

TRIPLE HELIX

Summer 2000

For today's
Christian doctor

**PHYSICIAN
ASSISTED
SUICIDE**

**APPRAISAL,
GOVERNANCE,
REVALIDATION**

GAY SEX
The risks to health

**THE HIV
PANDEMIC**
Hope alongside
the despair

ABORTION
Changing public
attitudes?

**OVERSEAS
OPPORTUNITIES**

**NOT FOR
RESUSCITATION**
The ethical issues
at stake

CYBERDOC
Websites advising gays

Triple Helix is the quarterly journal of the **Christian Medical Fellowship**

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Physician Assisted Suicide

The British Medical Association, has rejected a motion attempting to tighten the association's policy on physician assisted suicide. At its annual representative meeting in London on 27 June delegates welcomed the conclusion of the 3-4 March BMA consensus conference^{1,2} to reject moves to change the law on physician assisted suicide, but rejected calls for this to be 'the settled opinion of the BMA for the foreseeable future'. Michael Wilks, BMA ethics committee chairman, said that in order to 'lead the debate' the association should not be 'tied to any one position'. The BMA's failure to give a clear signal is further evidence that growing numbers of its members, not least leading members of its ethical committee, are unsure whether it is wrong for doctors to help patients kill themselves.

Medical technology and palliative care have now advanced to a level where most people in this country are able to die comfortably.

However, on rare occasions, patients' fears about distressing symptoms and loss of dignity or control over death can prompt them to request help in committing suicide. These fears may be potentiated by depression or a false sense of worthlessness and are often heightened by anxiety about overzealous and inappropriate medical intervention.

As well as treating physical and psychosocial symptoms, doctors have a duty not to administer intrusive medical treatment when the burden of that treatment outweighs its therapeutic benefit. Neither should they give treatment forcibly to competent patients who refuse it, even if that treatment is life-saving.

However, while upholding respect for patient autonomy, doctors must never intentionally give their patients advice or the means to commit suicide, either directly or indirectly. Any law allowing physician assisted suicide would threaten the trust necessary for the doctor-patient relationship to function, place pressure on patients (whether real or imagined) to request early death, and introduce a slippery slope to voluntary and involuntary euthanasia. Such legislation would also be impossible to police, might well undermine the development of palliative care services and could lead to patients being pressured to request suicide for economic reasons by family, carers or society at large.

Human beings are made in the image of God,³ and belong to God.⁴ Only God has the right to take life – and the taking of innocent human life (even if the life is 'one's own') is always wrong regardless of the wishes, circumstances or motivations of those involved.⁵ In the same spirit the Hippocratic Oath enjoins that doctors 'give no deadly medicine to anyone if asked, nor suggest such counsel'. Despite the many changes in medicine these time-honoured values must be reaffirmed by the profession.

Accordingly, whilst as doctors we have a responsibility to provide appropriate treatment, palliation and support to patients who are suffering from distressing symptoms (whether in the context of terminal illness or not) – we must continue to resist any change in the law to allow physician assisted suicide.

Peter Saunders

CMF General Secretary and Managing Editor of Triple Helix

- 1 BMA Consensus Statement on Physician Assisted Suicide. web.bma.org.uk/public/pubother.nsf/webdocswwIPASConf
- 2 Physician assisted suicide: consensus reached on key issues. *BMJ* 2000; 320:946 (1 April)
- 3 Genesis 1:27, 9:5,6
- 4 Psalm 24:1
- 5 Exodus 20:13



BMA guidance endangers doctors

Doctors who act in accordance with the BMA guidance on Withholding and Withdrawing Life-prolonging Medical Treatment may be breaking the law according to the Scottish Deputy Minister for Community Care, Iain Gray. The BMA guidance, issued on 23 June 1999, condones the withdrawal of artificial nutrition or hydration from patients who have suffered a 'serious stroke or have severe dementia', providing a 'senior clinician' agrees. In a parliamentary debate on the Adults with Incapacity Bill, Mr Gray commented, 'To withdraw hydration and nutrition from a non-PVS patient with the purpose of hastening death would leave a medical practitioner open to criminal prosecution. Let us be clear about that.'¹ Despite this, the BMA, at its annual representative meeting on 27 June, has rejected a motion calling on the BMA Council 'to reconsider those parts of the guidance document... which are incompatible with Scottish Law'. The BMA, rather than reviewing its recommendations, seemingly prefers to have the courts decide whether doctors, in any particular instance, have gone too far. The General Medical Council has not yet given its opinion on the guidance.

Peter Saunders

- 1 Scottish Parliament Justice and Home Affairs Committee, 1 March 2000

Surrogacy fiasco

A lesbian couple from Hollywood have adopted twin girls in a transatlantic surrogacy fiasco involving six other adults. An Italian businessman and his Portuguese wife living in France had commissioned a British surrogate, Claire Austin, to have embryos, produced from the eggs and sperm of two strangers, implanted by a Greek doctor in Athens. On discovering that the twins were girls the couple cancelled their order and demanded an abortion. The surrogate located the adopting parents through a gay and lesbian agency.

Meanwhile Britain's first gay couple to father surrogate children are planning to have another baby. Tony Barlow and Barrie Drewitt, who spent £200,000 paying a Californian surrogate to carry their twins, have just spent a week with another American woman who has agreed to carry their next child.¹ These extreme cases are a poignant reminder that God had good reasons for instituting marriage as a life-long, heterosexual, monogamous relationship;² thereby providing a stable base for imparting wisdom to the next generation.³

Peter Saunders

- 1 *Evening Standard*, 8 & 31 May 2000
- 2 Genesis 2:24
- 3 Deuteronomy 5:6-9

Educating African Doctors: Showing how it can be done



Prof 'Rab' Mollans and students

It is shameful that about 45% of the people of sub-Saharan Africa live on less than one dollar a day, a proportion that has scarcely changed in the last eleven years, the very period when the structural adjustment programmes of the World Bank and the IMF should have been having some effect.

The loss of skilled people from Africa continues, whether in the overseas diaspora or into more lucrative private employment at home, so that training institutions find it hard to recruit staff and even harder to retain them. The difficulties seem insuperable and, even worse, they are now compounded by the HIV/AIDS epidemic.

Is this fair? Should it be allowed to pass unchallenged? Can not something be done? If the morale of countless health care workers in sub-Saharan Africa is to be strengthened, if their vision is to be enlarged, and if their hope is to be sustained, they must be given the opportunity to have continuing training and a chance to develop their skills. Then, they will be able to approach their work, not with despair and bewilderment, but with growing confidence, resourcefulness and effectiveness.

Eleven years ago a group of friends decided that we could indeed make a difference, however small: we therefore established the Tropical Health and Education Trust (THET); to relieve this disadvantage where we could, and to strengthen training for health care. Our policy is to work with those who are responsible for training health workers, for example the Dean or the Director of Nursing, and then to plan programmes, which are specifically designed to strengthen local training and meet local needs, over at least three and preferably five years.

We do not prescribe what should be done: rather, we respond to needs and requests. One of the best methods has been to link an overseas hospital or training school with a counterpart in the United Kingdom, and such links cover a wide range of subjects and staff. Other examples of our work include: continuing education for rural medical officers and support for psychiatric clinical officers in Uganda, students' field work and training of ophthalmic field workers in Ethiopia, training of medical officers for life saving surgery in Ghana, a students' prize for the best project report in seven countries, and support of a course for orthopaedic clinical officers in Malawi.

Many of these activities depend on the time and skills of short term visitors from the United Kingdom, who are often prepared to use their leave or give up holiday to share their skills and do something practical for those whose responsibilities are so great and yet whose opportunities are so slender. We have seen morale raised, skills strengthened and hope kindled. We're working to see more.

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Appraisal, governance, revalidation: nothing but aggro?

Every doctor in the UK is about to face unprecedented quality control under the processes in the title. What's going on? And how should Christians respond? Clinical governance is about quality in institutions and was recently defined' as 'a framework through which NHS organisations are accountable for the quality of their services and the



environment in which clinical care is given'¹. Similar systems will apply to the private sector and other non-NHS institutions.

Each individual doctor will have to maintain a folder, describing what they do and containing such evidence of performance as educational activity, audit, and the views of their patients. As part of an annual appraisal, another registered doctor will review this folder, identify problems, and make constructive remedial suggestions. Every five years there will be a more formal process of revalidation, based on these appraisals. Most will sail through but the tiny minority who are not automatically revalidated, or who refuse to take part, will be referred into the General Medical Council's fitness to practise procedures. No revalidation – no registration. No registration – no work as a doctor.

It sounds draconian, but the need for such an emphasis on quality was being identified long before high profile cases in the mid-1990s. Many are understandably sceptical and have concluded these processes are not the whole answer to deficiencies in the NHS: 'It is all very well to proclaim the merits of revalidation and of clinical governance, but most practising clinicians have little confidence that either of these projects, as yet unfunded and somewhat ill defined, will improve the lot of the patient, or indeed maintain confidence in the profession'.² For example, more resources and more improvements all round in attitudes might help. But the reality is, these changes will be here a year from now. So how should we respond?

Christians will play their full part because of respect for authority: 'Everyone must submit himself to the governing authorities, for there is no authority except that which God has established'.³ As with every aspect of their work, Christians should give this their best shot: 'Whatever you do, work at it with all your heart, as working for the Lord, not for men'.⁴ Christians of all people should support accountability: 'man is destined to die once, and after that to face judgment'⁵ and should care about the quality revealed at that ultimate audit: 'work will be shown for what it is, because the Day will bring it to light'.⁶

Let's pray about the quality of our medicine, practise as best we can, play a full part in the continuing consultations before the above becomes enacted in law - and let's start preparing those folders!

Andrew Fergusson

Andrew Fergusson is Head of Policy at the Centre for Bioethics and Public Policy, and an elected member of the General Medical Council

REFERENCES

- 1 Smith R. The GMC: where now? *BMJ* 2000; 320:1356 (20 May)
- 2 Toft A. Has humanity disappeared from the NHS? *BMJ* 2000; 320:1483 (27 May)
- 3 Romans 13:1
- 4 Colossians 3:23
- 5 Hebrews 9:27
- 6 1 Corinthians 3:13

In the light of 'Section 28',
Trevor Stammers looks
at the medical risks
involved in gay sex

Far from 'Philadelphia'

In perhaps the most moving scene in the film *Philadelphia*, Tom Hanks as Andrew Becket, a lawyer wrongfully dismissed from his job because he has AIDS, is in his flat discussing his case with his defence counsel, Joe. An opera is quietly playing in the background. Becket, suddenly caught up by the music, starts talking about it to Joe.

It's Maria Callas singing Maddalena's aria from Giordano's *Andrea Chenier* in which she describes how, during the French Revolution, her mother set fire to their home in order to prevent it falling into the hands of the revolutionaries. Becket, fighting the terminal stage of Kaposi's sarcoma and in obvious pain, translates Callas' words as he circles the room, clutching his drip stand: *'The place that cradled me is burning. Do you hear the heartache in her voice? Do you feel it, Joe? I bring sorrow to those who love me.'* Who could not but feel compassion for him and be moved by the bitter irony in the words he quotes?

The entire film evokes our sympathy and paints a very positive picture of homosexual life. Becket is portrayed as a kind, sensitive and highly successful man in a loving supportive relationship with his partner. His family adores him and unconditionally affirms his lifestyle. His gay friends clearly enjoy life to the full and certainly know how to throw a great party.

In contrast to this idyllic tolerance, anyone who attempts to raise awareness of the medical dangers of gay sex is by definition in today's society, a homophobic bigot. Doctors are not immune to the stigma associated with such stereotyping and additional tensions may result from their drawing attention to the dangers of

gay life. Homosexuals do often face both prejudice and hatred in our culture and articles like this are sometimes misused to fuel such intolerance. That is not its intent however. Health care workers also face misunderstanding by the gay and lesbian patients for whom they care. Yet highlighting the risks of gay sex does not mean doctors do not feel compassion for their gay patients, whom they should serve to the highest professional standards. The Christian doctor should always remember that Christ died for gay and straight alike and both depend absolutely on his mercy and forgiveness.

This said however, as teenagers and even younger children are no longer to be protected under the law from material promoting homosexuality, there is a greater need than ever to heighten awareness of its risks. Around a quarter of all 14-year-old boys are ambivalent about their sexual orientation. Most of them will not be homosexual as adults and they need to know about the dangers of engaging in anal sexual activity.¹

Gay advocates often object that it is promiscuity and specific sexual *behaviours*, whether homosexual or heterosexual, that present the risks. Some would even take the view that homosexual sex is actually safer since there is no chance of an unplanned pregnancy, but one cannot be complacent even here. One review cautions, 'Because lesbians often engage in sex with men, pregnancy prevention and diagnosis should not be overlooked'.²

However, though the adverse consequences of heterosexual sex do of course lead to an immense medical and social burden, sex

Section 28

Section 28 of the Local Government Act 1988

'(1) A local authority shall not -

- (a) intentionally promote homosexuality or publish material with the intention of promoting homosexuality
- (b) promote the teaching in any maintained school of the acceptability of homo-sexuality as a pretended family relationship.

(2) Nothing in subsection (1) above shall be taken to prohibit the doing of anything for the purpose of treating or preventing the spread of disease.'

Bible Passages on Homosexuality

Genesis 19:1-29
Leviticus 18:22; 20:13
Judges 19:1-30
Romans 1:24-27
1 Corinthians 6:9-11

Recent Legal Developments

On 7 February 2000 the House of Lords threw out Government plans to repeal Section 28 (page 6), which prevents public money from being spent on the promotion of homosexuality in schools and elsewhere. However, three days later, on 10 February, the Scottish Parliament first voted in favour of abolishing Section 28 in Scotland.

Also on 10 February, the House of Commons approved legislation to lower the age of consent for male homosexuals from 18 to 16. This ruling cannot now be changed by the Lords, and it will therefore become law automatically in England, Wales and Scotland later this year. (*Telegraph* 2000; 11 February)

On 21 June 2000 the Scottish Parliament endorsed its earlier decision by voting 99-17 to repeal Section 28 formally as part of the Ethical Standards in Public Life (Scotland) Bill. This was despite the campaign of Brian Souter, head of the Stagecoach transport firm, who spent an estimated £2million on 'Keep the Clause' campaign materials and a referendum which found that 87% of Scots who responded wanted to keep the law. (*Times* 2000; 22 June)

Moves continue to repeal Section 28 in England and Wales.

...HIGHLIGHTING THE RISKS OF GAY SEX DOES NOT MEAN DOCTORS DO NOT FEEL COMPASSION FOR THEIR GAY PATIENTS

between men involves particularly high specific risks. Furthermore, sexual orientation and sexual behaviours are intimately related. It is not likely that men engaging in straight sex or lesbians in gay sex will have ano-receptive intercourse for example. Finally, though promiscuity is all too prevalent in heterosexual relationships, the British survey on sexual attitudes and lifestyles (The Wellings Survey) nevertheless indicates that promiscuity is higher in gay relationships. In an interview with *The Independent*, the researchers comment: 'The proportion of homosexual men reporting ten or more partners within the past five years was 9.1% against 5.2% of heterosexual men. If we eliminate those who have not had partners for the past five years, the contrast is even more marked: 23.8% of homosexual men against 5.3% of heterosexuals. This calculation, it must be emphasised, is based on small numbers.'³

The most unequivocal indicator of the higher risk posed by sex between men is the fact that those who have engaged in it, even only once, are not ever allowed to donate blood in the UK. The National Blood Service advice states, 'You must not give blood if you are a man...who has *ever* had sex with another man'.⁴ The main reason for this prohibition is, of course, the high risk of transmission of AIDS. Sex between men was and is the major route of HIV infection in Britain.⁵ A recent review on HIV prevention estimates that 'the risk of contracting HIV from one sexual act may be around 1 in 1000 from penile - vaginal sex, and as much as 30 times higher for receptive penile-anal intercourse'.⁶

Gay advocates often point out that anal intercourse is not universally practised by gay men and is used by many heterosexuals. However a recent view concludes that among heterosexuals '10% seems a conservative estimate of the proportion of sexually active Americans who engage in this behaviour with some regularity'.⁷ The Wellings survey similarly found that only 13.9% of men had ever had anal sex with a woman.⁸ By contrast 89.5% of men who had had genital contact with

another man had had anal intercourse.⁹

The incidence of anal cancer has increased in recent decades, particularly among women in whom receptive anal intercourse particularly before the age of 30 has been shown to be a risk factor.¹⁰ In gay and bisexual men, however, the incidence of anal cancer now exceeds the incidence of even cervical cancer in women.¹¹ Anal squamous epithelial lesions were diagnosed in 36% of HIV positive and 7% of HIV negative gay and bisexual men in one study.¹² Another study concludes 'a history of receptive anal intercourse was strongly associated with the occurrence of anal cancer (relative risk 33:1)'.¹³ In addition to the risks of HIV and anal cancer, anal intercourse is also associated with the spread of a wide variety of other sexually transmitted infections,¹⁴ the 'gay-bowel syndrome'¹⁵ and rectal incontinence.¹⁶

A further important issue is the high rate of use of drugs and alcohol in the gay community both to facilitate intercourse and generally to enhance sexual pleasure. Most comprehensive reviews comment on this and Chris Woods, a leading gay journalist, has commented that 'the fleeting nature and instability of many gay and lesbian relationships... mean that drug consumption, namely the lowering of barriers plays an important role in our social habits'. Studies have reported that gay men and lesbians are often unable to have sex unless using drugs of some nature - usually alcohol.¹⁷ The use of poppers (amyl nitrate) to relax the anal sphincter is 58 times greater by homosexuals than by men in general.¹⁸

The condom is still widely perceived by many people as being synonymous with safe sex. However anal intercourse with or without a condom is dangerous. A review article cites one study which found a condom breakage rate of 32% and slippage of 21%. This is significantly higher than the corresponding rates of 5.3% and 6.3% respectively cited for vaginal intercourse.¹⁹

Some who consider the above to be an unrepresentative view of homosexual life argue that most studies recruit from genito-urinary medicine clinics and hence are not



TRUE 'BROTHERLY LOVE'
(PHILADELPHIA)
IS AS MUCH NEEDED TODAY
AS IN THE EARLY CHURCH.

representative of the gay community as whole. However the Wellings data showed that of those who had any sexual partners in the previous five years, 25% of gay men had attended a GU clinic during that time compared with only 3% of straight men.²⁰ Whilst it is quite possible that the other 75% of gay men who may not appear in most studies celebrate their sexual lives in exclusively monogamous, long term relationships in which they never take drugs or have anal sex and always wear a condom, the evidence of morbidity amongst the remaining quarter of gay men is disturbing enough.²¹

Receptive anal intercourse, whether hetero or homosexual, is surely not to be commended by those who understand that their bodies are 'a temple of the Holy Spirit'²² True 'brotherly love'²³ (philadelphia) is as much needed today as in the early church. The New Testament plainly teaches that such love is intimately connected with purifying ourselves 'by obeying the truth'²⁴ and living 'a holy life'. Such concepts seem far removed from the homosexual lifestyles of *Philadelphia*.

Trevor Stammers is a General Practitioner in West London who writes and broadcasts on sexuality.

References

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|---|---|--|
| 1 Remafedi G, Resnick M et al. Demography of sexual orientation in adolescents. <i>Pediatrics</i> 1992; 89:714-721 | 10 Frisch M, Glimelius B et al. Sexually transmitted infection as a cause of anal cancer. <i>NEJM</i> 1997; 337(19):1350-8 | 15 Quinn T. Clinical approach to intestinal infections in homosexual men. <i>Med Clin N Amer</i> 1986; 70:611-34 |
| 2 Huwiler S, Remafedi G. Adolescent homosexuality. <i>Advances in Pediatrics</i> 1998; 45:107-144 | 11 Palefsky J, Holly E et al. High incidence of anal high-grade among HIV-positive and HIV-negative homosexual and bisexual men. <i>AIDS</i> 1998; 12(5):495-503 | 16 Miles A, Allen-Marsh T. Effect of anoreceptive intercourse on anorectal function. <i>J R Soc Med</i> 1986; 70:144-7 |
| 3 <i>Independent on Sunday</i> 1994 (23 January) | 12 Palefsky J, Holly E et al. Anal squamous intra-epithelial lesions in HIV-positive and HIV-negative homosexual and bisexual men; prevalence and risk factors. <i>J of AIDS and Human Retrovirology</i> . 1998; 17(4): 320-6 | 17 Woods C. <i>State of the Queer Nation- A Critique of Gay and Lesbian Politics in 1990s</i> . Britain:Cassell, 1995:55 |
| 4 National Blood Service Form FRM/SEZ/BT/006/01 November 1997 | 13 Daling J, Weiss N et al. Sexual practices, sexually transmitted diseases and the incidence of anal cancer. <i>NEJM</i> 1987; 317:973-7 | 18 Myers T. HIV, substance misuse and related behaviour of gay and bisexual men. <i>Br J Addiction</i> 1992; 87:209 |
| 5 Hughes G, Lamagni T et al. Sexually transmitted infection in women who have sex with women [letter]. <i>BMJ</i> 1998; 316:557 | 14 Abdalian S, Remafedi G. Sexually transmitted diseases in young homosexual men. <i>Semin Pediatr Infect Dis</i> 1993; 4:122-30 | 19 Silverman B, Gross TP. Use and effectiveness of condoms during anal intercourse. <i>Sex Trans Diseases</i> 1997; 24:11-17 |
| 6 Fidler S, Weber J. Preventing HIV infection. <i>Prescribers' Journal</i> 2000; 40:4-9 | 15 Ibid | 20 Wellings K, Field J et al. <i>Sexual Behaviour in Britain</i> . Penguin, 1994:300 |
| 7 Seidman S, Rieder R. A review of sexual behaviour in the United States. <i>Am J Psychiatry</i> 1994; 151(3):330-341 | 16 1 Corinthians 6:19 | 21 1 Thessalonians 4:3-10 |
| 8 Johnson A, Wellings K et al. <i>Sexual Attitudes and Lifestyles</i> . Blackwell, 1994:163 | 17 1 Peter 1:22 | |
| 9 Ibid:216-217 | | |

KEY POINTS

Contemporary culture portrays homosexuality in a positive light; presenting gays as sensitive, caring and successful, gay partnerships as enjoyable, fulfilling and healthy and by evoking sympathy for those suffering from AIDS. Those questioning the paradigm run the risk of being labelled homophobic bigots. But as well as showing Christ-like compassion for gay people as patients, Christian doctors need to be honest with both them and society at large about the well-documented physical and psychological consequences of gay sex. The high incidence of promiscuity, unsafe sex practices and drug misuse among gay men are plainly reflected in the (not widely publicised) adverse affects on both morbidity and mortality.

A New Religion?

Richard Lovelace sees the growing acceptance of homosexuality within the church as due to a 'false religion' opposed to biblical revelation and the authority of Scripture, an 'antinomian ethic' that undercuts the balance between law and gospel, a 'cheap grace' that ignores repentance and a 'powerless grace' that denies the possibility of change. (Lovelace R. *Homosexuality and the Church*. Lamp, 1978:65-86)

Veronica Moss

surveys the HIV pandemic and finds hope alongside all the despair

Gloom and

The HIV pandemic in the year 2000 is confronting the world with enormous challenges. The statistics and the predictions for the 21st Century are indeed gloomy. By the end of 1999 at least 50 million people had been infected by HIV. 33.6 million were still living with the effects of the infection and 1.2 million of these were children under the age of 15 years (UNAIDS/WHO estimates December 1999). Women, children and young people are the most vulnerable. Around the world, about 7,000 young people aged 10-24 years are infected with HIV every day; five every minute. Every year, 1.7 million young people are infected in Sub-Saharan Africa and close to 700,000 in Asia and the Pacific region.

Regional realities

In the industrialised countries, prevention measures have resulted in some plateauing of new infection rates. The worst predictions of the late 1980s in the UK did not materialise, which led to a certain amount of complacency and a feeling that the scientists, doctors and politicians had been exaggerating the risks. The availability of antiretroviral drugs in the 1990s have re-inforced that complacency, even though there is still no cure, and more young people are taking risks again. Antiretroviral combination therapies are indeed reducing the progression of HIV infection to AIDS and the number of AIDS related deaths has declined, but the decline is now tapering off.

The 'wonder

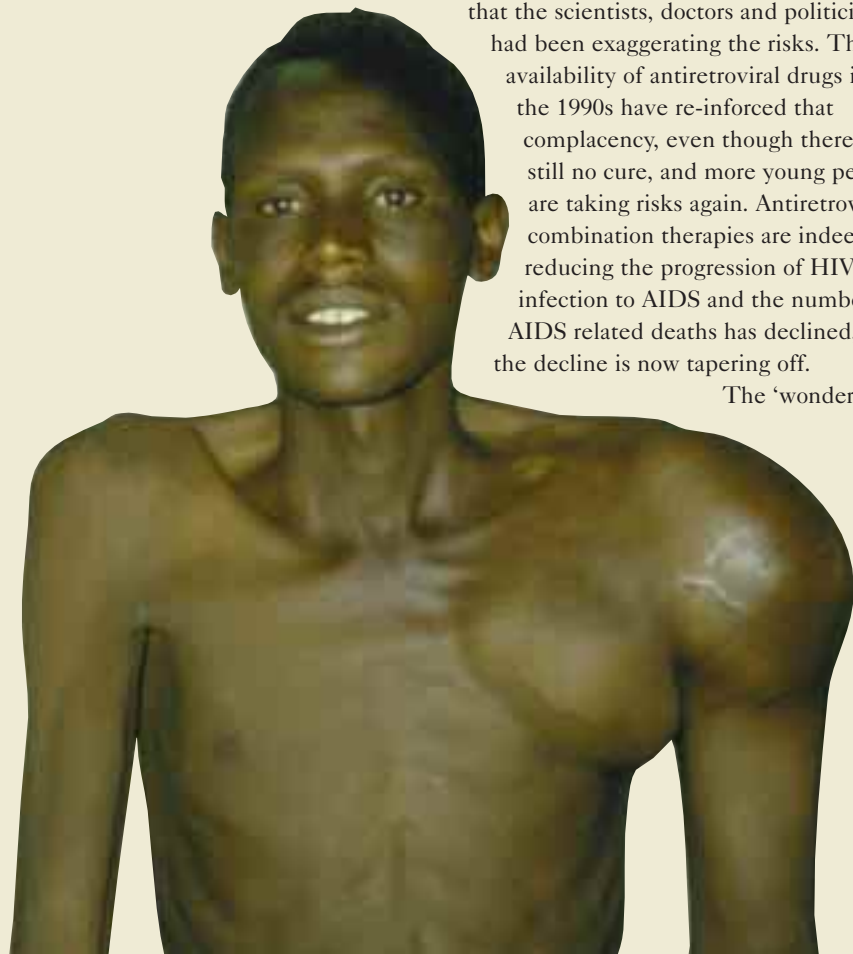
drugs' have been found to cause their own problems, with side-effects, interactions, adherence issues and the development of resistance.

In Eastern Europe and Central Asia the epidemic is showing signs of increasing spread, much of it through intravenous drug use. In the former Soviet Union, reported HIV figures have doubled in the last two years, the steepest rise being due to drug injection. The total number of AIDS cases in the Middle East is still low in comparison to other regions, but drug injection is responsible for 66% of infections in Bahrain and for 50% in Iran.

Central American infection rates are rising, and the Caribbean has some of the worst epidemics outside of Africa: the adult prevalence rate for the Caribbean as a whole is 1.96%, second to Africa's 8%, with similar epidemiology. Brazil and Argentina have a similar epidemiological picture to other industrialised countries, and are providing antiretroviral drugs to HIV/AIDS patients.

6.5 million people were estimated to be living with HIV across Asia and the Pacific Region, four million of these in India where the epidemic is spreading at an alarming rate. People who are known to be infected in India are highly stigmatised, with women usually taking the blame for the spread. Women who are working as commercial sex workers in the Red Light District of Bombay, as well as in many other Indian cities and towns, have usually had little choice in the matter, many having been kidnapped, sold or lured (by promise of good work and money by pimps) into prostitution from Nepalese or Indian villages; others have been born in the District to mothers who are working there, and are naturally forced into the life. However, if there were no clients there would be no prostitution, and it is the clients who travel the truck and rail routes of India. There are high concentrations of people living with HIV in the large cities, but as yet the rural areas have not been so severely affected. Nevertheless, the potential for an epidemic approaching, or even surpassing, the African one is very real.

95% of people living with HIV are in developing countries where poverty, poor health systems, and limited resources for care and prevention encourage the spread of infection. In these countries, about 50% of those who are infected, acquire HIV before they are 25 years old and typically die before their 35th birthday.



Glory

Sub-Saharan Africa

70% of the world's HIV positive people, 23.3 million, live in Sub-Saharan Africa, which is home to only 10% of the global population. Most of them will die within ten years for lack of basic treatment for opportunistic infections or access to antiretroviral drugs.

In Malawi, the National AIDS Co-ordination Programme estimates that 25-50% of the urban working population will have died of AIDS by between 2005 and 2010. One of the major problems in Malawi in dealing with the care needs of those who are infected, is the lack of basic drugs. Patients who are diagnosed as having an AIDS related illness in hospital are, in many instances, simply assigned to 'home based care' where there may not even be access to paracetamol to treat the severe headache of cryptococcal meningitis.

In Kenya, one sugar estate found that 25% of its workforce was infected; in another one, 33% were positive. All over Sub-Saharan Africa, especially in East, Central and Southern regions, large commercial companies and banks are having to face the impact of HIV on their work output, and some are developing policies and employee services that take HIV into account. Government services, such as Health and Education Ministries, are severely crippled by the number of health workers and teachers who are infected, ill and dying.

AIDS is now the 4th leading cause of death in children under 5 years in Uganda and it is estimated (UNAIDS) that it may increase infant mortality rates by 75%.

15 studies conducted in rural and urban areas in nine Sub-Saharan countries suggest that 12-13 African women are infected to every ten African men. Girls aged 15-19 years are five to six times more likely to have HIV than boys of the same age. In Uganda, 62% of girls will have had a pregnancy by the age of 19 and 43% of all first pregnancies are in teenagers.

There are many reasons for the

EVERY YEAR, 1.7 MILLION YOUNG PEOPLE ARE INFECTED IN SUB-SAHARAN AFRICA AND CLOSE TO 700,000 IN ASIA AND THE PACIFIC REGION

differences between the infection rates among boys and girls. These include the biological vulnerability of young girls, especially if they are forced into sexual intercourse through rape, and the fact that many older men will induce sexual compliance in return for school fees in countries where schooling is not free, and the only way out of the poverty trap is through education. This is the 'sugar Daddy' phenomenon, and can apply to other advantages as well as to school fees. The men may believe that having sex with a virgin will cure them of HIV - this, among other things, is leading to increasing rape figures of young children. Others will look for a young girl on the basis that she is unlikely to be positive and so will make a suitable girlfriend, wife or mother.

Children and AIDS

During 1999 an estimated 570,000 children globally were newly infected with HIV. Of these, 90% were babies born to HIV positive mothers, 90% of them in Sub-Saharan Africa. The cumulative total of children under 15 years of age who had lost their mother to AIDS, and maybe father too, had reached 11.2 million worldwide. By the year 2010, there will be almost 40 million such children in 19 African countries. From a study in eight African countries with high prevalence rates, it is estimated that 25% of all children in these countries who are less than 15 years old will be AIDS orphans.

Across Africa, grandmothers are burying their own children and taking in orphaned grand children, in some cases as many as 15-20. When a grandmother is unable, or unavailable, to take them in, siblings are separated and 'farmed out' to aunts and uncles; some are welcomed and well cared for, but others are resented and neglected; some end up on the streets. Some children are looked after by an older sibling, who may herself or himself be no more than 14 or 15 years old, in child-headed households.



GLOBAL SITUATION (UNAIDS/WHO)

People newly infected in 1999	5.6m
Adults	5.0m
Women	2.3m
Children	570,000
People living with HIV in 1999	33.6m
Adults	32.4m
Women	14.8m
Children	1.2m
AIDS deaths since the beginning	16.3m



KEY POINTS

Whilst prevention measures and antiretroviral medication have eased the AIDS burden borne by the developed world, the epidemic continues to spread at an alarming rate in Eastern Europe, the CIS, Asia and Central America. But it is still Sub-Saharan Africa, with 70% of the world's HIV positive people, which is suffering the most devastating sociological and economic effects. The most distressing consequences are for children; both those infected, and those left behind as AIDS orphans. In the midst of this gloom and despair there are signs of hope with increasing international co-operation, new scientific advances, and the wide range of efforts, many pioneered by Christians, to supply both palliative care and preventive education. There remains a huge role for Christians to play - and every individual helped is a manifestation of God's glory.



COMPASSION
AND
ACCEPTANCE IS
TAKING THE
PLACE OF
MORALISING
AND
CONDEMNATION

The Glory

Is it really possible to find any glory in the midst of all this gloom? The glory lies in seeing God's hand of love in the many efforts that are being made all over the world to prevent the further spread, to alleviate physical and emotional suffering, to support widows and orphans, and to seek for lasting answers and solutions.

Scientists are seeking to find effective and affordable vaccines that will prevent infection. They are also constantly seeking for more effective treatments, ultimately hoping for a cure. God is at work through their scientific skills. There is increasing co-operation and collaboration between governments and NGO's (non-governmental organisations, many of them mission hospitals and other Christian organisations, others are secular aid agencies) in seeking to prevent the spread and to deal with the effects of the virus on communities and individuals.

Many mission hospitals, which in most developing countries provide a substantial amount of the health care, are quietly dealing with overwhelming numbers of patients with HIV related illnesses and a resurgence of tuberculosis. Many of them are leading the way in setting up services such as HIV clinics and home care services for people with advanced AIDS. Some examples are Nsambya, Kitovu and Lachor Catholic hospitals, and Kisiizi and Mengo Protestant hospitals in Uganda; Chikenkata Salvation Army Hospital in Zambia and many, many others.

Compassion and acceptance is taking the place of moralising and condemnation. Churches, both Protestant and Catholic, are now not only teaching about Christian standards of behaviour, but setting up caring and supportive services, developing behaviour change programmes, and community, schools and youth projects, such as the Youth Alive Programme in Kampala. When Bishops find HIV in their own families their perspectives often change. In South India, a missionary doctor has developed a hospice for patients with AIDS; in Kenya and

Uganda, Hospice Africa, primarily set up to provide home care for patients with cancer, also sees many patients with advanced AIDS and provides symptom-control and care for them.

Conclusion

A man was walking along a beach one day, and found it covered with stranded starfish. He looked up to see a young girl picking them up, one by one, and throwing them into the sea. He said to her: 'What is the point? There are so many here, you can't possibly make a difference.' The girl replied, as she threw another one in: 'It will make a difference to this one'. People all over the world who care are making a difference through

- supporting someone with HIV/AIDS
- prevention and behaviour change projects through churches, mission organisations and others
- scientific research into vaccines and treatments
- teaching and training about prevention and care
- providing care for sick people, widows, orphans and all those affected by HIV/AIDS in their communities
- supporting those who provide the care through prayer, interest and money

In Matthew 25:40, Jesus says: 'The King will reply: "I tell you the truth, whatever you did for one of the least of these brothers (or sisters) of mine, you did for me".'

Veronica Moss is Director of The Mildmay Centre Uganda and Medical Director of Mildmay International. Mildmay Mission Hospital in east London set up Europe's first specialist AIDS hospice in 1988. Its work has since expanded to Eastern Europe, Asia and Africa. This article is based on the Rendle Short Lecture 2000.

Howard Kelly (1858-1943)

Gynaecology pioneer Howard A Kelly was, with William Osler (medicine), William S Halsted (surgery) and William H Welch (pathology), one of the 'Big Four' of the Johns Hopkins Hospital in the USA. He was a skilled and artistic surgeon and it is claimed that he laid the foundations of modern surgical gynaecology, introducing many new techniques. One historian of the Johns Hopkins said of Kelly that he 'was the only surgeon I ever knew personally who indulged in prayer before he began operating'. Kelly venerated the Bible and was staunch in its defence. 'Where the Bible is dishonoured, life becomes cheap and science an early victim,' he once declared.

...WE MUST CONCENTRATE ON FINDING
AND DEVELOPING PRACTICAL, REALISTIC
ALTERNATIVES TO ABORTION

John Wyatt identifies a
decisive shift in public
attitudes to the unborn child

The new ethics of abortion

It is striking how the age-old debate about abortion seems to have changed irreversibly just in the last few years. The stereotyped confrontation between the 'right to life' of the fetus and the 'right to choose' of the mother has become much more complex. Some commentators are now talking about the 'new ethics of abortion'. So what are the factors which have changed the debate so profoundly?

Factors changing the debate

Firstly, there is much greater public awareness of the development of the unborn child, particularly because of the almost universal use of antenatal ultrasound screening. Advances in fetal physiology have also received widespread publicity. We now know that the fetus responds to stimulation from the first trimester, develops complex stress responses to the insertion of a needle from before 20 weeks, learns to distinguish sounds, tastes and vibrations, orientates itself in space and actively interacts with its intrauterine environment.

Secondly, continuing advances in neonatal intensive care mean that survival of extremely preterm infants at 23 and 24 weeks is now almost a matter of routine. Many parents, families and professionals are exposed to the remarkable sight of tiny infants attached to all the paraphernalia of life support machinery. Charities and individuals donate many thousands of pounds to buy intensive care equipment for their local baby unit. Behind the widespread interest and support lies more than mere sentimentality. There are deep-rooted intuitions that the protection, support and nurturing of vulnerable human beings, offering a chance of life to those who cannot fight for themselves, is an essential duty of a civilised society.

Thirdly, at the same time, there has been remarkable growth in antenatal screening for fetal malformations and genetic abnormalities, and an

increasing 'medicalisation' of pregnancy. The new consumerist rhetoric of 'providing choices for pregnant women' has become widespread amongst health professionals. As the number of genetic tests increase, the problems of providing suitable counselling and information is likely to become more intractable. It seems inevitable that more and more couples will face decisions about terminating affected pregnancies.

The painful reality of trying to cope with a bewildering range of choices is changing the experience of pregnancy for many women. One study found that 79% of pregnant women were made anxious by the screening tests, and there is interesting evidence that the anxiety about fetal malformation often persists even when a test has given a reassuring result. Some have argued that antenatal testing encourages women to view their babies as commodities that may be rejected if found to be substandard. The effect of fetal screening is that many mothers hold back from relating to their unborn babies until tests have revealed that the baby is healthy. The pregnancy is tentative - some women don't tell anyone they are pregnant until the test results come back, sometimes 20 weeks or more into the pregnancy.

The growth of antenatal screening has 'medicalised' pregnancy by raising the expectation that medical expertise is capable of providing a baby free from impairment or illness, and that it would be 'selfish' or even 'antisocial' for parents not to avail themselves of this service. So technology has had the effect of encouraging a mother to distance herself from the child she carries. In some ways it seems to me that fetal screening offers a false hope, a technological mirage. It seems to offer the anxious parents the possibility of the security and confidence that their baby will be 'all right'. But the unpalatable truth is that no technology can guarantee a perfect child or a healthy outcome.

Fourthly, another major development is the

**RCOG says
'abortion is a
healthcare need'**

New guidelines to doctors issued by the Royal College of Obstetricians and Gynaecologists say that abortion is a 'basic health care need', the cost of which should always be met by the taxpayer. They say that doctors should respect a woman's right to choose, that abortions should be carried out as soon as possible, and that no woman should have to wait more than three weeks. The guidelines which have been funded and approved by the Department of Health were produced in conjunction with the British Pregnancy Advisory Service (BPAS), the nation's largest abortion 'provider' and 'reviewed' before their final draft by a host of other pro-choice groups. They are available on the College website. (www.rcog.org.uk)

IN MANY CASES ABORTION REPRESENTS AN ATTEMPT TO PROVIDE A QUICK TECHNOLOGICAL FIX... BUT MEDICINE ALONE CANNOT SOLVE THE AGE-OLD HUMAN DILEMMAS OF THE UNWANTED OR DISABLED CHILD



growth of the disability rights movement. One eloquent voice is that of Tom Shakespeare, an academic sociologist who happens to have achondroplasia. He argues that ‘disabled people are not consulted on matters which affect us: professionals, un-representative charities and governments all make decisions about disability, without considering that the best experts on life as a disabled person are disabled people themselves. Politicians, scientists and doctors alike must realise that disabled people do have a particular interest in prenatal testing and should therefore be systematically involved in the public debate’. Many disabled people regard antenatal testing for fetal abnormalities as a form of social discrimination against people like them. They argue that it is disingenuous for scientists and clinicians to claim that the development of antenatal genetic testing is neutral and value-free. The option of abortion for a range of genetic disorders places a negative value on people with the condition, and implies that it is socially desirable to prevent the birth of certain fetuses.

The obvious counter-argument is that abortion of a fetus with Down's syndrome, for example, does not necessarily imply disrespect for people with Down's syndrome, provided we accept that the fetus is not yet a person. It is argued that the decision to abort is intended to prevent a disabled person coming into existence - it has no wider social implications. But this is surely disingenuous. There is widespread condemnation of the use of abortion in India to allow parents to choose a male fetus for social reasons. This practice is seen as supporting social discrimination against women. In the same way social approval of abortion of fetuses with Down's syndrome can be seen as ‘chromosomalism’, enshrining social discrimination against certain forms of DNA! In the words of one disabled person, ‘To the extent that prenatal interventions implement social prejudices against people with disabilities, they do not expand our reproductive choices. They constrict them.’

In the new debate about abortion the social dimension is increasingly coming to the fore. The truth is that in many cases abortion represents an attempt to provide a quick technological fix - a medical, technical solution

to what is a complex social phenomenon. But medicine alone cannot solve the age-old human dilemmas of the unwanted or disabled child. And women and health professionals contemplating abortion cannot regard this decision as a purely private, medical one. The social context in which abortion takes place and its implications for society as a whole cannot be ignored.

A Christian response

So how can Christian doctors and health professionals make a practical contribution to the debate about the new ethics of abortion? Whilst we must seek to protect the vulnerable fetus from abuse, we must never forget the human pain that lies at the heart of these complex issues. The truth is that many women (and their partners) in our society are carrying painful and secret memories of past abortions. Instead of criticism and judgement, our duty is to empathise, to enter into the experience of pain, despair and perplexity.

Firstly, we must continually learn from the example of Christ. The Incarnation and the Cross are both supreme examples of empathy in action. Jesus did not condemn from the outside. He experienced humanity from the inside. He entered into human pain and perplexity, in order to transform it with forgiveness and hope. So whenever we engage in the abortion debate we should do so with sensitivity, with gentleness and with compassion.

Secondly, as health care professionals, we must not limit our involvement to the biological and medical aspects of pregnancy. Elaine Storkey in her meditation on the experience of Mary, the mother of Jesus, expresses sensitively the intuitive sense of wonder and the emotional demands of pregnancy from the mother's perspective.

‘Pregnancy is itself a symbol of deep hospitality. It is the giving of one's body to the life of another. It is a sharing of all that we have, our cell structure, our blood stream, our food, our oxygen. It is saying “welcome” with every breath, and every heartbeat...the growing fetus is made to know that here is love, here are warm lodgings, here is a place of safety. This is one of the reasons why the decision for abortion is such a painful and heavy one. Of course there are those who have been taught by our culture to present themselves to the clinic with barely a second thought, accepting the sterile terminology of the hospital for what they are about to do: “a termination of pregnancy”. Yet for many other women who have had an abortion there has been anxiety and grief and a sense of loss. In spite of all the reasons which directed them to take this step, some feel guilty of a deep betrayal of trust. They could not find within themselves the hospitality that was needed to sustain this life...’

The concept of pregnancy as hospitality has deep resonances with Christian thinking about community and neighbourliness to strangers. The challenge for us is how to communicate

New booklet criticised

A new Family Planning Association booklet titled ‘Abortion – just so you know’ has been criticised as making no reference to the physical and psychological dangers of abortion to women or of organisations which offer women choices other than abortion. In defending the publication, Anne Weyman, chief executive of the FPA, has said that the booklet addresses a real concern among teenagers for more information on a subject which they no longer saw as a taboo. (BBC News Online, 9 June & SPUC media release, 8 June)

these profound concepts in ways which are intelligible to modern secular people.

Thirdly we should identify with those who feel stigmatised and rejected by the practice of antenatal screening and termination. However admirable and compassionate may be our motives, when we contemplate abortion for a malformed fetus we are sending an implicit message of rejection. We are saying that we don't wish to accept this new other, to offer basic human hospitality. This, of course, is why disabled people represented by Tom Shakespeare and others, react to the practice of genetic screening and therapeutic abortion of affected fetuses. It strikes at the heart of a Christian understanding of community, and the responsibilities and duties we owe to one another. One of the unfortunate consequences of rapid advances in genetic knowledge may be the formation of a 'genetic underclass' – a growing group of individuals who are socially stigmatised in various ways by their DNA. The identification of a particular genetic sequence may mean that an individual is unable to obtain a job, purchase life or health insurance, obtain a mortgage or find a marriage partner. Since the days of the early church, the Christian community has seen a duty to provide practical protection and support for social outcasts of all sorts. Perhaps in future Christians will need to find new ways of supporting the outcasts created by genetic testing. The theologian Joseph Pieper once defined the essence of Christian love, 'Love is a way of saying to another person, "It's good that you exist; it's good that you are in this world".'

Fourthly, we must concentrate on finding and developing practical, realistic alternatives to abortion. The way of practical, supportive

caring is never an easy alternative. It is costly in terms of time, emotional involvement and financial commitment. But it is an essential response if Christians who defend the rights of the unborn child are not to be guilty of hypocrisy. Unless we are in the forefront of providing practical care and support for those with problem pregnancies, helping parents struggling with the implications of bringing up a disabled or impaired child, and defending the rights of the disabled and stigmatised within our community, our supposed commitment to the sanctity of human life is deeply suspect.

There is no doubt that rapid advances in medical practice coupled with profound social changes have irreversibly altered the age-old ethical debates about abortion, disability and the sanctity of human life. Yet the new landscape offers remarkable opportunities for Christian insights and influence. The challenge for health professionals is to find ways of translating Christian caring into clinical practice in a way which is relevant and intelligible to modern secular people.

John Wyatt is Professor of Neonatal Paediatrics at University College London and Chairman of the CMF Medical Study Group.

FURTHER READING

Meilander G. *Bioethics: a primer for Christians*. Carlisle: Paternoster Press, 1997
 Shakespeare T. *Choices and Rights: eugenics, genetics and disability equality*. *Disability and Society* 1998; 13:665-681
 Storkey E. *Mary's Story, Mary's Song*. London: Fount, 1993
 Wyatt J. *Matters of Life and Death*. London and Leicester: IVP/CMF, 1998



KEY POINTS

The abortion debate is being made more complex by greater awareness of fetal development, advances in neonatal intensive care, the increase in antenatal screening and the growth of the disability rights movement. Christian doctors must continue to seek protection for the unborn; but we must also show empathy by entering into the experience of pain, despair and perplexity generated by the abortion issue. We can do this by modelling Christ's gentleness and compassion, promoting a positive view of pregnancy as hospitality, identifying with the disabled who have feel stigmatised by search and destroy technologies and supporting practical realistic alternatives to abortion. The new debate thereby offers real opportunities for Christian insights and influence.

Changing policies leading to 6 million abortions in Britain since 1968

'I will not give to a woman a pessary to produce abortion.' *Hippocratic Oath*

'I will maintain the utmost respect for human life from the time of conception even against threat...' *The Declaration of Geneva (1948)*

'The spirit of the Hippocratic Oath can be affirmed by the profession. It enjoins... the duty of caring, the greatest crime being destruction in the co-operation of life by murder, suicide and abortion' *BMA Statement (1947)*

The child deserves 'legal protection before as well as after birth'. *The UN Declaration of the Rights of the Child (1959)*

'Therapeutic abortion' (may be performed in circumstances) 'where the vital interests of the mother conflict with those of the unborn child'. *Declaration of Oslo (1970)*

'I will maintain the utmost respect for human life from its beginning...' *The Declaration of Geneva (amended 1983)*

'Abortion is a basic health care need.' *RCOG(2000)*

Making Opportunities

The developing world's medical needs are overwhelming. In the West we are insulated from feeling them and isolated from seeing the connection between our lifestyles and others' poverty. We are also often blinded to the temporal and eternal consequences of choosing either to meet these needs or to ignore them – consequences for both us and for those affected.

At CMF we are dedicated to help you find the opportunity that God has prepared for you – so that you use your skills to serve others in Jesus' name.

But we musn't just wait for opportunities to crop up. We also need to make opportunities. A recent email in the *ihealth@egroups.com* discussion group described an imaginative general practice model in Canada. The doctors rotate one at a time, to a developing country hospital at which one of the partners served 25 years previously. Although each spends only one month per year there, constant cover is maintained.

Initiatives

The following initiatives were reported in the overseas section of the **RCOG News** April 2000 – but the basic concepts could work in almost any specialty. If you cannot fill one of these needs perhaps you could initiate something similar elsewhere.

Olive Frost (CMF member) had visited a hospital in Kampala to teach **colposcopy**.

Charlotte Patient describes a **work camp** to a remote part of Nepal organised by the **International Nepal Fellowship** at which about 100 women are seen each day and 83 operations performed (75 majors). Each camp lasts about three weeks and costs about £1,000 per person including transport from and to the UK. (To get involved in future camps contact 'Ellen' at *camps@inf.org.np*)

John Kelly describes **Fistula Training Workshops**. The communiqué following the International workshop on Vesico-vaginal fistula (VVF) held in Nigeria in 1998 stated that 'VVF is a condition that afflicts two million women in Africa and Asia... it will take between 30 and 40 years to clear the existing backlog without attending to new cases'. John reports that funding is difficult to obtain and that in Tanzania the local VVF project group found that the only agency which would support treatment was the Church.

Peter Milton the RCOG Senior Vice President and Overseas Officer reported that **Rotary International** of Great Britain and Ireland maintains a register of active medical practitioners willing to work in developing countries for short periods. (Contact Israel Rocker, 2 Stow Park, Circle, Newport, South Wales, NP9 4HE)

A list of more specific vacancies sent out with the Spring Millennium edition of Triple Helix is also still available on request.

Mozambique

Mozambique may be out of the headlines, but for the survivors of the horrendous floods the hard work of rebuilding lives and communities is just beginning. We have been privileged to become involved with this resilient and cheerful people through GP friends who have been out short term to support an organisation called Iris Ministries. They had been working amongst the destitute and the orphans for 5 years, but have seen their opportunities for ministry mushroom since the floods. Alongside their orphanages, they have distributed food, seeds, hoes and blankets as well as sending medical teams to isolated groups of refugees. The warm welcome, heartfelt appreciation and hunger for the Gospel that these teams encounter are deeply moving. Could you spare 2-3 weeks leave to help these people? Do you have a contact at work or church who might? Do you have drug samples going to waste in your cupboards or pharmacies? We have reports, videos and e-mail contacts aplenty, so why not check out the website or contact Drs Peter and Ruth Cureton. Email: *parcureton@aol.com*. Tel: 01252 671965. Website: www.savemozambique.com

Specific Posts

A list of service opportunities for all Christian health professionals for Spring 2000 is available in *Saving Health* published by MMA HealthServe, First Floor, 106-110 Watney Street, London, E1W 20E. Tel: 020 7790 1336. Email: *health157@aol.com*.

Interserve alone are looking for 200 health professionals!

Kenya

Ann Fursdon writes that she may be the only doctor left in Kapsowar Hospital by early August. A surgeon is urgently needed for six months along with other doctors with more general experience to cover medicine, paediatrics and obstetrics. Contact Ann at AIC Kapsowar Hospital, PO Box 68, Kapsowar, Kenya. Tel: +254 (0)328 61542. Fax: +254 (0)328 61543. Email: *ann.fursdon@aimint.org*. Alternatively, contact AIM International, 2 Vorley Road, Archway, London N19 5HE. Tel: 020 7281 1184.

United Arab Emirates

Oasis Hospital is a 'Family Hospital' operated from the US and needing doctors and other staff in most disciplines. Contact Oasis Hospital, PO Box 1016, Al Ain, Abu Dhabi, United Arab Emirates. Tel: +971 3 641252. Fax: +971 3 666007

Church Mission Society

Doctors are needed for Dem Rep Congo (primary health care), Nigeria (GP), Tanzania (hospital), Uganda (consultant surgeon), Aden (clinic director), Egypt (hospital), North Africa and Pakistan (community health).

Samaritan's Purse

This organisation places doctors and dentists who can pay the airfare and living expenses in evangelical mission hospitals around the world for periods from weeks up to a year.

Contact Samaritan's Purse International Ltd, Victoria House, Victoria Road, Buckhurst IG9 5EX. (Most of the above posts need self funding – please enquire from Contact addresses)

Conference

The 3rd International Meeting of the German Society for Tropical Surgery will be held in Homburg/Saar, Germany from 14-16 September this year. Contact Dr Peter Mues, Surgical Department of the University of Germany 66421 Homburg/Saar, Germany. Tel: +49 6841 162618 Fax: +49 6841 162497 Email: *chpmue@med-rz.uni.sb.de* ('AFRO-NETS' 10 June)

Resources

TALC (Teaching Aids at Low Cost)

New products and books include; PictureCards (simple training packages); Essential Malariology; Choices (a guide to young people growing in Africa in the AIDS environment); A Narrow Escape (explaining HIV/AIDS through story); Obstetrics Illustrated; Where there is No Vet; ABC of AIDS (described by South African Medical Journal as probably best available overview); ABC of Sexually Transmitted Diseases; The Open Secret (Strategies of Hope publication describing how Uganda breached the wall of silence surrounding HIV); The Pocket Paediatrician; Training for Transformation (for workers encouraging development of self-reliant communities). Contact TALC, PO Box 49, St Albans, Herts, AL1 5TX. Tel: +44 (0)1727 853869. Fax: +44 (0)1727 846852. Email: *talculuk@btinternet.com*

Mildmay International

An independent Christian organisation providing consultancy, training and AIDS palliative care services worldwide; founded in 1996 as a subsidiary company of Mildmay Mission Hospital (London). Mildmay Uganda has opened a specialist referral centre 6km from Kampala. Contact Mildmay International, 1 Nelson Mews, Southend-on-Sea, Essex, SS1 1AL, UK. Tel: +44 1702 394450. Fax: +44 1702 394454. Email: *mildint@globalnet.co.uk*

Compiled by David Clegg
CMF Overseas Support Secretary

EUTYCHUS

Where have the women gone?

A study released by UNICEF, the United Nations Children's Fund, has claimed that selective abortions, as well as infanticide and inferior access to food and medicines, have led to there being 60 million fewer women globally than demographic trends suggest there should be. The report said: 'They are victims of their own families, killed deliberately or through neglect, simply because they are female'. (*The Independent*, 1 June 2000 and *ABC News online*, 31 May 2000)



Cloning backtrack

A member of the team that created Dolly, the first cloned sheep, has admitted that expectations for the technology have been unfulfilled. Professor Keith Campbell of Nottingham University, UK, said: 'Cloning is turning out to be very expensive and very inefficient'. A report in the June issue of *Science* claims that even after cloned

embryos are implanted in a surrogate mother's womb, only two in 100 are successfully born. (*Daily Express*, 19 June 2000)

Discriminatory directive

A new EU directive has been proposed which could make it much more difficult for churches, religious organisations and church schools to retain a distinctive religious ethos. The directive makes it illegal for a Church to advertise for Christian staff to fill posts such as verger or vicar's secretary. Christian medical practices may no longer be able to prefer Christian doctors and hospices might be barred from preferring pro-life staff opposed to euthanasia. The government intends to sign the directive, which would apply to all faiths, in September. (*The Christian Institute*, June 2000)

Jehovah's Witnesses' rule change

The Jehovah's Witnesses' twelve-member world governing body has ruled that members of the six-million-strong cult will no longer be excommunicated if they accept blood transfusions. Instead, they will be 'given support' and welcomed back if they make the decision during 'a moment of weakness' and later regret it. (*Evening Standard*, 14 June 2000) The JW stand is based on a misinterpretation of Genesis 9:4, Leviticus 17:10-14 and Acts 15:20,29.

Ethical paternalism?

The BMA Ethics Committee chairman Michael Wilks has come under attack from the chairman of the association's students' committee for complaining about an article included in the students' annual conference pack. The piece, written by CMF student representative, Laurence Crutchlow, criticises the BMA's policy on the withdrawal of artificial hydration and nutrition. Students' leader Nick Jenkins used his annual conference address to berate Wilks, calling his letter 'patronising and confrontational' and accusing him of '(violating) the autonomy and indeed the very purpose of having a student body' by insisting that his comments be circulated to student delegates. (*Doctor* 2000; 6 April:25)

The sins of the mothers?

The British government has announced a campaign to persuade pregnant women to stop smoking in a bid to cut miscarriages and stillbirths. It is claimed that 400 children die in the UK every year before or shortly after childbirth as a result of their mother's cigarette habit. The initiative will cost 1 million British pounds and include a 'kick the habit' telephone hotline. (*Daily Mail*, 20 June 2000)

Paying to serve

Students reading medicine could have to pay up to £36,000 to become a doctor under 'reforms' proposed by economists working for the Russell Group of 19 leading universities. The report claims that the American-style funding system will involve tuition fees of up to £6,000 per year. (*The Times*, 31 May 2000)

Doctors are not prophets

A study published in the *British Medical Journal* has found that physicians tend to overestimate probable length of survival by a factor of five. Overly optimistic predictions were most likely to be given to cancer sufferers. The researchers conclude that 'undue optimism about survival prospects may contribute to late referral for hospice care, with negative implications for patients'. (*Reuters Health* 2000; 18 February)

The politics of the parapet

Cardinal Thomas Winning, Archbishop of Glasgow, has defended the right of the Catholic Church to speak out on life issues. He said, 'It is because the Church loves that she speaks out. And so when we criticise the loophole in the law which we believe could allow backdoor euthanasia, when we say that handing out abortifacients is wrong, we do so because we care. To follow the politics of the parapet, ducking every time an issue is raised, is unworthy of Christians. For them it is simply not an option.' (*Daily Telegraph*, 9 June 2000)

New European Charter

A draft of a new European Charter of Fundamental Rights outlaws human cloning, as well as eugenic practices and financial gain from the human body. The document, obtained by *The Times*, lists 50 rights in a wide variety of areas. The British government is reported to be hostile to the charter which, if incorporated into European law, would override the national laws of European Union member states. (*The Times*, 1 June 2000)

Turning back the years

In a major Canadian centre, life expectancy at age 20 years for gay and bisexual men was 8 to 20 years less than for all men. If the same pattern of mortality were to continue, the authors estimated that nearly half of gay and bisexual men currently aged 20 years would not reach their 65th birthday. Under even the most liberal assumptions, gay and bisexual men in this urban centre were now experiencing a life expectancy similar to that experienced by all men in Canada in the year 1871. (Hogg RS et al. Modelling the impact of HIV disease on mortality in gay and bisexual men. *Int J Epidemiol* 1997; 26(3):657-61)

Michael Webb-Peploe
offers a Christian
Perspective

Not for Resuscitation?

In a recent British Medical Journal editorial,¹ Professor Shah Ebrahim drew readers' attention to the dossier of over 50 cases assembled by Age Concern England and publicised in the national press where 'not for resuscitation' was posted on the notes of elderly patients without this being discussed with either patient or relatives. An independent review of one of these cases noted: 'It was hard to avoid the conclusion that that the treatment plan... was to do little more than allow the patient's life to ebb away'.²

In 1999, The British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing jointly said that 'do not resuscitate' (DNR) orders could be considered only after discussion with the patient or others close to the patient, and that they should be reviewed at regular intervals. It appears that these guidelines are frequently flouted. In one American series,³ over two thirds of the patients studied were not involved in their own DNR decisions. Even if there is discussion, information given is often not recalled, viewpoints often change as the disease progresses (or regresses), and decisions are poorly understood.^{4,5}

What is even more disturbing is that DNR orders result in a greatly reduced quality of medical and nursing care and attention. One study found a greater than thirty-fold increased risk of dying in patients with DNR orders even after adjusting for disease severity, prognostic factors, age and other covariates.⁶

But Cardiopulmonary Resuscitation (CPR) after an in-hospital arrest is effective in only about 20% of patients,⁷ and in many cases will have to utilise the scarce resource of an intensive therapy unit (ITU) bed.

In the present day National Health Service, this may deny another patient (perhaps with a better long-term prognosis) their chance of life-prolonging and quality-of-life enhancing treatment such as coronary artery bypass graft surgery. The attempt to resuscitate is sometimes (to use Ebrahim's headline) flogging dead horses, a messy and futile exercise denying the patient a dignified death.

What does the law say? In the United States, the body of law known as right-to-die cases extends ordinary treatment-refusal doctrine to end-of-life decisions.

The courts, having affirmed a right to refuse life-sustaining treatment, could find no rational distinction between competent versus incompetent patients, withholding versus withdrawing treatment, and ordinary versus extraordinary treatment. The courts, however, have persistently affirmed one categorical distinction: between withdrawing life-sustaining treatment



DOCTORS MAY DETERMINE WHETHER A TREATMENT IS FUTILE, BUT THEY CAN NEVER DETERMINE WHETHER A LIFE IS FUTILE

on the one hand and active euthanasia or physician-assisted suicide on the other. In *Washington v Glucksberg and Vacco v Quill*, the Supreme Court unanimously held that physician-assisted suicide is not a fundamental liberty interest protected by the American Constitution.⁸

New York State Statute governing resuscitative decisions requires that:

1. All persons be presumed to have capacity to make their own treatment decisions, and thus incapacity must be established by written determination of the attending physician; failure to do so is sufficient basis to rescind DNR orders requested by a surrogate.

2. Surrogate decision to request a DNR order must be supported by the patient's current medical condition and fulfil statutory criteria; physicians' opinions regarding hypothetical future conditions without firm evidence of the 'medical futility' of treatment for that patient are inadequate support for a surrogate DNR decision.

3. Statutory provision allowing a surrogate to authorise a DNR order on the basis that resuscitation measures would pose an 'extraordinary burden' for the patient is unconstitutionally vague.⁹

In the United Kingdom, some consider that DNR decisions can legitimately be made without consulting the patient if:

- Morbidity scores indicate that they are unlikely to survive CPR
- They are mentally incompetent.

In one survey of the case notes of elderly medical patients,¹⁰ 30% were predicted not to survive CPR, another 28% were deemed incompetent. Of those with DNR orders, 59% were predicted not to survive CPR, a further 24% were incompetent, and discussion of resuscitation would have been appropriate in 17%. Little mention was made of the family in these discussions.

Mental competence is a very grey area. DNR decisions analysed for 97 admissions to a psychogeriatric ward of a Dutch general teaching hospital showed that at the end of six weeks DNR orders were predictable by the four variables of dementia, use of antidepressants, age and

pre-arrest morbidity index in that order.¹¹ The association of the use of antidepressants with the presence of a written DNR order is surprising, and raises the strong possibility that an overly pessimistic view of quality-of-life by a depressed patient unduly influenced the DNR decision.

A Christian Response

Does the Christian faith shed any light on the DNR debate? I believe that it does, and here I must acknowledge my debt to John Wyatt's book *Matters of Life and Death*, and in particular to his chapter ten, 'A better way to die'.¹²

The biblical world view provides us with the following insights:

1. Human beings, even in an agony of suffering, or in a twilight mental state, are God-like beings. And any being made in God's image deserves a range of responses: wonder, respect, empathy, and above all protection from abuse, from harm, from manipulation, and from wilful neglect.

2. In the incarnation, God re-affirmed once and for all the value that he places on humanity, created in his image. Every patient, no matter how deformed the body, deranged the mind, diminished the personality, carries this double hallmark of divine value.

3. Human life is sacrosanct, and there is a strict line drawn between removing suffering and removing the sufferer. Euthanasia (homicide) and suicide (whether physician-assisted or not) are both opposed. The deliberate destruction of a human life (whether by its own hand or by that of another) desecrates God's image.

4. Not only is each individual human life special, but we are all part of the human family, created to be in community. To think that matters of life and death can be decided in isolation, by a single individual, is a dangerous illusion.

5. Death as a consequence of the fall is the 'last enemy',¹³ an evil and an outrage to be fought. Similarly, the loss of function, infirmity and the degenerative disease that come with age are real evils. Dylan Thomas expressed this in striking

terms writing of his father's blindness;

*Do not go gentle into that good night
Rage, rage against the dying of the light.*

Old age itself is not an evil, but rather a stage of life to be respected and honoured. For those trapped in a fallen and decaying body, living a severely limited and frustrating existence, death can come as a merciful release, a sign of God's grace. Christian attitudes to death reflect this strange ambiguity: on one hand it is an evil to be fought; on the other hand it may at times be accepted, even welcomed, as a sign of God's mercy and grace.

6. Pain and suffering are the inevitable consequences of man's rebellion against God, of our turning our backs on obedient communion with our creator. Suffering is a painful and universal reality which we can either accept or reject. If accepted from the hand of a loving God, he can transmute the evil of pain and grief into the good of deeper communion with himself. As CS Lewis wrote:¹⁴ *'The human spirit will not even begin to try to surrender self-will as long as all seems well with it. Now error and sin both have this property, that the deeper they are the less their victim suspects their existence; they are masked evil. Pain is unmasked, unmistakable evil; every man knows something is wrong when he is being hurt....*

Pain insists upon being attended to. God whispers to us in our pleasures, speaks in our conscience, but shouts in our pains: it is his megaphone to rouse a deaf world.'

Christianity teaches us to value human beings because of who they are, because of how they have been made, because they are known by God and immensely valued by him, rather than on the basis of what they can do.

Medicine cannot hope to eliminate all suffering and death but must always seek to eliminate unnecessary suffering and untimely death. Quoting Wyatt again:¹² *'The essence of being a good doctor is to know when "enough is enough". But how do we know when we should withdraw treatment, or withhold it? It is when the burdens of any particular medical treatment outweigh its benefits.... There is, however, a fundamental*

difference between making treatment decisions, and making value-of-life decisions. Doctors are qualified to make treatment decisions: to decide which treatment is worthwhile and which is not. But doctors are no better qualified than anybody else to make value-of-life decisions: to decide which life is worthwhile and which is not. Doctors may determine whether a treatment is futile, but they can never determine whether a life is futile. When we withdraw or withhold treatment, we are expressing a belief that the treatment is valueless, not that the patient is valueless.

Applying these insights to the DNR debate we can conclude:

1. The doctor has the responsibility of determining the likelihood of success of CPR in the event of an arrest. A variety of 'pre-arrest morbidity' scoring systems exists and can be useful to formalise an assessment of the usefulness or futility of CPR.

2. Value-of-life in any individual patient can only be assessed by discussion with all those concerned: patient, relatives, medical and nursing staff, the patient's spiritual adviser (if known). In the presence of depression or dementia, the patient's views may be unreliable or unobtainable. Surrogate views from relatives may be influenced by the vested interests of physical or

financial exhaustion or by 'carer's burn-out'. But such reservations are no excuse for failure to discuss value-of-life issues, and, in many cases, these issues will need to be revisited and updated at regular intervals. Failure of communication between doctors, patients and relatives lies at the heart of the present furore over DNR orders.

In an editorial entitled: 'How to improve communications between doctors and patients',¹⁵ the authors distinguish three approaches to treatment decision-making:

Paternalistic. Doctors using this approach want short descriptions of physical symptoms easily transformed into diagnostic categories which in turn lead to treatment decisions considered by the doctor to be 'in the best interests of the patient', without having to explore each patient's values and concerns.

Informed (or Consumerist). The doctor's role is here limited to providing relevant research information about treatment options and their benefits and risks, leaving the patient to make an informed decision.

Shared. Doctors commit themselves to an interactive relationship with patients in developing a treatment recommendation that is consistent with

patient values and preferences. For this to happen, the doctor needs to create an open atmosphere in which information exchange helps the doctor understand the patient, and ensures that the patient is informed of treatment options and their risks and benefits. Treatment decisions are made jointly (not solely by a paternalist doctor, nor solely by a consumerist patient), and patients can assess whether they feel they can build a relationship of trust with their doctor.

The highest form of inter-personal (and thus of doctor-patient) relationship is a covenant commitment of respect-love. But as Wyatt points out:¹² *'caring for people with respect does not mean that we are obliged to provide intensive and burdensome medical treatment to prolong life at all costs. As in all other clinical situations, the burdens of any proposed treatment must be weighed against its benefits... Withdrawing or withholding medical treatment is not the same as intentional killing. We retain the basic attitudes of wonder, respect, empathy and protection'*.

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KEY POINTS

Recent high profile cases and literature reviews confirm that 'not for resuscitation' guidelines are frequently flouted on both sides of the Atlantic. 'DNR' orders have also been shown to affect adversely both attitudes to patients and the standard of care they are given. A Christian response must be based in a biblical worldview that affirms the dignity, worth and interconnectedness of all human beings as being made in God's image. Whilst recognising that pain, suffering and death are, to some extent, inevitable consequences of the Fall we must always seek to eliminate unnecessary suffering and untimely death. Good DNR decisions should be made in partnership with patients and relatives, and be based on evidence-based survival prospects rather than value-of-life assessments.

References

- 1 Ebrahim S. Do not resuscitate decisions: flogging dead horses or a dignified death? *BMJ* 2000; 320:1155-6
- 2 Mendick R, Dillon J. Fifty elderly on NHS death dossier. *Independent on Sunday* 2000; 16 April:1
- 3 Levin JR, Wenger NS, Ouslander JG et al. Life-sustaining treatment decisions for nursing home residents: who discusses, who decides and what is decided? *J Am Geriatr Soc* 1999; 47:83-7
- 4 Krumholz HM, Phillips RS, Hamel MB et al. Resuscitation preferences among patients with severe congestive heart failure: results from the SUPPORT project. Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment. *Circulation* 1998; 98:648-55
- 5 Sayers GM, Schofield I, Aziz M. An analysis of CPR decision-making by elderly patients. *J Med Ethics* 1997; 23:207-12
- 6 Shepardson LB, Youngner SJ, Speroff T, Rosenthal GE. Increased risk of death in patients with do-not-resuscitate orders. *Med Care* 1999; 37:727-37
- 7 De Vos R, Koster RW, de Haan RJ et al. In-hospital cardio-pulmonary resuscitation: prearrest morbidity and outcome. *Arch Intern Med* 1999; 159:845-50
- 8 Gostin LO. Deciding life and death in the courtroom. From Quinlan to Cruzan, Glucksberg, and Vacco – a brief history and analysis of constitutional protection of the 'right to die'. *JAMA* 1997; 278:1523-8
- 9 Anonymous. In *re Finn*. *Issues in Law and Medicine* 1996; 11:437-40
- 10 Stewart K, Wagg A, Kinirons M. When can elderly patients be excluded from discussing resuscitation? *J Roy Coll Phys Lond* 1996; 30:133-5
- 11 Dautzenberg PL, Hooyer C, Schonwetter RS et al.: Dementia in resuscitation policy: a prospective study of a psycho-geriatric ward in a Dutch general teaching hospital. *Age & Ageing* 1996; 25:234-8
- 12 Wyatt J. *Matters of life and Death*. Leicester: IVP, 1998:192-212
- 13 1 Corinthians 15:26
- 14 Lewis CS. *The Problem of Pain*. London: Geoffrey Bles, 1940:80,81,98
- 15 Charles C, Gafni A, Whelan T. How to improve communication between doctors and patients. *BMJ* 2000; 320:1220-1

Review WWWs with Cyberdoc

Cyberdoc reviews homosexuality online – the words in bold correspond to links on Cyberdoc’s website at xtn.org/cyberdoc/homosexuality/

Homosexuality remains a controversial subject amongst Christians. The electronic version of the British Medical Journal contains a veritable avalanche of e-letters mostly by Christian doctors in response to a 1998 personal view by Sheard (BMJ 1998;317: 1532 (28 November)). This claimed that Christian doctors who believed homosexuality was medically dangerous were basing their views on inadequate research. In an evident display of the heat that surrounds this subject, he is himself criticised for implying homosexuality is more common than it in fact is. It is sad to see people speaking with such ferocity towards others who share the label Christian on a secular website, but some of the postings are quite useful.

Free to be me is aimed at youth and teens who are, or wonder if they are, gay or lesbian. It seems to aim to be non-confrontational, but suggests the possibility of not acting on same-sex attraction, and suggests change in orientation is possible. There are links to organisations like **Exodus International** which is an umbrella organisation providing links to many organisations offering Christian support for homosexuals ‘seeking sexual purity’. Good examples of these, based in the UK³ are **True Freedom Trust** and **COURAGE Trust** which offer pastoral ‘befriending’ and counselling, rather than the ‘reparative therapy’ promoted actively by the **National Association for Research and Treatment of Homosexuality** (NARTH). Both sites are united in their belief that far from being irrevocably ‘born gay’ many homosexuals are able to change in their orientation. The **CMF** website expresses the

traditional Christian view of homosexuality well.

Whosoever is a web site that espouses a different view. It contains many articles claiming that when the Bible mentions homosexuality it really means ‘temple prostitution’, and denies the claims made by others that homosexuals can and do change. Certainly this is the most comprehensive collection of resources that are both ‘gay and Christian’ I have ever come across. There are some powerful arguments here, but much of the explanation assumes that the Bible couldn’t possibly say that all sexual relationships outside heterosexual marriage are less than God’s ideal for people. A page on the **Religious Tolerance** website claims to be portraying both sides of the argument but leans rather heavily towards a liberal approach. There is much on the web from this perspective. **Homosexuality and the Bible** states its credentials as written by ‘a Bible Scholar’, who precedes to worm his way out of Paul’s condemnation of homosexual sex as ‘un-natural’ by claiming that the Apostle was ignorant of the concept of sexual orientation. In our enlightened age, gay people are simply doing what is ‘natural’ to them. I’m afraid that such an attitude to God’s Word simply will not do.

In the same vein, **Roy Clements**, recently fallen from a prominent position in evangelicalism as a result of his professed homosexuality, hosts a



rather disappointing site containing an article (rather sadly titled ‘living with our fallibility’) reviewing the church’s historical mistakes in Bible interpretation on a host of issues and implying (the second part of the article is still to be posted) that similar errors have been made with homosexuality. There is also an open letter to Brian Souter, the *Stagecoach* Director who championed the ‘keep the clause’ campaign opposing repeal of section 28 in Scotland.

So, with a sigh, and in preparation for a sackload of letters, electronic and otherwise, let me finish by saying that despite all the best efforts of these websites, some of them no doubt genuine in their purpose, I could find nothing on the web that can honestly prove that the Bible is in favour of any form of sex that takes place outside of marriage. This may well be an unpopular message today, and there are precious few Christian websites I could find proclaiming it. Provided, however, we exhibit Christ-like love for those (homosexuals and heterosexuals) whose sexual behaviour counts as sin (John 8:11), I can see no reason why at the beginning of the third millennium we should be ashamed to believe the traditional biblical view of sexuality.

This and previous Cyberdoc website reviews Websites can be found at xtn.org/cyberdoc/

Cyberdoc is **Adrian Warnock**, SHO in Psychiatry and previous editor of *Nucleus*.



Dutch Courage - In sickness and in health

Dirk van Zuylan

Alpha 1999

£5.99 Pb 225 pp

ISBN 1 89893 868 7



This small and easy to read autobiography of Dirk van Zuylan is an eye-opener for those caring for patients with long term illnesses, and more specifically those who have renal failure.

The book follows his life through his childhood of moving to Canada and then back to Holland. It is there that he becomes a Christian and starts his work in the Navigators, an organisation that reaches and disciples students for Christ. His work brings him to England where he falls in love with Sandra and they marry and have children.

Early in their marriage, Dirk discovers that he has renal failure. He goes onto dialysis but eventually requires two kidney transplants. Later, he is diagnosed as having cancer. Dirk talks frankly about the physical, emotional and spiritual struggles of being ill, and the effect these have on those who love him. He doesn't duck the enormous questions that arise but rather walks us through them from his perspective in a honest and frank manner. In the last chapter he asks the question, 'How does God feel about all the suffering in the world?'. He concludes that the only way of finding out is to look to Jesus, for in Jesus we see compassion and love demonstrated to the point of dying for us so that we can be restored to God.

By the end of the book, Dirk is enjoying better health but is honest about the scars. He has become a different man; he is more sensitive and feels others pain more deeply. In one of his concluding paragraphs, he talks of his confusion about God's delay in answering his prayers, but balances this with the truth that God is always his anchor in the storm.

This book does not offer a deep understanding of the theology of suffering but rather describes the

personal experiences of a man who, after suffering for many years, it is continuing to work out the huge questions that arise such as God's sovereignty and his own self-worth. If I have any concern, it is his lack of emphasis on God's sovereignty.

This book can help people in different ways: firstly, it gives insight into the difficulties of living with a chronic disease such as renal failure; secondly, it challenges the Christian to think about suffering in this context; and thirdly, it introduces the non-Christian to Christian truths in a way that is unthreatening and easy to understand.

Annie Leggett is an oncology nurse and past UCCF staffworker to student nurses.

Christians and Bioethics

Edited by Fraser Watts

SPCK 2000

£7.99 Pb 84pp

ISBN 0 281 05194 1



This book began as a series of lectures in Cambridge. Its six chapters are of interest as much as for their authors as for their subjects.

They include: 'Cloning: After Dolly', by Rev Dr John

Polkinghorne, a member of the Donaldson Committee, an expert advisory group on therapeutic cloning; 'Genetic Engineering of Food', by Professor Derek Burke CBE, who chaired the Advisory Committee on Novel Foods and Processes; 'Reproductive Medicine', by Rev Dr Tim Appleton, a biology teacher, Anglican priest and a founder member of the ethics committee at Bourne Hall Clinic run by Steptoe and Edwards, the test tube baby pioneers. Transplantation ethics and euthanasia are also discussed.

The strong points of this book are the brief history of biotechnology, which includes discussion of legislation and ethical dilemmas in this area, and helpful suggestions for further reading at the end of each chapter. Michael Rees' insistence that God has revealed his truth to us in the Christian message, absolute truth that speaks about what it means to be human, is welcome.

Despite some Bible references, the book lacks commitment to the Bible as our ultimate authority. Certain relevant biblical truths such as God as creator, the perfection of God's original creation, the uniqueness of man as made in the image of God, the historicity of the fall bringing about disease, suffering and death to the world are muted, ignored or even implicitly denied. There is no mention of the sixth commandment nor of the incarnation of Christ who, conceived by the Holy Ghost, shared our humanity from conception and thereby gave dignity to human life from the time of fertilisation. Indeed, Fraser Watts espouses an evolutionary world view and states that: 'To assume that an individual comes about immediately after fertilisation is taking too simplistic a point of view'.

Those seeking a specifically Christian response to biotechnology will be disappointed. The latest edition of *Ethics and Medicine* (2000;16:2) is more helpful.

Stephen Browne is a General Practitioner in Birmingham

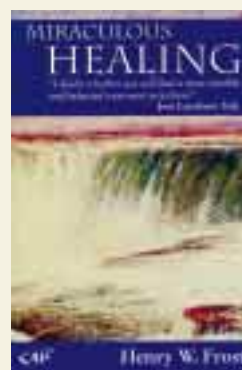
Miraculous Healing

Henry W Frost

OMF 1999 (First published 1931)

£5.99 125pp

ISBN 1 85792 530 0



This classic book on healing, described by Dr Martyn Lloyd-Jones as the best he had ever read on the subject, was first published in 1931 and has recently been reprinted for a

new generation of readers. The author, Henry Frost, worked for the China Inland Mission (now OMF International). He had a wide experience of Christian ministry and was friends with many Christian leaders of his day. The book springs from his personal experiences but always seeks to measure that experience against scripture.

The strength of the book lies in its balance. The main text starts with two chapters describing five notable healings known to the author, followed by five notable 'failures'. The author demonstrates that issues such as the faith

of the patient and the energy or godliness of those praying do not determine whether healing occurs.

I was deeply attracted to the humility and transparent godliness of the author. He believes in healing but his trust is in God. The high point of the book is his chapter on Christ's sovereignty. This preaches no easy evangelical triumphalism but rather explores the mystery of those multitudes alive in Palestine at the time of Christ, and yet whom Christ did not heal.

There are many things one could criticise if one wished. The style and form are, naturally, old fashioned and occasionally tedious to the post-modern brain. Medical terminology is often used to establish the credibility of the anecdotes. Much of this terminology and the disease models that go with it now seem archaic. (This should of course alert us to the transience of medical truths.) As ever, the problem arises as to whether a miraculous recovery from 'illness' actually denotes a miraculous recovery from 'disease'.

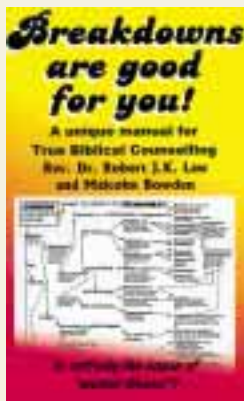
What can a book published in 1931 say to us, the children of the new millennium? Firstly, if the language were updated, the book would immediately contribute to our contemporary debates. Frost is a voice calling from the centre, urging us to look to Jesus, to trust in him alone and to support and pray for our fellow believers. Secondly, I could not help being struck by the way Frost chose to structure the book. It starts and finishes with Frost's testimony of sickness and of healing within his own family. There is no hint of superior triumphalism as Frost wrestles, like we all do, with his failure to see prayers for healing answered. Within the book there is both a reverence for the mystery of God's will and a persistent call to look to Jesus, whatever happens. As long as we can match Frost's attitude of trust, we will not be found far from Jesus, whatever our stand in the debate on healing.

I'm glad I read this book. In the midst of controversy it led me to consider Jesus. I think you might be glad to read it too.

David Misselbrook is a General Practitioner in London, and Course Organiser of the Lewisham Vocational Training Scheme.

Breakdowns are good for you!

Rev Dr RJK Law & M Bowden
Sovereign Publications 1999
£9.95 270pp
ISBN 0 95060 425 9



This is an extreme book. The authors, one of whom worked as a doctor in psychiatric hospitals for four years before entering the Anglican ministry, believe that self pity is at the root of all

'mental illness'. Breakdowns are considered good because the patient comes to a moral realisation that they are responsible for their illness. The authors argue that schizophrenia and depression are not mental illnesses at all, 'schizophrenia is almost entirely due to bad (ie self-pitying) behaviour'. This book reminds me of Thomas Szasz' famous book, *The Myth of Mental Illness*, where he too argues that all non-organically proven conditions like schizophrenia are not mental illnesses. According to Szasz, it is wrong to exculpate criminal behaviour on the basis of 'non-illnesses' like schizophrenia. Likewise, Law and Bowden state that schizophrenic patients are 'crooked' and schizophrenia is not considered to be an organic disease. 'Environmental and genetic predispositions do not control our activity - they can always be over-ridden'.

This is a simplistic, albeit imaginative, attempt to classify all mental disorders under one large explanatory theory. They are all here - anorexia nervosa, alcoholism, multiple personality disorder, narcolepsy, personality disorder, mania, depression, schizophrenia.

According to Law and Bowden 'True Biblical Counselling' is made up of three propositions:

1. All problems that can be dealt with and solved in counselling sessions are always due to the pride, self-centredness and self-pity of the counsellee.

2. Medical (ie organic) illnesses do not make us sin.

3. Where there is said to be a medical problem, whether it is true or not, or where they have been classified as 'mentally ill', self-pitying counsellees invariably use this to excuse their behaviour.

The authors advocate 'true biblical counselling' for case examples such as, 'Anne's moody husband', 'Bill has a problem with his new manager', 'Fred's anger'. In treating Fred's anger and self-pity, there is useful biblical material in the approach taken by the authors when they go through 'The 5R's: Responsibility, Repentance, Reconciliation, Restitution, and Rebuilding on Christ'.

The problem arises when the authors use the same approach for schizophrenia and depression, neither of which they consider to be mental illnesses. They cite a *Weekend Telegraph* columnist, Cressida Connolly, 'as an independent confirmation of our basic argument which is that depression, irrespective of medical aspects originates within the depressives themselves'. Theirs is a rigid view of depression.

In the case of schizophrenia, the authors write that symptoms appear in early adulthood because of the 'high level of achievement expected of young people'. This is where the book is very difficult to get along with, because of the lack of genuine evidence. Moreover the evidence which is cited comes from William Glasser's book *Reality Therapy*. Glasser quotes his teacher Dr GL Harrington, who in 1962 had taken over the care of 206 schizophrenic in-patients and managed to discharge many of them by increasing their freedom to take more responsibility for their activities, so gaining self-worth. The philosophy was one where 'mental illness was not accepted'. To reject all biological theories of schizophrenia on the basis of this one non-randomised un-controlled trial is unscientific.

The authors have some useful advice on, 'How the Christian should deal with life's problems', 'How the Christian should handle personal problems', 'Living the full Christian life'. But, while the authors' wide use of scripture seems impressive, it is not matched by reasoned understanding of mental health issues.

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Letters

Postcoital contraception

Sheffield GPs **Mark Houghton** and **Chris Bronsdon** continue the debate about the status of the embryo.

Mandi Fry (*Triple Helix* 1999; 9:6,7) attempted to help us think through in advance a right practice on 'emergency contraception'. However we feel it is disappointing that her reasons for choosing implantation as the start of life are not evidence-based or Bible-based.

Mandi uses the argument that since God allows the wastage of 30-60% of unimplanted embryos, then they are not yet alive to him and therefore we can discard them too. There are several problems with this argument:



1. Many unimplanted embryos have lethal chromosomal abnormalities, and therefore do not continue as a successful pregnancy. Only God knows

which these are, and to say that we can discard an unimplanted embryo, because God chooses to allow some to die, is to put ourselves in God's place.

2. Using this logic that 'high death rate equates with no value', then many children in developing countries where the perinatal mortality rate is about 50%, also have no value before God.

3. Many patients do not believe that life begins at implantation. In the main patients know quickly and intuitively that life begins at fertilisation. The common-sense view is that a new person (or persons) are created at fertilisation. In other words they know that the nuclear fusion of the egg, which is part of person A with the sperm which is part of person B creates a third person C. This person C has a distinct, unique genetic makeup and value of their own regardless of whether or not implanted yet. Many patients realise that destroying C is to take life.

4. Furthermore, and of course most importantly, it is congruent with the overall thrust of scripture, which for Christians should have authority over human authority

(such as the Faculty of Family Planning) if the two disagree. Many verses such as Jeremiah 1:5 'before I formed you in the womb I knew you', speak of a God who creates and knows people even before fertilisation has occurred. Greg Gardner has shown (*Triple Helix* 1999; 10:20) that Jesus was a person from the moment of fertilisation.

If scientists find that the moment of the beginning of life is unclear (Berry C. *Beginnings*. Great Britain: CMF, 1993) it is not unclear to God. Christians must not be naive. There is a massive industry that wants us to believe that life does not start until implantation or later, and has deliberately lied and attempted to redefine conception and pregnancy.

Population and famine

Surrey GP **Margaret White** takes issue with the claim that population increase maintains poverty.

Professor John Guillebaud (*Triple Helix* 1999; 10:4-5) is quite correct in part of his maxim of a vicious cycle of population; poverty certainly maintains population increase. Everyone needs one child alive and well to feed them when they are unable to work and one of the best contraceptives is an old age pension. He is wrong, however, in saying that population increase maintains poverty. It may do sometimes, but often the reverse is true – look at Hong Kong and Singapore!

At the many United Nations conferences on the family the delegates from the western world (lavishly funded by their governments) demand that 'reproductive health' – which includes abortion – be made a 'human right'. This would force every country in the world to provide abortion on demand. Delegates from the Third World, the Middle East and the Vatican have so far managed to out-vote them. It will however be brought up repeatedly so that in the end the poor countries won't be able to afford to send delegates to places as distant as Rio de Janeiro and Peking – and the eugenicists will have won.

End of life issues

Manchester pro-life commentator **Stuart Cunliffe** warns about phraseological slippery slopes.

I am grateful to Greg Gardner for his reminder of how language has been perverted in order to push particular causes. (*Triple Helix* 1999; 10:20)



But have we all noticed what is happening with euthanasia? We were told that withholding food and water from Tony Bland was nothing to do with euthanasia. We had always understood that euthanasia was a deliberate act or omission intended to take the life of the patient.

In 1997 the Government, which has always insisted it is opposed to euthanasia, defined euthanasia in its Green Paper *Who Decides?* as 'a deliberate intervention with the express aim of ending life' - no mention of omission - and suggested legalising withholding nutrition and hydration. Last year the BMA (having claimed that withholding food and fluids in its new guidance was not euthanasia but withdrawing treatment in the best interests of the patient) insisted, in the debating pack it issued before its forthcoming conference on physician-assisted suicide, that euthanasia, PAS and withholding treatment should be kept 'phraseologically distinct'.

Can we be sure that we are clear on the issues and that we are not taken in by linguistic gymnastics?

Editorial Note

Associate Editor **John Martin** apologises.

Michael Cotton has pointed out that contrary to what we said in the Millennium *Triple Helix* (*Triple Helix* 2000; 11:19) David Livingstone died at Chitambo in present day Zambia (not Tanzania). I've re-checked. He's right. Mea culpa!

Refined by fire

One of my favourite childhood memories was waiting for goods trains to pass the level crossing a few miles down the dusty road from our farm in inland Australia. Most of the cargo, on its way to the coast from the remote mining town of Broken Hill, was raw silver, lead and zinc.

From my vantage point you would never have thought the grey ore in the rail trucks had much value. Only when these stones were crushed, sifted and subjected to enormous heat would their real value and beauty emerge.

The refining of silver is a delicate process. Ask any silversmith. The temperature has to be just right. If it's too low the process of refining won't even begin. If the furnace gets too hot, the silver will be spoilt. How, then, does the silversmith know for sure that he's getting it right?

First, refining silver requires enormous concentration. The silversmith needs to observe carefully as the heat does its work on the molten metal, never taking his eyes off the action for even a moment. Then, timing is everything. Leave the silver on the heat seconds longer than the ideal and its value is seriously diminished.

That raises an all-important question. How does the silversmith know that the molten silver has been heated for the optimum time, at the optimum

temperature? The answer is that there comes a magic moment when the silversmith can see his image reflected in the precious metal in his charge. Then, and only then, it's time to take it off the fire.

The Old Testament prophet Malachi compares God to a silversmith. 'For he will be like a refiners fire...' (Malachi 3:3). There are times when, under God's providence, we will be tested and refined by fires of adversity. These times can be devastating, as Job found. But as we trust his grace the image of the divine silversmith will become even more visible in us, and people will notice. As St Paul wrote, 'And we, who with unveiled faces reflect the Lord's glory, are being transformed into his likeness with ever-increasing glory, which comes from the Lord...' (2 Corinthians 3:18).

There's an old chorus that I've often used as a prayer dedicated to colleagues and the people around me:

Let the beauty of Jesus be seen in me.
All his wondrous compassion and purity.
Come thou, Spirit divine,
All my nature refine,
'till the beauty of Jesus is seen in me.

John Martin
Associate Editor of *Triple Helix*

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