-week trip to southern Uganda. The group would be based at Kisiizi Hospital. If you are interested in finding out more about mission work in an African country - whether GP, specialist or other healthcare professional – or would like to contribute your skills in a needy area, then please let me know.

John and Heather Knowles are likewise looking into the possibility of taking a similar group to Ekwendeni Hospital in northern Malawi.

The leaders of both trips have worked in the areas they are visiting and maintain contacts there. They have a wide experience and knowledge of medical mission work. We have members and associates currently working at each of these hospitals and in the surrounding areas. The exact programme for each trip will be determined, to a large extent, by the nature of the group that comes together. Dates have yet to be defined but the trips could take place later this year. We would like to receive expressions of interest to get some idea of the numbers and experience of those who would like to be involved.

Developing Health Course Oak Hill - 23 July – 4 August 2006

The 2006 programme should be up on the overseas website (*www.healthserve.org*) by the time you read this (as are application forms) and a printed, programme will be available from the Office. Please contact *laura.risdale@cmf.org.uk* for more information.

The course has been moved to later in July this year to avoid a clash with the Sydney ICMDA Conference. Several new speakers have been invited and new topics included and the continuing move to more interactive presentations continues. The programme has been arranged in such a way as to allow for applicants to attend for specific themed days that might be of interest to them.

Developing Health Course CD ROM 2006

A new edition of the CD-ROM of the Developing Health Course is planned for later in the year and editing is in hand. The CDs will contain presentations from the 2004/5 Developing Health Course and much else besides. Watch this space for more details.

Further news from Nigeria

Arising out of our involvement in the Developing Health Course held in Nigeria last year, we have been able to encourage our colleagues in the Nigerian CMDA by giving HealthServe grants to three of their members to help towards the cost of travel to India and meet up with colleagues in EMFI and EHA and to take part in a medical missions course run by EMFI. The Nigerian CMDA is moving ahead with plans for second DHC to be held this year.

A busy day?

In a recent prayer letter, one of our members working overseas described a busy Sunday on call

0700	Up to perform an emergency Caesarean section for prolonged labour
0800	Off to teach at Adult Sunday School class (asked colleague to do ward round) Followed by an evangelistic outreach meeting at the local prison
Midday	Called to deal with a botched abortion necessitating an emergency laparotomy and treatment of massive intra-peritoneal sepsis.
1600	Preached at church service
Late evening	called back to hospital to see heavily bleeding patient with Hydatidiform Mole, eventually needed to carry out an emergency hysterectomy.

All part of a day's work, following up the Lord's command to go into all the world to preach and heal!

Please continue to pray for our members working overseas around the world. A brief outline prayer diary is available from the office, on request.

Overseas Vacancies currently advertised on the Opportunities Pages of our overseas website (*www.healthserve.org*) include:

- Locum Obstetrician needed at LAMB Hospital, Bangladesh between April 2006 and January 2007 or any part of that time
- Health co-ordinator needed in Chad
- Doctors needed by International China Concern and the Jian Hua Foundation in China
- Orthopaedic Surgeon needed in Malawi
- General Surgeon at the Seventh Day Adventist Ile Ife Hospital in Nigeria
- Doctor for Rumginae Rural Hospital in Papua New Guinea
- Obstetrician/Gynaecologist to work as Outreach centre/Site co-ordinator at the Fistula Hospital in Addis Ababa
- Ophthalmologist needed in Yemen
- Also a number of openings with PRIME in a variety of countries

Peter Armon *is CMF Overseas Support Secretary*

Peter Armon on God's dream for nations, communities and us

Transformation

It doesn't take much to transform some situations. A simple slip on the wet grass - my leg broke and immediately life took on a new perspective, as even the simplest of tasks became a major exercise. Now, as I sit recovering at my bedroom window, I see another scene gradually transforming before my eyes: snowdrops, crocuses and daffodils begin to burst into flower, covering the bare earth with splashes of glorious colour.

I've just finished reading a book by Desmond Tutu, *God has a dream, a vision of hope for our time*.[1] The dream of transformation he describes seems a far cry from grim reality as portrayed on our television screens. We could be forgiven for thinking that the world is beyond such hope. Responding to our problems in the UK, Tony Blair is trying to transform our society with calls for more respect, a greater police presence and education system reform. Gordon Brown, meanwhile, dreams of making global poverty history. Yet, Bishop Tutu reminds us that God has a dream - a dream of transformation:

I have a dream, God says. Please help me to realise it. It is a dream of a world whose ugliness and squalor and poverty, its war and hostility, its greed and harsh competitiveness, its alienation and disharmony are changed into their glorious counterparts, when there will be more laughter, joy and peace, where there will be justice and goodness and compassion and love and caring and sharing. I have a dream that swords will be beaten into ploughshares and spears into pruning hooks, that my children will know that they are members of one family, the human family, God's family, my family.

Recalling his own experiences under the South African apartheid regime, Tutu remembers that transformation can occur in even the most oppressive circumstances. And although we sometimes have to wait a while, such regimes must fall because God made us for freedom.[2] Tutu has seen God honour his word.

I am reminded of a video I once saw that looked at the amazing ways in which whole neighbourhoods and towns around the world had been transformed by the gospel.[3] In each case, the changes began as local churches came together in renewed, right relationships that were living expressions of forgiveness, unity and reconciliation.

Transformation begins in the heart of God and involves the cross, itself a symbol of a cruel and oppressive regime. Lasting personal transformation can only happen if we come to the cross where Jesus died, acknowledge our sin, and surrender our lives to Christ's lordship.[4] It is a gradual process as God's Spirit works in us, transforming us into his likeness.[5] The more time we spend with someone, the more alike we become.[6] We need to offer our bodies to him and allow his word to penetrate and transform our minds. And as we ask him to create in us a clean heart and renew a right spirit within us, then we will find that he causes us to walk in his ways.[7] This process demands our active participation and collaboration. We need to put some things off and put other things on but he will renew our minds. As he does so, the transformation will take place and God's dream will become a reality.[8]

***Peter Armon** is CMF Overseas Support Secretary*

references

1. Tutu, D. *God has a Dream*. London: Rider and co, 2005
2. Habbakuk 2:3
3. *www.sentinelgroup.org/showing.asp*
4. Acts 4:12
5. 2 Corinthians 3:18
6. Romans 12:1-2
7. Psalm 51:10; Ezekiel 36:25-27
8. Ephesians 4:22-24

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