TRIPLE HELIX

Summer 2003

For today's Christian doctor

DESIGNER BABIES

NEW EUTHANASIA BILL

SEXUAL HEALTH ENQUIRY

HOMEOPATHY

UNFPA

CONTRACEPTION

DEPRESSION

SPIRITUAL CARE

OVERSEAS OPPORTUNITIES

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EDITORIALS

Patient (Assisted Dying) Bill

A dangerous document that Christian doctors should oppose


Photo: Wellcome Photo Library

A new Bill attempting to legalise Dutch-style euthanasia throughout Britain is making its way through the House of Lords. Lord Joffe's Patient (Assisted Dying) Bill[1] passed its second reading on 6 June without a vote, and now goes to the committee stage, where it can be amended and revised before returning for a third reading and final vote probably this autumn. If it traverses the House of Lords it then faces the much easier challenge of three readings in the Commons before becoming law.

The Bill seeks to legalise euthanasia for any patient with an 'irremediable condition' (defined as 'a terminal or serious physical illness') with 'unbearable suffering' (as defined by the patient) provided that two doctors can confirm that the patient is of sound mind and has made the request voluntarily. If passed it would open the floodgates to euthanasia in this country given the current climate of favourable public opinion, some willing doctors, and many patients already feeling a burden to relatives, carers and society at large.

Requests for voluntary euthanasia are rarely free and voluntary, and in fact extremely rare when patients' physical, psychological and spiritual needs are properly met. CMF has consistently opposed euthanasia on the grounds that it is unnecessary (because alternative treatments exist), dangerous (because of the slippery slope) and morally wrong (contrary to all historically accepted codes of medical ethics and the Judeo-Christian ethic).

We can be encouraged from the House of Lords debate that the Bill has drawn together a strong opposing coalition consisting of people who would not normally be on the same side in other bioethical debates, especially those concerning the beginning of life: Lord Alton and the All-Party Parliamentary Prolife Group, Archbishop Rowan Williams, Broadcaster Robert Winstone and Richard Harries, Bishop of Oxford.

It is noteworthy that a House of Lords Select Committee on Medical Ethics in 1994 opposed any change in the law to allow euthanasia after an extensive enquiry and concluded that 'it was virtually impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law in the United Kingdom could not be abused.' They 'were also concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death.' We need to pray that this wisdom continues to prevail.

Christian doctors are encouraged to write to individual House of Lords members, encouraging them to oppose the Bill, at House of Lords, London, SW1A 0PW. A full list of members, along with instructions on how to address them is available on the internet.[2]

Peter Saunders
Managing Editor of Triple Helix

1 *www.parliament.the-stationery-office.co.uk/pa/ld200203/ldbills/037/2003037.pdf*
2 *www.publications.parliament.uk/pa/ld/ldinfo/a-z.htm*

The Sexual Health Enquiry

Good on diagnosis but offers an ineffective prescription

On Wednesday 11 June 2003 the much leaked in advance House of Commons Health Committee Report on Sexual Health[1] was published. Having been one of just two GPs who gave oral evidence to the Committee, I was not surprised at its findings.

David Hinchliffe the Labour chair of the committee was widely quoted as saying that sexual health in the UK was 'in crisis' and 'We do not use the word "crisis" lightly'. This remark was prompted not only by the steep rises in STIs (gonorrhoea rates have doubled and syphilis risen by 500% in the past 6 years) but by the breakdown in GUM services to cope with this rise. People were reported as being turned away from clinics and told to come back two weeks later!

In terms of diagnosis the report in its shortest section quite correctly highlights changes in sexual behaviour such as increasing numbers of both serial and concurrent sexual partners, decreased age of first intercourse, increasing numbers of men ever having had sex with other men, increasing numbers of men paying for sex and increasing frequency of anal sex for both men and women.

The prescription for improving sexual health does not lie in modifying these behaviours however but in reducing the risk by greater condom use and more (and compulsory) sex education in schools. No reference at all is made to the increasing evidence of the ineffectiveness of condoms to prevent the spread of the most common STIs such as HPV, HSV and chlamydia[2] and there is no convincing evidence anywhere in the world that the sort of sex education programmes which this report promotes achieve either a reduction in teenage pregnancies or in STI rates. Despite the evidence I presented[3] along with Robert Whelan, the Director of Family Education Trust on the evidence for the effectiveness of abstinence education the report states, 'We see no benefit in preventative approaches based primarily around promoting abstinence'.

What they do promote as a model to follow is the Swedish system of care. This is quite bizarre since the report also states that 'our visits to Sweden and the Netherlands also showed us that the public health problems caused by sexual ill health are increasing rapidly even in countries where such good practice is found'. Quite so. The chlamydia rate in Sweden has risen by 60% in the past four years and rates of STIs are rising at an alarming rate in the Netherlands. Why is their practice then considered 'good' by the committee?

Professing to be wise, this report shows that they are fools.[4] Putting potted plants and wicker chairs in the GUM clinic waiting room may be laudable but the government's blind refusal to tackle behavioural change as a primary prevention priority will mean that sexual health in the UK will be much worse in ten years time in spite of the committee's good work in highlighting the severity of the problem that exists even now.

Trevor Stammers
General Practitioner in West London

1 www.publications.parliament.uk/pa/cm200203/cmselect/cmhealth/69/6902.htm
2 Stammers T. The Condom Controversy. *Triple Helix* 2002; 20:10,11 (Summer)
3 www.famyouth.org.uk/Inquiry.pdf
4 Romans 1:22

Two controversial designer baby cases have recently aroused public controversy. **Peter Saunders** asks how far we should allow the new gene technology take us.

The Hashmi family

Photo: PA

Designer babies

On Tuesday 8 April the Court of Appeal gave the go-ahead for the Hashmi family to have a child by in vitro fertilisation in order to provide a 'life-saving' bone marrow transplant for their son Zain, who has B-thalassemia major. The ruling overturned a December 2002 High Court judgement in favour of 'Comment on Reproductive Ethics' (CORE) and was widely applauded in the press, and in particular by the Human Fertilisation and Embryology Authority (HFEA) and the British Medical Association (BMA).

More recently on 16 June Britain's first 'designer baby' was born in Sheffield. Michelle and Jayson Whitaker's baby Jamie was genetically selected in a Chicago Clinic, whilst still an embryo, to be a near perfectly matched blood stem cell donor for his four-year old brother Charlie who suffers from Diamond-Blackfan Anaemia. The HFEA had earlier opposed the Whittakers having embryo selection in the UK on the grounds that it would not directly benefit the selected embryo, and stood by its earlier decision, this time unsupported by the BMA.

Media and public opinion seemed to be strongly behind the parents in both cases; but there were several things that disturbed me.

First, I was concerned by the way public opinion was manipulated by selective and inaccurate reporting of the medical facts. The impression given by the media, that both Zain Hashmi and Charlie Whittaker would die soon without the transplants and that the transplants would be straightforward and uncomplicated, was quite misleading.

There is no doubt that both B-thalassemia and Diamond-Blackfan anaemia (DBA) are serious conditions. Before any treatment was available all sufferers died within a year from the inability to produce red blood cells. Treatment with regular monthly blood transfusions (the only treatment still available in most developing countries) extends life-span to the early teenage years, but then most patients die from the complications of iron deposition. This can be ameliorated with chelation treatment using desferrioxamine, given five times a week by slow subcutaneous infusion (usually over night). This has made possible a median survival of 31 years for DBA and 40-50 years for B-thalassemia, and results are improving all the time.

Bone marrow transplantation from a tissue-matched donor (almost always a sibling or close family member) for both conditions offers the only chance of a complete cure but there are risks. 5% of patients do not survive the procedure, and a further 10% are not cured; and there are also the long-term risks of debilitating 'graft versus host disease' and the side-effects of immuno-suppressant drugs, which include increased susceptibility to infection and some forms of cancer. Gene therapy may offer further treatment options in the future but not yet. Haematologists themselves remain divided over whether transfusion/chelation or bone marrow transplant is best in any given case; it is by no means clear-cut.

In the Whittaker's case a suitable donor may have already been found (in newborn baby Jamie) although seven embryos of the 'wrong' tissue type were discarded in the selection process and one other that was implanted failed to survive. Ironically it is still possible (up to 25% chance) that Jamie too may turn out to suffer from DBA and that the Whittakers may be left with two children with the condition! For the Hashmi's, only about one in five embryos produced by IVF will be the right HLA tissue type and free of the disease and in a woman of Mrs Hashmi's age the chance of any implanted embryo surviving is around 10% per cycle (with each cycle costing around £2,500). So, in other words, we can expect around 50 embryos, all human lives in their own right, to be discarded or lost for each one that survives. And even then there are difficulties with pre-natal screening. Zain himself initially tested normal, and an earlier sibling who was thought to be a good match turned out not to be. Another sibling was aborted when found to have Zain's condition. The rush to conceive a sibling is not because Zain is about to die, but because his mother's biological clock is ticking such that an IVF child will not long be an option.

Second, it is often said that 'hard cases make bad law' and the Hashmi ruling has, I believe, created a very dangerous precedent. Many of us already have severe misgivings about pre-implantation diagnosis, a procedure already legal in this country, whereby human embryos having various disabilities are searched out and destroyed. This seems to strike at the very heart of Christian morality, which decrees that the strong have a duty to protect and respect the weak. It also runs counter to the Declaration of Geneva (1948), which calls doctors to 'maintain the utmost respect for human life from the time of conception even against threat'. After all, what human life is more vulnerable and defenceless than an embryo with special needs? But the Hashmi ruling goes a step further because it has opened the door for human beings to be manufactured for the prime purpose of providing tissue for someone else. It is particularly disturbing that a case where the proposed treatment involves significant mortality (not just for the discarded embryos but also possibly for the sick child) and where the chances of success are so low should have been used to legitimise the highly controversial practice of embryo selection for tissue type.

The Court of Appeal, HFEA and BMA have taken a quantum leap down the slippery slope to 'designer' babies, whereby human embryos can be created and discarded for increasingly trivial reasons. The Hashmi decision was made in haste in an emotionally charged atmosphere where a proper objective consideration of the facts of the case and consequences of the judgement was well-nigh impossible. I am convinced that we will come to regret it.

Peter Saunders is General Secretary of Christian Medical Fellowship

George Smith continues his series with a look at this widely used alternative medicine

Homeopathy

KEY POINTS

Homeopathy was first developed by Samuel Hahnemann in the early 19th century and is based on the principle that extremely diluted and shaken solutions of substances that produce similar symptoms to a given disease, have curative properties. Although relatively safe (apart from its use possibly delaying effective orthodox treatment) it has no rational scientific basis and extensive reviews have shown no conclusive or consistent evidence of efficacy. Furthermore there are links to New Age pantheism and diagnostic methods used by some practitioners have occult associations. Homeopathy cannot be recommended on the basis that it appears to be neither biblically sound nor evidence based.

Homeopathy is one of the most popular and controversial of the plethora of alternative therapies available within and without the NHS. The word homeopathy is derived from two Greek words, *homoios* meaning 'like' and *patheia* meaning 'pain or suffering'. Homeopathy epitomises the strong paradox inherent in the present attitude towards so-called integrative medicine. On one hand, there is a desire to pursue clinical excellence, properly dependent upon evidence-based medicine; on the other, there is a somewhat illogical desire to embrace alternative therapies dependent on unscientific philosophies such as *ch'i*, life force and universal cosmic energy.

Origins

No clear ancient origins exist, although both Hippocrates (c460-370 BC) and Paracelsus (1493-1542 AD) considered that healing might be facilitated by medicines that produce symptoms similar to those of the disease. They didn't consider using extreme dilutions, a process of shaking or potentisation and neither followed their thinking through into practical medicines.

Samuel Hahnemann (1755-1843) was the founder of homeopathy. He was born in Meissen, Saxony and studied medicine and chemistry at the universities of Leipzig, Vienna and Erlangen. He graduated with a degree in medicine in 1779 and began to practice in a variety of posts but continued his research into chemistry. He soon became disillusioned with the ineffective, painful and sometimes fatal treatments of his day that included bloodletting, leaches, purging and medicines containing dangerous chemicals such as arsenic and mercury.

He gave up his practice and turned to research and translation. After translating a treatise on *Materia Medica* by William Cullen, an Edinburgh physician, he became interested in Peruvian cinchona bark as a treatment for malaria.[1] Having tested it on himself, he believed that small doses produced symptoms similar to those of malaria. After testing other substances, a process called provings, he concluded that they could be used to treat diseases with similar symptoms. He formulated his first principle (sometimes known as 'law') of homeopathy: *similar similibus curantor* meaning 'let like be cured by like'.

Hahnemann returned to medical practice and put his newfound theory into practice but with limited success. Concerned about side effects called aggravations, he decided to dilute his original medicines or mother tinctures. One drop was diluted with nine or ninety nine drops of solvent (water and alcohol) making a dilution of one in ten (lx) or one in a hundred (lc) respectively. This process was repeated six, twelve or 30 times, eg 6c, 12c or 30c. This process of dilution is the second principle of homeopathy.

Still dissatisfied with clinical results, Hahnemann decided to shake the solutions between each dilution, a process he called succussion, which he believed potentised the resulting remedy with some form of vital force. Potentisation is the third principle of homeopathy.

In 1810 he set out his findings in the Organon of Rational Medicine, later to be called the *Organon of the Rational Art of Healing*.[2] He later published a six volume *Homeopathic Materia Medica*.[3] Despite widespread opposition, he continued to teach and practise his new system of medicine, based on these three essential principles, in his native Germany and later in Paris where he died in 1843. Although his views were generally unpopular with the medical establishment, a few doctors did accept his principles and there was a gradual worldwide spread, which we continue to witness today. It is recorded that Hahnemann was born into a Christian family but became a very active Freemason and later followed the teachings of Confucius.[4]

Homeopathy in Britain

Dr Frederick Quinn studied under Hahnemann and believed that he had been healed of cholera by a homeopathic preparation of camphor. He went on to introduce homeopathy into England in 1826,

Can we, with integrity, prescribe a medicine that does not contain one molecule of effective remedy?

setting up a practice in London and establishing the British Homeopathic Society in 1832. The London Homeopathic Hospital was founded in 1850 and there are now similar hospitals in Bristol, Glasgow, Liverpool and Tunbridge Wells. Established in 1978, the Society of Homeopaths grants registration (RSHom) and fellowships (FSHom); medically qualified practitioners may become members of the Faculty of Homeopathy (MFHom).[5]

Today, homeopathy is the third most popular therapy (after osteopathy and chiropractic) in the United Kingdom. Queen Adelaide (wife of William IV), who came from Saxony and was a contemporary of Hahnemann, started the Royal Family's custom of using homeopathic medicines and recent monarchs have regularly appointed a homeopathic physician. Prince Charles, a strong supporter of many forms of alternative medicine, advocates homeopathy for both humans and animals.

Homeopathic diagnosis includes a full medical history, examination and special investigations although these are necessarily restricted in those without a medical qualification. Homeopaths assess appearance, constitution and personality and arrive at a symptom picture. When homeopathy is presented in New Age settings such as Mind, Body, Spirit Festivals or Psychic Fayres, diagnosis may include divination, astrology and pendulum swinging. In the United Kingdom most medically qualified homeopaths would distance themselves from such practices.

Homeopathic treatment today still depends on Hahnemann's three original principles. Having assessed the symptom picture, treatment is based on matching this with a remedy picture selected from a *homeopathic pharmacopoeia*.[6] The remedy may be given perhaps for six doses; if not effective, a further selection is made. If a 6c dilution does not work, a 30c strength may then be selected. 6x is the usual strength for over-the-counter preparations but 6c and 30c would be common starting strengths for trained homeopaths. It is presumed that the more extreme the dilution, the greater its efficacy.

It is commonly believed that homeopathic remedies are based only on herbs, plants and other natural substances assuming that 'natural means harmless'. However, many of the substances in the mother tincture are noxious and poisonous including anthrax poison from the spleen of an infected sheep, rattlesnake and cobra venom, discharge from a scabies blister, sulphuric acid and arsenic. But no harm results because of the extreme dilution.

Medical Checklist

1. Does it have a rational, scientific basis?

The idea that 'like may cure like' is quite contrary to orthodox medical principles. Symptoms are usually treated and respond to medicines with the opposite effect: diarrhoea responds to constipating medicines such as codeine rather than bowel irritants such as castor oil. This is termed *allopathy*, the opposite principle to homeopathy. Within therapeutic limits, conventional pharmacology dictates that a higher drug concentration gives a more powerful effect. Homeopathy turns this on its head: the extreme dilutions involved mean that, from the dilutions of 12c onwards, not one molecule of substance is present in the homeopathic preparation, be it liquid, powder or tablets. Homeopaths do not dispute this but believe that some form of imaging or ultra molecular action takes place in the solvent during the process of potentisation. Evidence for this is not forthcoming. The recent chance finding that molecules in solution cluster together as the solution is diluted was thought to have a possible relevance to the preparation of homeopathic remedies but this has not been progressed to a scientific conclusion.[7,8] Homeopathy is not scientifically comparable with vaccination, immunisation or allergic desensitisation. Homeopaths maintain that the process of potentisation produces a healing power in the remedy called a vital force. This term clearly equates to the *ch'i* of Chinese acupuncture, the *prana* of Ayurvedic medicine and the universal cosmic energy associated with New Age advocates of alternative therapies.

2. Does it work?

It is generally accepted that anecdotal observations are insufficient to demonstrate the validity of any therapy, be it orthodox or alternative. A considerable number of scientific investigations into homeopathy have been attempted. Results have been correlated, (particularly by meta-analysis) and subjected to clinical, scientific and statistical scrutiny in the Department of Complementary Medicine at Exeter University, directed by

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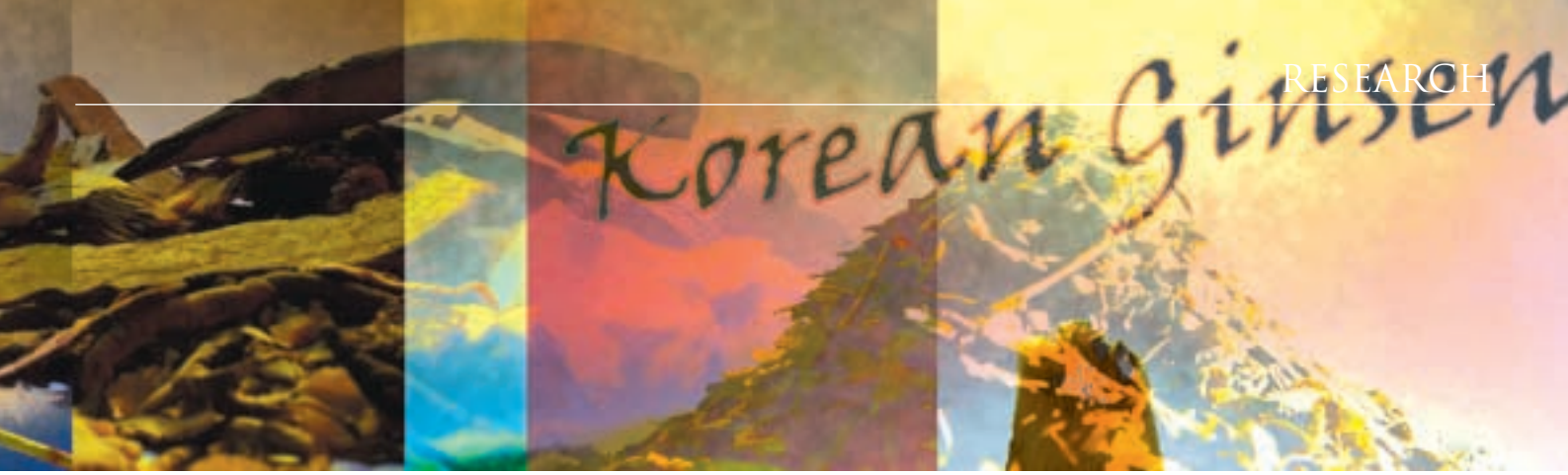

Professor Edzard Ernst. Almost 50 reports have been published in their journal *FACT* over the past six years.[9] Methodology has been of varying standards but after excluding results due to non-specific placebo effects no consistent or conclusive evidence of efficacy emerges. A paper published in the *European Journal of Clinical Pharmacology* set out to evaluate the clinical efficacy of homeopathy. It emphasised the difficulties encountered because there was no consensus as to the treatment in particular situations. Furthermore, it noted that the more rigorous the trial, the less likely it was to produce possible evidence in support of the homeopathic preparation. The authors recommended that more research be carried out but stated, 'There is simply not enough evidence to conclude that homeopathy is clinically effective'.[10]

It is generally agreed that the placebo effect is of real importance in general medical care, in the use of alternative therapies and in scientific assessment of all medical treatments undergoing clinical trials. Professor Ernst discusses this in depth in his book, Complementary Medicine – An Objective Appraisal.[11] Of course, with its present popularity and wide royal and celebrity patronage, a significant degree of placebo effect is to be anticipated from homeopathy. Patients may well feel better but whether any pathological process has been improved or cured is very much in doubt.

3. Is it safe?

Homeopathy is often considered to be safe for minor and self-limiting complaints. There are no reasonable grounds for advocating its use instead of orthodox immunisation in children. Generally, it is not considered appropriate for serious or life threatening illness. A valid criticism of homeopathy is that it can encourage serious delay before seeking proven conventional treatment. Dr Andrew Lockie's popular textbook, *A Family Guide to Homeopathy*, is subtitled 'A Safe Form of Medicine for the Future'. So it is somewhat disconcerting to read advice that suspected ectopic pregnancy may be treated homeopathically for two hours before seeking orthodox treatment![12] Similarly, twelve hours' homeopathic treatment for suspected deep vein thrombosis is considered acceptable before considering orthodox treatment.[13] These potentially life-threatening conditions should receive proven treatments as soon as they are diagnosed. To recommend otherwise is not safe medicine!

Christian Checklist

There are significant areas of concern. Can we, with integrity, prescribe a medicine that does not contain one molecule of effective remedy? Is it good practice to prescribe remedies that have been investigated without producing any consistent evidence of efficacy? Is it responsible to delay or withhold orthodox proven medical treatment whilst relying on an unproven alternative remedy? Is it acceptable to use a therapy that relies on the principle of vital force, clearly comparable with the *Ch'i (yin and yang)* of Eastern religions and the cosmic energy of New Age philosophies? Should we use a therapy that some practitioners mix with divination, astrology and pendulum swinging, which are clearly forbidden in the Bible?[14]

Miranda Castro FSHom states: 'Homeopaths believe that there is a balancing mechanism that keeps us in health, provided that the stresses on our constitution are neither too prolonged or too great. This balancing mechanism Hahnemann called "vital force" and he believed it to be "that energetic substance, independent of physical and chemical forces that literally gives us life and is absent at our death"'[15]

Summary

It is appreciated that there are committed and zealous Christians - including past and present doctors, nurses and missionaries - who have found homeopathy acceptable and useful in their ministry. In today's climate of integrative medicine, it is particularly relevant for Christian doctors and nurses to decide whether or not they find homeopathy acceptable. Scientific evidence, biblical guidance and discernment from the Holy Spirit all play a part in making this decision.

Having said this and taking into account everything discussed in this article, it is my own conviction that homeopathy clearly falls far short of being a therapy that can be acceptable to use or recommend.

Prove all things, hold fast to that which is good, abstain from all appearance of evil. (1 Thessalonians 5:21-22, King James Version)

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Clare Cooper looks at an agency in crisis

The United Nations Population Fund

KEY POINTS

The United Nations Population Fund (UNFPA) has done some good work in antenatal and postnatal care, reducing maternal morbidity and mortality, and provision of gynaecological services; but there have also been serious allegations about its complicity in coercive population control, secret abortion promotion, and financial and programme mismanagement leading to the USA and Spain withdrawing funding. This article documents specific abuses in programmes in China, Vietnam and Peru and gives examples of botched projects and misuse of funds. In the face of this it has to be asked why the EU and UK are still providing funding to this international agency.

Isaiah tells us that God 'tends his flock like a shepherd: he gathers the lambs in his arms…he gently leads those that have young'.[1] Sadly, humankind does not always follow God's example.

The United Nations Population Fund (UNFPA) is one of the world's most controversial international organisations. Serious allegations have been made by donor nations and human rights groups: complicity in coercive population control, secret abortion promotion, financial and programme mismanagement. The USA and Spain have withdrawn their funding and there is disagreement in Europe over the agency's future role.

The International Organizations Research Group investigated UNFPA's activities.[2] Their findings were presented to the European and British Parliaments this January and are summarised here.

Coercive population control

UNFPA was set up in 1969 to slow population growth. It is the largest international sponsor of population programmes.[3] Some of these are invaluable: antenatal and postnatal care, efforts to reduce maternal morbidity and mortality, and provision of gynaecological services.[4] Other projects are causing worldwide concern. By funding and assisting in coercive population control, UNFPA has been complicit in human rights violations.

China

In 1979 UNFPA gave China a grant of $50 million and assisted in the implementation of the One Child Policy. A demographic institute collected data, conducted research and disseminated information on population and family planning.[5] So, the Chinese State Family Planning Commission were able to tell where women were evading family planning regulations and so set regional contraceptive and abortive quotas. In 1985, the US Agency for International Development (USAID) stated, 'The kind and quality of assistance provided by UNFPA contributed significantly to China's ability to manage and implement a population program in which coercion was pervasive'.[6]

UNFPA is still active in 32 Chinese counties on the understanding that quotas and birth restrictions have ceased.[7] In October 2001, a human rights group alleged continuing coercion. They described secret interviews by the US-based Population Research Institute (PRI) with women in Sihui county. The women testified to forced abortions and sterilisations, arrests and detention. One woman, pregnant with her second child, told PRI that officials 'wanted me to report to the hospital for an abortion but I refused to go. I went into hiding in my mother's village. They arrested six people in my mother-in-law's family and destroyed three homes'.[8]

UNFPA's own investigators didn't find any evidence of coercion. Still, none of the team met with women without the knowledge or presence of Chinese officials; there weren't any private, unmonitored or confidential meetings. In May 2002 the United States government sent its own investigative team. They found that UNFPA works in one county where women with more than one child must pay a 'social compensation fee', up to three years' income. Based on these findings, the Bush administration ended all UNFPA support. Secretary of State, Colin Powell, wrote, 'UNFPA's support of, and involvement in, China's population-planning activities allows the Chinese government to implement more effectively its program of

Photo: Welcome Photo Library

coercive abortion'.[9] He also criticised their supplying of computers and medical equipment to family planning offices engaged in coercive practices.

Vietnam

Vietnam's population programme calls for coercive measures in a third pregnancy: a 'two child policy'. Parents may have to pay health and education costs of a third child, land may be confiscated and Communist party members are expelled.[10] A 1989 report stated that women had been forced into abortions and IUCD use.[11] By 2001 Vietnam had one of the world's highest abortion rates.[12] According to a UN document, 'Vietnam is undergoing the demographic transition which is usually necessary for a sustainable reduction of poverty. Although government policy bears the main responsibility for this achievement, UNFPA's assistance in preparing for and supporting the policy reform provided necessary capacity and support for implementing it'.[13] UNFPA gives financial and public relations support for this programme.

Peru

In 1995 Peru embarked on a massive sterilisation programme but reports of human rights abuses quickly arose.[14] USAID voiced concerns over coercive practices - promises of food for sterilised women and bonuses for health workers who brought women for sterilisation - and withdrew its family planning funding in Peru.[15,16] UNFPA neither publicly acknowledged coercive practice nor stopped funding. In June 2002 a Peruvian congressional commission noted that 90 percent of the 200,000 sterilised women had been pressured or tricked. 'UNFPA, known for its support of population control in developing countries, took charge. For that end, UNFPA acted as Technical Secretary.'[17]

Abortion

UNFPA's policy is not to provide assistance for abortions or abortion services.[18] Yet it conducts abortion research and advises abortion providers on specific procedures.[19] Their refugee camp 'emergency reproduction health kits' have included emergency contraceptives, IUCDs and manual vacuum aspirators (MVAs) alongside useful obstetric equipment.[20] These three items used to be distributed in sub-kits called 'pregnancy termination kits'.[21]

Programme mismanagement

In 1999 the UN Board of Auditors uncovered evidence of programme mismanagement. UNFPA have purchased contraceptives without checking quality, delivery or supply.[22] In 2002 Tanzania rejected an $800,000 shipment of ten million faulty condoms after they failed Tanzanian permeability tests.[23]

Financial mismanagement

UNFPA couldn't account for 50 percent of money given to nations and non-governmental organisations in 1998-99.[24] This amounts to tens of millions of dollars that could have been used effectively. One audit criticised UNFPA's project formulation and 'poor project design [which] hampered the effective measurement of the impact of projects'; 75 percent 'failed to deliver all their planned outputs'.[25] UN financial regulations were frequently breached.[26] Now UNFPA claims to have 'greatly strengthened its internal audit capacity'.[27]

Conclusion

When the USA withdrew its $34 million funding, the EU pledged to replace the lost funds.[28] However, UNFPA's core resources last year fell from $269 million to $256 million; future fundraising is likely to be a major challenge.[29] The UK government has been challenged to reconsider its funding: letters to MPs and MEPs should keep this issue in mind. It would be an improvement if money were given for specific projects; better still, funding could be switched to alternative development programmes. The USA transferred its funding to USAID; they concluded that good economic policies reduce poverty better than family planning programmes.[30]

Christians know a Father who gently leads those with young and this should be reflected in healthcare planning. In view of UNFPA's failure to care for people as individuals or speak out for justice, a new international medical agency should be established to provide care for parents and their children, treating them with respect and dignity.

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Camille De Blasi looks at the reasons for the Western world's cultural demise

How to heal the CULTURE

The good news is that Western culture is not terminally ill. It is just critically sick.

There's little doubt that Western culture is starving to death. In ten years of professional pro-life education, I have observed large numbers of young people who think the elderly have a duty to die, elderly people who think the preborn are a threat to global health, and healthy people who think the sick and disabled would be better off dead.

The trouble with our culture seems to be a spiritual ignorance about who we are and what human beings are meant for. People are not able to understand the meaning of suffering if they do not sense that they are made in the image and likeness of a God who created them to share in his life-giving and love-giving legacy. Instead of viewing suffering as a profound opportunity to share more fully in the mystery of self-gift, they perceive it as debilitating, embarrassing, humiliating, undignified and useless. In turn, they resent a God who allows it and convince themselves that compassion means avoidance of suffering at all costs. That's precisely what abortion, euthanasia, cloning, and destructive stem cell research seek to do. Healing will only come through a conversion of the heart concerning what we, as a culture, are living for.

In his groundbreaking book, *Healing the Culture, A Commonsense Philosophy of Happiness, Freedom, and the Life Issues*, Robert J. Spitzer, President of Gonzaga University, offers a guide to effective pro-life education by looking to the four basic desires within the human soul which motivate what we do and how we live.[1]

The first human desire is for *physical pleasure*. It can be immediately satisfied, uses very little of our human powers to fulfill, and is necessary for existence. While there is nothing wrong with physical pleasure in itself, a person who makes it his *raison d'etre* will soon become unsatisfied. He will sense that he is radically under-living his life. This is the soul's way of indicating that there are deeper powers to the human nature yet unfulfilled.

The desire for 'something more' is the catalyst for awakening our second human desire: *ego-drive* or the desire to create a self-identity through comparison, competition, success, popularity, recognition, power and control. While there's nothing wrong objectively with it, pursuing ego-gratification as one's final end will make life fraught with jealousy, anxiety, suspicion, fear, aggression, obsessive compulsions, contempt for others and even self-hatred.

Many philosophers point out that the solution to this crisis is to look beyond the self to the needs of others. This third desire – to *contribute* and enter into communion with one another – can lead to some of

Keeping

I couldn't do without 'to do' lists. Recently, I read an interesting list for growing older! Written by a Harvard medical school professor, '*Aging Well – Surprising Guideposts to a Happier Life*' suggests the following:

don't smoke
adopt an adaptive coping style
avoid alcohol abuse
maintain a healthy weight
keep stability in marriage
look out for the younger generation
exercise regularly
complete an education[1]

the greatest moments of common cause. It can also lead to some of the darkest moments of despair as we quickly become idealists.

The trouble is that we begin to seek fulfillment not in mere love but in perfect, absolute, infinite and unconditional Love. If a person tries to fulfill this desire with imperfect, finite human beings, he will experience inevitable frustration and dashed expectations. On the other hand, if he responds to this desire by entertaining a *faith* that goes beyond what he can see, then this fourth desire for ultimacy has the potential to lead him to God and the joy that results from entering into relationship with absolute and unconditional Love.

These four levels of happiness - physical, ego, contribution and faith – offer us a key to the crisis of modern man. The culprit seems to be an identity that ignores the ultimate yearnings of the human soul – indeed, ignores the very existence of the soul – and focuses instead on trying to fulfill a spiritual self with material goods and ego-gratification. This attitude can have devastating effects.

Consider a person who has spent a lifetime defining happiness in terms of physical pleasure and ego-gratification. *Success* is defined as independence, control, and avoiding pain and loss; he views disabilities with contempt. *Quality of life* is judged by the ratio of what he has to what he does not have; he may view euthanasia for the terminally ill as liberating. *Love* is equated with lust, admiration, and domination over the other; sex is seen as the satisfaction of his animal appetite. *Suffering* is only useful if it can be controlled, and completely useless if it cannot; consequently he may view abortion in Third World countries as compassionate. *Ethics* entails a calculation of harms and benefits; research on frozen embryos seems like a good ending to a sad story. *Freedom* means escape from externally imposed obligations and commitments; he sees rules against cloning as thwarting scientific advancement. To this person, *rights* and *personhood* have become a Peter Singer-like description of functions and abilities; he may even call into question partially born and newborn infants. From his perspective, abortion and euthanasia appear to be good answers to human suffering. We cannot change his answers unless we change his viewpoint.

So, let us consider God's point of view. True success doesn't come from the things of this world but from belief in Christ.[2] The quality of our lives is not based on what we have but on the fact that God wants us for himself.[3] Love is not about sensation and control but involves compassion and self-sacrifice.[4] Suffering teaches us to be gentle and humble of heart.[5] Ethics is not cold calculation but is about being true, noble, pure, lovely and admirable.[6] Freedom should be used to serve one another in love.[7] Personhood and rights belong to each one of us from the moment we are created in the womb.[8]

If we want a culture that respects the dignity of all human life, we need to awaken the desire for higher ideals in the individuals that constitute that culture. This can be accomplished in small ways such as speaking with family members, friends and colleagues, leading them to consider deeper levels of human purpose.[9] It can be done in bigger ways such as establishing a corps of hospital volunteers who are trained to help patients find deeper meaning in their suffering.[10] It can also be accomplished in more formal ways: through retreats, lectures, articles, media interviews, public discussions, or classroom activities.[11]

The good news is that Western culture is not terminally ill. It is just critically sick. But it needs desperately to be fed a vision of hope, dignity, love, compassion and faith. There is much to be optimistic about. The human spirit that flounders under the weight of ignorance is also the human spirit that will soar to untold heights when liberated by a vision of its own dignity.

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KEY POINTS

The increasing acceptance of abortion and euthanasia is simply a symptom of spiritual ignorance in our culture. Human desires can be thought of as operating at four levels; physical pleasure, ego-drive, contribution to others and faith. If life is simply seen to be about maximising physical pleasure and gratifying the ego then success, quality of life, suffering and freedom will be viewed within these parameters. But seen through the eyes of faith they take on completely different meanings. If we are to change the way people think about pro-life issues then we must first change the way they think about what it is to be human.

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Lists

Most of us keep to-do lists. But might we take God's instructions with the same seriousness, wonders **Bob Snyder**

The Bible suggests that God keeps lists as well.

'*There are six things the Lord hates, seven that are detestable to him:*

haughty eyes,
a lying tongue,
hands that shed innocent blood,
a heart that devises wicked schemes,
feet that are quick to rush into evil,
a false witness who pours out lies and
a man who stirs up dissension among brothers.'
(Proverbs 6:16-19)

As we draw up this week's 'to-do' list, let's seriously consider and act upon God's list.

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Family planning professor **John Guillebaud** brings an update on the options available for contraception and the scientific facts on how and when they actually do their work

Photo: Wellcome Photo Library

When do contraceptives work?

KEY POINTS

The status of the human embryo remains controversial within CMF, but a significant number of Christian doctors believe that human life should be shown the utmost respect from the time of fertilisation and so are unwilling to prescribe or recommend 'contraceptives' that may act after this event. Because most non-Christian colleagues do not share these concerns, and because there is no reliable biochemical marker for fertilisation as opposed to implantation, the facts on which to base such prescribing decisions can be difficult to obtain. This article reviews the available scientific evidence and divides contraceptives into those that act before and those that act after fertilisation.

Most Christian doctors have reached a personal opinion on when life starts and are unwilling to prescribe a drug or device that acts at or after that point. It's also an important issue for many couples when deciding on a contraceptive. It's important that we are armed with the facts.

When do you consider life to start? Is it at fertilisation? Does it start later: before, during or even after implantation? This debate is ongoing in CMF and will not be considered here. Most Christian doctors have a personal opinion; though this varies, they are united in being unwilling to prescribe a contraceptive drug or device that acts at or after that point. It's also an important issue for many couples when deciding on their own method. We need to be armed with the facts. Yet, partly because non-Christian colleagues often do not share our concerns, accurate scientific information can be hard to obtain.

Two research review articles are worth considering.[1,2] The take-home message is that human chorionic gonadotrophin (hCG) is first measurable in the maternal circulation *shortly after the time of implantation*.[3] Hence, research showing no hCG or other known embryo-specific substances in the maternal blood during contraceptive use, only tells us that it does not operate after implantation. At least on some occasions, it might operate after fertilisation, by prevention of implantation or direct destruction of the blastocyst. Clearly, any method linked with the presence of serum hCG would be off-limits to someone requiring a contraceptive that only operated before fertilisation.

Intrauterine contraceptive devices (IUCDs)

The following table summarises the interesting results of a study.[4]

Population	Sample size	Percentage of sample with hCG increase
Control (sexually active without contraception)	22	32
Inert IUCDs	40	20
Copper IUCDs	41	4
Levonorgestrel-IUS (Mirena)	19	0

On this evidence, both copper and inert devices sometimes operate well after fertilisation. The findings regarding the *Levonorgestrel-intrauterine system (levonorgestrel-IUS)* are compatible with absent fertilisation, either through the levonorgestrel effect on cervico-uterine mucus blocking sperm migration or anovulation in a proportion of cycles. Yet unfavourable cervical mucus is not always observed and we know that ovulation still occurs in most cycles.[5] Is the levonorgestrel effect on sperm migration within the uterine fluid always enough to stop the sperm reaching any egg in the tubes? Although there are no direct data, the very rare cases of ectopic pregnancy in women using this method provide indirect evidence that fertilisation can occur.

Several studies have demonstrated that hCG is not the earliest signal of pregnancy. Although not testable in clinical laboratories, Early Pregnancy Factor (EPF) is part of the materno-embryonic immunomodulatory interaction. It appears two to six days earlier than hCG and can occur two to seven days after ovulation in women who have conceived.[6] In fact, EPF is

detectable in maternal serum in some cases within 24-48 hours of fertilisation.[7] However, the vast majority of research using EPF has been for detecting very early pregnancy in subfertile women, not for aiding our understanding of the exact modes of action of various contraceptives. More research is needed in this area. So, as there is no routinely testable biological marker of the time between fertilisation and implantation, we must remain unsure that the *Levonorgestrel-IUS* absolutely never operates post-fertilisation.

Systemically applied hormonal methods

With the notable exception of *Cerazette*, the progestogen-only pill (POP) sometimes acts post-fertilisation.[8] It permits ovulation in many cycles. Reduced sperm-penetrability of cervico-uterine mucus is unlikely to explain all the failures to conceive in the presence of ovulation. As with IUCDs, the occurrence of ectopic pregnancies provides further evidence, though not proof, of this.

However, the conscientiously taken low dose combined oral contraceptive pill (COCP), *Cerazette* (a particular POP), the *Depo-Provera* injection and implant *Implanon* are all such effective anovulants (preventing ovulation and therefore fertilisation) that it is scientifically justifiable to conclude that they operate prior to fertilisation. *The fact that they are capable of blocking implantation does not mean that they ever have to use this back-up mechanism.*

Obviously a *forgetful* COCP user, particularly if taking *Loestrin 20*, *Mercilon* or *Femodette* (the lowest dose UK products), might run the risk of ovulation. It is the lengthening of the pill-free interval that causes pill-failure pregnancies and 'near-misses'. Without lengthening of the pill-free time beyond seven days through non-compliance, fertile ovulation is very rare.[9] Even if ovulation did occur without subsequent pregnancy, it does not follow that the COCP acted post-fertilisation: the sperm may have been blocked by COCP's well-known effect on the mucus. Most experts believe that if sufficient pills were missed to cause the mucus mechanism to fail as well, there still wouldn't be any interference beyond fertilisation; the anti-implantation effect (being the COCP's weakest contraceptive effect) would fail also, leading to conception. Of course, one couldn't be certain of this over many years of forgetful pill-taking. Still, we are talking about a *forgetful* pill-taker taking one of the *weakest* available pills.

If a couple hold the view that blocking implantation is a form of abortion and are worried about their own pill-taking compliance, one could recommend that they shorten their pill-free intervals and/or use the tricycle regimen (see below).

Depo-Provera (D-P) is a brilliantly effective anovulant if injected accurately every 12 weeks. For someone with concerns regarding its modes of action, there is the option of having the injection every ten weeks. This gives added confidence that ovulation is always blocked with the unacceptable back-up mechanism never being utilised.

Summary

Assuming perfect compliance, I feel one could be confident that, even after say 20 years' perfect use of the COCP, *Cerazette*, *Implanon* or *Depo-Provera*, there would not have been a single occasion when a post-fertilisation mechanism would have been utilised. *Moreover, having done everything possible in the light of the best available scientific data, might not a believer legitimately ask her omnipotent Lord to ensure that this would be so for her?*

After prayerful consideration, my own personal view is that implantation is the biological event that separates family planning from abortion.[10] Still, I conclude by listing methods that are entirely secure for those who hold the absolutist ethical position that blocking implantation is a form of abortion.

- **Male and female sterilisation.**
- **The combined oral contraceptive pill (COCP)**, provided the pill-free interval (PFI) is never lengthened. For added security, the PFI could be shortened to 4 days on a regular basis; or there is the option of a tricycle regimen. - in which the PFI is eliminated usually for four, three or sometimes (for better bleeding control) two *monophasic* pill cycles and then also shortened after each run of packets.[11]
- ***Cerazette*** is a new continuously-taken POP that is as effective as the COCP at blocking ovulation plus blocks sperm by the mucus effect. Moreover, it is taken 365 days a year and so does not have the COCP's weakness of regular 7-day breaks from its actions.
- ***Implanon*** is a subdermal implant whose hormone content and actions are very similar to *Cerazette*. It should be replaced no later than the licensed three years.
- ***Depo-Provera*** is another anovulant method. If the 12 week injection interval is never exceeded, it is not thought that *Depo-Provera* would ever use a post-fertilisation mechanism. Someone wanting even greater confidence on that point could be offered injections every 10 weeks.
- **Full breast-feeding combined with the POP or *Depo-Provera*.** With the old-type POP, there would only be a slight risk of breakthrough ovulation (and hence the back-up anti-implantation mechanism being used) during weaning. As soon as the baby was not obtaining 100 percent of its nutrition from breast-feeding, the woman should change to *Cerazette*, a *COCP*, *Depo-Provera* or use additional barrier contraception effectively.
- **Male and female barrier methods** and all **spermicides**, though the latter have a high failure rate.
- **All fertility awareness methods**.
- **Coitus interruptus**.

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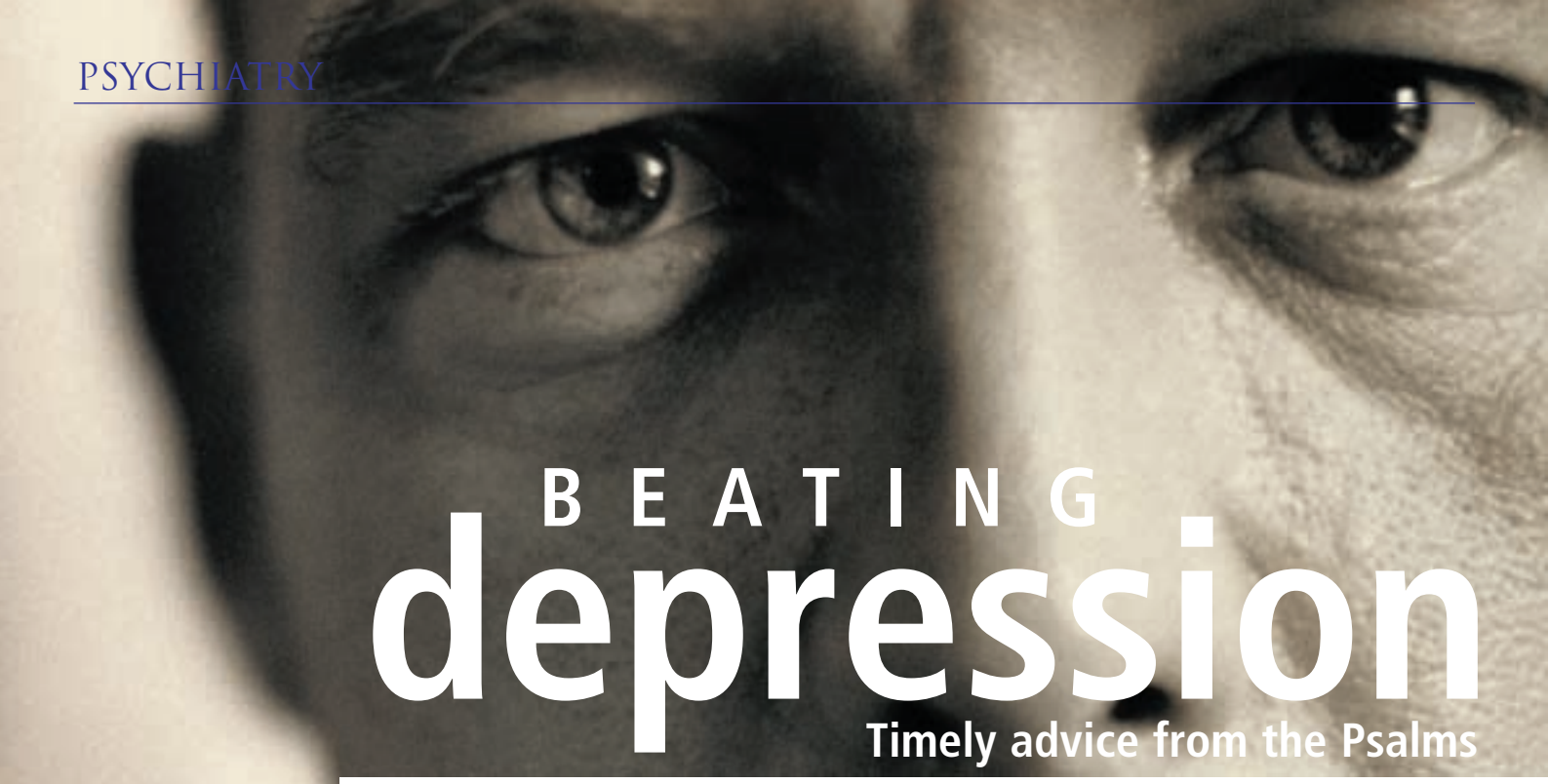

BEATING depression

Timely advice from the Psalms

KEY POINTS

Psalms 42 and 43 give a good description of the clinical features of depression and provide assurance that depression is both part of normal human experience and understood by God. The psalmist describes the depressed person's mood changes, loss of appetite, grief and mourning, difficulty in planning and paranoia. The immediate cause is not clear – but may have been due to circumstances, as a result of physical symptoms or spiritual. Depressed people often find prayer difficult so need friends who will pray for them, encourage them to put their hope in God and remind them that better times will come.

One of the glories of God's Word is that it speaks of human experience just as vividly now as when first written. For a detailed account of the vicissitudes of old age look no further than Ecclesiastes 12:1-7, which describe fading eyesight, poor dentition, tremor and fear of falling. Or perhaps Proverbs 23 :29-35 for the experience of the bloodshot, bruised, swaying and hallucinating alcoholic. Depression is commonly diagnosed in general practice and up to half of us may suffer depression at some time in our lives. Might there be something in God's Word to describe depression? I believe psalms 42 and 43 give us a good insight.

All of us will come across depression at some time, whether in ourselves or others. These psalms suggest that it is a common part of the human experience and give us a clear view of how it feels to be depressed. The psalmist describes his *mood as* 'downcast' and 'disturbed' three times. He says, 'tears have been my food,' suggesting a *chronicity* to his condition, and perhaps loss of appetite. His depression has physical sensation, 'My bones have suffered mortal agony' with perhaps an indication of morbidly expecting his own death. Depressed people often have feelings of *grief and mourning* either as a cause or effect of depression, 'Why must I go about mourning' occurring in both psalms 42 and 43. He has feelings of chaos, represented by the deeps in the waterfall, and of being overwhelmed: 'all your waves and breakers have swept over me.' Many depressed people do seem to struggle with organising their thoughts and feel out of control. *Planning* in depressed people may become difficult: 'When can I go and meet with God?' *Paranoia-like* feelings may occur in depression and are described in 43:1.

Since there is such a detailed description of depression in God's Word, we can reassure depressed Christians that God understands the depressive condition. Some depressed people report feeling guilty that they do not feel happier, considering all of God's gifts to them. These psalms give us *'permission' to be depressed*.

The cause for the psalmist's depression is not clear. The cause may be *spiritual*; a felt separation from God. One of the striking features of these two psalms is this feeling. From the beautiful and well-known opening verses of Psalm 42 describing thirsting for God, he asks rhetorically, 'where can I go and meet with God?' and poignantly, 'why have you forgotten me?' This separation is felt rather than real as Romans 8:39 reassures us that 'neither height nor depth nor anything else in all creation will be able to separate us from the love of God that is in Christ Jesus our Lord.' His sense of separation from God may be either a cause or a consequence of his depression. Certainly no Christian can be content or complete without fellowship with God.

Perhaps it is his *circumstances* that are causing his depression. He is separated from his fellows and may be lonely living in Jordan away from his Jerusalem home. Perhaps he has withdrawn from his friends as a result of his depression. Persecution undermines the toughest man (Ps 42: 3), and the depressed Christian maybe more susceptible to mocking, 'Where is your God?' *Physical symptoms* can be a cause or at least a precipitation for depression. It might, however, be argued that the psalmist rejects any of these as the cause of his depression as he repeatedly asks why he is depressed. The Christian depressive and his attendants may find it difficult to separate cause and effect; spiritual, physical or emotional. Since the answer eloquently stated in these psalms is to turn to God, this may not matter very much anyway.

Some of the *distortion and slowing of mental processing* which may occur in depression can prevent the depressed Christian from praying to God for himself. The practical effects of this means that his *Christian friends* may need to do the praying for him. The very fact of the depressed person's inability to pray can add to his feelings of guilt. Since he may already have low self-esteem and low

self-confidence or even paranoia, he will not find it easy to express this inability to Christian brothers and sisters. These two psalms then give us one way to pray for, and counsel, the depressed Christian. We can point out that the depressed person should try to put their *hope in God*, for he sends forth his light and truth, which will guide our depressed brother. We can reassure our brother that he *will praise God* again and that God will be his delight (43:3-4), even if he doesn't feel it possible at that moment. The psalmist makes a deliberate decision to put his hope in God (42 :5, 11, 43:5). He is entirely confident that God will *respond* - that God will send forth his light, guide him, and that he will be with God on his Holy Mountain, where there is no chance of depression.

I am very grateful to my friends, brothers and colleagues, Dr Leon LeDune and Dr Joss Bray for their helpful criticism and comments.

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Psalm 42

For the director of music. A maskil of the Sons of Korah.

[1] As the deer pants for streams of water,
so my soul pants for you, O God.
[2] My soul thirsts for God, for the living God.
When can I go and meet with God?
[3] My tears have been my food
day and night,
while men say to me all day long,
'Where is your God?'
[4] These things I remember
as I pour out my soul:
how I used to go with the multitude,
leading the procession to the house of God,
with shouts of joy and thanksgiving
among the festive throng.

[5] Why are you downcast, O my soul?
Why so disturbed within me?
Put your hope in God,
for I will yet praise him,
my Savior and [6] my God.

My soul is downcast within me;
therefore I will remember you
from the land of the Jordan,
the heights of Hermon-from Mount Mizar.
[7] Deep calls to deep
in the roar of your waterfalls;
all your waves and breakers
have swept over me.

[8] By day the LORD directs his love,
at night his song is with me-
a prayer to the God of my life.

[9] I say to God my Rock,
'Why have you forgotten me?
Why must I go about mourning,
oppressed by the enemy?'
[10] My bones suffer mortal agony
as my foes taunt me,
saying to me all day long,
'Where is your God?'

[11] Why are you downcast, O my soul?
Why so disturbed within me?
Put your hope in God,
for I will yet praise him,
my Savior and my God.

Psalm 43

[1] Vindicate me, O God,
and plead my cause against an ungodly nation;
rescue me from deceitful and wicked men.
[2] You are God my stronghold.
Why have you rejected me?
Why must I go about mourning,
oppressed by the enemy?
[3] Send forth your light and your truth,
let them guide me;
let them bring me to your holy mountain,
to the place where you dwell.
[4] Then will I go to the altar of God,
to God, my joy and my delight.
I will praise you with the harp,
O God, my God.

[5] Why are you downcast, O my soul?
Why so disturbed within me?
Put your hope in God,
for I will yet praise him,
my Savior and my God.

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Depression

Non-drug therapy

Psychoanalysis

- Classical Freudian psychoanalysis is based on a naturalistic philosophy and underlying determinism
- Psychoanalysis of Carl Rogers is based on liberal humanism
- Both conflict, at least in part, with Christian theology

Behavioural Therapy

- Based on behaviourism and determinism
- This robs man of his significance and personal responsibility

Cognitive Behavioural Therapy

- Loosely based on behaviourism but this is much less strictly adhered to
- The morality of the therapy can be determined by the shared beliefs of the therapist and patient, making the technique adaptable to Christian counselling

Drug therapy

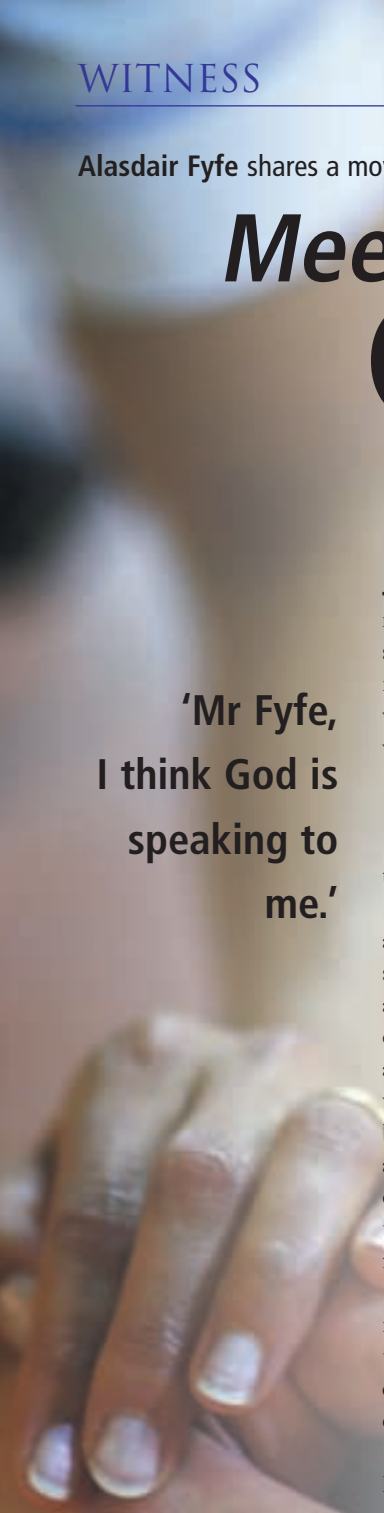
- Well established and evidence-based
- Morally neutral but may fail to recognise the psychological, social, spiritual and environmental factors in the development and maintenance of mental illness

For further information see articles written by Consultant Psychiatrist Nick Land: *Psychiatry and Christianity* (parts 1 and 2)

1. *Nucleus* 2002; July: 13-19.
2. *Nucleus* 2003; April:12-20.

Alasdair Fyfe shares a moving story of God breaking into the life of a mother of a three year-old patient

Meeting God in hospital



'Mr Fyfe, I think God is speaking to me.'

As we talked about her three year old son's impending operation, it became clear that this mother was full of irrational fears. I tried, but failed, to reassure her that the procedure would be very straightforward. 'Lord,' I prayed silently, 'This mum is so anxious, please help me find the right words to say.' I found myself asking audibly, 'Do you believe in God?'

'Yes,' she replied, 'I'm a Catholic.'

'Do you believe that God loves your child?' I asked.

'I suppose he does, though I don't think I've thought about that before.'

'Well,' I said, 'I promise to pray that God will look after him if you do the same. He is more than able to see him through the operation, don't you think?' She agreed hesitatingly, and the consultation came to an end. On admission to the ward some weeks later she and her boy were given a 'parent and child' cubicle. It very soon became clear that things were not going to be easy – this mother's anxiety level was 'sky-high' and made all our efforts to care for her boy exceptionally difficult. The operation came and went uneventfully. The boy was discharged home after a few days.

Some weeks later, the boy made his return visit to my clinic. His post-operative progress had been uneventful – thankfully. When I thought the consultation was finished, I said, 'So God answered our prayers then?'

She replied, 'Mr Fyfe, I think something strange is happening; I think God is trying to speak to me.'

'What makes you say that?' I asked, with another silent prayer.

It was a fascinating story. On the way out of the local supermarket one morning, she had been struggling with her boy in one arm, and the bag of foodstuff in the other. A stranger helpfully opened the shop door and then offered to carry her shopping bag to her car in the car park. On the way there, this unknown woman said, 'I hope you don't mind me saying this but I'm a Christian, and as I was praying this morning, into my mind came a picture of a little boy – and it was your boy. Do you mind if we pray for a minute?' So, there in the local car park, this unknown lady prayed with a perfect stranger.

'Mr Fyfe, I think God is speaking to me.'

To this I readily agreed, and suggested that during the coming week she should simply ask God to speak to her each day, and then read one of the Gospels. She promised to come to our Church the following Sunday morning.

When she did arrive at Church that next Sunday, she was wearing what appeared to be a very expensive purplish (my wife says-lilac!) gown. Remarkably, the preacher that morning spoke on the parable that Jesus told about the rich person dressed in purple [1]. This lady quietly wept throughout the service.

Elizabeth Croton asks if doctors should enquire about

Spirituality

Patients entering hospital experience a variety of emotions and utilise differing coping mechanisms to help them. One such mechanism is the presence of a personal religious faith. [1] Increasingly, it is recognised that faith and hope are valuable adjuncts to the healing process. [2,3] Yet there has not been much research on doctors' roles in patients' spiritual affairs. Research carried out in a pulmonary outpatient department indicated that 94% of patients would welcome physician enquiry into such issues but only 15% had ever had experience of this. [4] Physicians themselves report varying approaches to spiritual assessment but they affirmed that spiritual discussion should be approached with sensitivity and integrity. [5]

Method

I carried out an 11-point interviewer-directed questionnaire survey to determine participants' religious backgrounds, practices and views regarding physician enquiry into their spiritual beliefs. South Birmingham Local Research Ethics Committee approval was obtained. Hospital inpatients on acute wards in a Birmingham teaching hospital were randomly selected (using the PAS computer database system) for inclusion into the study between August and November 2001. Patients who lacked sufficient mental capacity to answer the questions posed were excluded. No patient refused to take part.

Results

The group of 43 patients was 53% female, 58% over 60 years of age and 98% white European. 63% said they were Christian but 56% never attended church and only 18% attended weekly. 77% believed in God, but only 56% believed in life after death. 81% had never had a doctor enquire about their religious

At lunch in our home later she told me about her week. She said, 'I don't know what is happening to me. Normally I can't get up in the mornings, I'm always rushing frantically at the last minute to get the children ready for school, things are usually chaotic. This week, however, I've been wakening at 6 am, and I'm desperate to read the Bible, and I can't stop praying! I've learnt so much, and I feel so much at peace.'

This lady was radiant with a new-found joy that only Christ could bring, she had found the Lord without realising it. I said, 'I believe you have been born again. You asked God to speak to you, and he did; you opened yourself to him and read his Word, and he has come – at your invitation.'

There, in our lounge, I had the privilege of praying with this lady whom the loving God had carefully and persistently sought and found. It was a special holy moment, and a fresh realisation for me that God will stop at nothing to seek and to find the lost so that he came 'that they may have life and have it to the full'.[2] I thank God for a faithful unknown Christian lady in a shopping centre who dared to be obedient to her Lord, who dared to pray with a stranger, not knowing the response. I thank God for allowing me to witness the wonder of his new birth, the transforming work of grace in someone's life.

And so it was. Her mind and heart were at peace, knowing that her God was in control. It made all the difference in the world. 'Therefore, if anyone is in Christ, he is a new creation; the old has gone, the new has come.'[3]

Alasdair Fyfe is a Consultant Paediatrician in Glasgow

References

1. Luke 16:19-31
2. John 10:10
3. 2 Corinthians 5:17

their patients' spiritual beliefs?

and health

beliefs, but 67% felt it was perfectly appropriate for doctors to do so and 44% felt that doctors should pray with patients. Only 28% felt it was inappropriate for doctors to share their own religious beliefs if asked by the patient.

The demographic data reflected the demography of the Selly Oak area of Birmingham. Compared with a recent national census, the percentage of participants declaring themselves as 'Christian' was relatively small.[6] The small sample size arose because of time constraints and delay in obtaining ethics committee approval. Consequently, I did not perform statistical analysis.

Discussion

Spirituality has been defined as 'a quality that goes beyond religious affiliation, that strives for inspirations, reverence, awe, meaning and, purpose, even in those that do not believe in any god'.[7] It has been argued that all individuals have a unique personal spirituality, irrespective of religious orientation.

Traditionally, spiritual care has been perceived as a nursing role.[8] Indeed, British nurse education has long acknowledged the importance of addressing spiritual issues in patient care.[9] Interestingly through, over three quarters of nurses surveyed felt that spiritual care was best provided by a multidisciplinary team including a physician.[10]

There is little data on physicians' roles in their patients' spiritual affairs. Reasons for this are unclear. Research amongst nurses has shown a number of barriers to spiritual care provision: lack of knowledge of other religious faiths, time shortage, fear of personal prejudices.[11] It is possible that these issues apply to medical staff as well. However, a survey carried out amongst American family physicians revealed that the vast majority felt that doctors could address religious issues with patients; 37% had prayed with patients and 89% of these felt that that it had been of some help.[12]

The issue of physicians sharing their own religious faith with patients is more contentious. Concerned that doctors could abuse their authority and force personal beliefs onto vulnerable patients, there has been much debate amongst medical organisations of late.[13] The GMC have considered the matter: 'The Council has hitherto taken the view that the profession of personal opinions or faith is not of itself improper and that the Council could intervene only where there was evidence that a doctor had failed to provide an adequate standard of care…it would not be right to try to prevent doctors from expressing their personal religious, political or other views to patients'.[14] In this study, half of the patients would have welcomed such discussion.

Conclusion

Spirituality appears to be an important issue amongst hospital inpatients. Whilst not guaranteeing recovery from illness, spiritual beliefs act as coping mechanisms for hospitalised patients through illness. Medical staff should be aware of this dimension to healthcare provision and endeavour to consider the spiritual needs of patients under their care. It is imperative that spiritual discussions between doctor and patient are broached sensitively and with the patient's consent. This study adds to the literature by suggesting that many patients feel it appropriate for doctors to share their own religious beliefs and even pray with consenting patients. I am planning another larger study and encourage other CMF members to consider doing the same.

Elizabeth Croton is a surgical SHO in Birmingham
Correspondence should be sent to CrotonLizzieC@aol.com

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10 McSherry W. *Art cit*

11 *Ibid*

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EUTYCHUS

New Genetics White Paper

A new government white paper suggests that all newborn babies could in future be screened for a full genetic profile, which would form part of their medical records. Health Secretary John Reid said that the government's vision was 'for the NHS to lead the world in taking maximum advantage of the safe, effective and ethical application of the new genetic knowledge'. He promised £50million for investment on new initiatives. The Human Genetics Commission and the National Screening Committee will be asked to report on the ethical, social, scientific, economic and practical considerations by the end of 2004. The paper can be found at *www.doh.gov.uk/genetics/whitepaper.htm*. (*The Times* 2003; 25 June:8)

Chinese orphans

There are over three million children in Chinese orphanages, mainly girls, and most victims of a population control policy that limits most couples to one child. Adoption into Chinese families is rare due to cultural, legal and financial barriers; and yet only 10,000 get adopted overseas each year, of which 3,500 go to Britain. British adopting couples are attracted by the relatively good health of Chinese children and the low cost (usually £10-12,000). This works out cheaper than IVF assuming a 20% success rate and £2,500 cost per cycle. (*The Times* 2003; 16 May:8)

Dutch Utopia?

Teenage pregnancy rates in England and Wales are four times that of the Netherlands, a fact often put down to the Dutch having more open attitudes to sex and earlier explicit sex education. These beliefs are hotly disputed in a new publication, *Deconstructing The Dutch Utopia*, published by the Family Education Trust (available on www.famyouth.org). Dutch Sociologist author Dr Joost van Loon found that, contrary to claims made by UK family planning agencies, sex education in Dutch primary and secondary schools is not more explicit and neither does it start at younger ages than in Britain. Rather Dutch parents and school governors are given more control over what is taught and family links in the Netherlands are far stronger, with British children five times more likely to live in households headed by lone parents. He further notes that teenage extra-marital sex and pregnancy are socially frowned upon and that welfare benefits for teenage mothers are low.

Free condoms to under 16s

Leading sexual and reproductive health agency Marie Stopes International UK is offering free condoms to 11-15 year-olds on its sexual health website *www.likeitis.org.uk*. The initiative came as an independent survey commissioned by the organisation and featured in the March 2003 edition of Britain's best-selling girls' magazine *Sugar* revealed that over 50% of 11-15 year-olds were unaware that using condoms could prevent HIV/sexually transmitted infections (STIs).

Partial birth abortion ban

The US Congress voted 282-139 on 3 June to ban partial birth abortion, whereby a late term baby is removed feet first vaginally after puncturing and aspiration of the partially delivered skull. President Bush is expected to support the bill and has said it 'will help build a culture of life in America'. Pro-abortion groups claim that the ban is unconstitutional and intend to challenge the ruling in the Supreme Court. (*CNN*, 4 June)

Most doctors oppose euthanasia

Two major opinion polls have shown that most British doctors still oppose euthanasia. A joint survey of 3,000 doctors by *Hospital Doctor* and the Nuffield Trust showed that 57% were opposed to legalising the practice. (*Hospital Doctor* 2003; 13 March:3) In May a major survey of 986 doctors via the website *doctors.net* revealed that 75% of all doctors and 100% of palliative care specialists would refuse to participate in euthanasia even if it were legalised. BMA Ethics committee chairman Michael Wilks said that BMA policy was to oppose euthanasia and assisted suicide 'for the time being'.

Suspended – guilty until proven innocent?

About 100 doctors in the UK are currently suspended from their employment mostly for whistle-blowing, disputes over private practice and for challenges to trust policy. Complaints by patients account for just 2.5% of suspensions and about 86% of suspended doctors are exonerated. Hospitals reinstate 60% of male consultants and 40% of female consultants once their names have been cleared with the remainder being offered compensation. The Suspended Doctors Group, run by the Society of Clinical Psychiatrists, offers advice and support. For more information phone 01725 513367. (*Hospital Doctor* 2003; 17 April:28)

Lucrative organ trade

Organ harvesting for the black market is most prevalent in Turkey, India and Central and Eastern Europe. Kidneys, lungs, pieces of liver, corneas, bones and heart valves are all available for purchase with kidneys yielding £1,500 for the donor but up to £150,000 for the broker. (*The Times* 2003; 27 May:13)

Cloned mule

Idaho Gem, the first cloned mule, was born on 4 May at the University of Idaho, USA. DNA from mule foetal cells cultured in a laboratory since 1998 was placed into an enucleated horse egg. This was the only surviving mule from 113 attempts, only eight of which resulted in pregnancies beyond eight weeks. (*The Times* 2003; 30 May:13)

When life begins in America

Nearly half of all Americans believe that life begins at conception according to a Newsweek Survey. 46% believe that life begins at conception, whilst a further 12% cite implantation. However 49% considered it acceptable for IVF clinics to destroy human embryos with the consent of the parent. (*SPUC Digest* 2003; 2 June)

Ectopics on Levonelle

Taking Levonelle 2 (the morning after pill) may put the user at increased risk of ectopic pregnancy, according to an editorial in *Trends in Urology Gynaecology and Sexual Health*. The increased risk is thought to be small and a causal association between the drug and ectopic pregnancy is not proven. The Medicines Control Agency data of 12 ectopics out of 201 pregnancies (5.9%)following failure of the drug, is thought to be an inaccurate assessment as either event might be under-reported. The mechanism of action of the morning after pill has yet to be determined although altered tubal motility may be a factor. (*TUGSH* 2003; 8(3):5-6)

OPPORTUNITIES ABROAD

Specific Vacancies by Continent and Country

Posts mainly require you to be **UK-based** with your own **financial** and **prayer** support. The contact details given are to enable you to start researching possibilities. For many other posts see previous recent issues of *Triple Helix* and the Opportunities supplement to *Healthserve* magazine. The latter is available from MMA HealthServe at Barker House, First Floor, 106-110 Watney Street, London, E1 2QE. Tel: 020 7790 1336 Email: info@healthserve.org

Better still visit the vacancies page at *www.healthserve.org* which is updated weekly.

Afghanistan

PRIME have the possibility of being involved initiating and guiding a 3 year programme for training GPs in Kabul at a brand new and well equipped primary care centre. Would suit an experienced GP willing to spend time in the country or experienced trainers willing to pay visits of 2 weeks or so at a time. A suitable posting for an exciting and meaningful sabbatical.

Contact David Chaput de Saintonge at *chaput@onetel.net.uk* or tel: 01892 822188

Bangladesh

There is an urgent need for an Ophthalmologist who can at least perform cataract surgery and lens implants in the busy Eye Department of a Christian Hospital in Bangladesh. He/she would be part of a team of 3 Consultants presently diminished by one on study leave and the current vacancy. **Contact** Simon Loader at *simonloader@lineone.net*

Nigeria

Needed for a hospital in Plateau State, visiting medical and surgical specialists, in particular Orthopaedic and Plastic Surgeons, to carry out reconstructive surgery and provide training for local surgeons.

Contact Medic Assist International, by email jmuir@medic-assist.org or see *www.medic-asssist.org* for further details of the crisis situation which Medic Assist is responding to.

Pakistan

Kunri Christian Hospital is urgently seeking a female Obstetrician. The hospital will provide accommodation. The hospital is situated in Tharparkar and is run by the Diocese of Hyderabad. **Contact** Dr Jacoob Zahiruddin, Medical Superintendent at *jacoobz@yahoo.com* for further details.

South Africa

Three Radiologists experienced in the use of Ultrasound needed for a **one week training course at St Barnabas Hospital, near Umtata, Eastern Cape from 13-20th September 2003**. Providing training to rural medical officers on the use of diagnostic and basic interventional ultrasonography. The course will focus on abdominal, pelvic and gynaecological ultrasound but those interested will be invited to help formulate the course programme according to their expertise. Those interested would be asked to find their own sponsorship of approximately £1000 but accommodation and subsistence will be provided. This project is being sponsored by the Christian charity Links International. **Contact** Peter Willson, Consultant Surgeon, Kingston Hospital, Gallsworthy Road, Kingston, Surrey KT2 7QB. E-mail: *peter.willson@ntlworld.com*

United Arab Emirates

The Oasis Hospital is looking for an Obstetrician (female), Anaesthetist, General Surgeon with laparascopic skills, Paediatrician with neonatal experience and a Cardiologist. This is a well equipped 45 bedded modern hospital in the oasis city of Al Ain. The staff of some 150 people come from 20 different cultures. **Contact** Dr Larry Liddle at *lliddle@oasis.smart.net*

Uganda

Medical Superintendent needed for **Kiwoko Hospital** in Luwero, Uganda. Ideally to be in place by April 2003. Doctor required with at least 5 years experience. Involves supervision of all the hospital activities including community care (CBHC), junior doctors, a nurses training school and chairing the management team. The hospital comes under the Church of Uganda but candidate would not need to be an Anglican. **Contact**: Nick Wooding, Kiwoko Hospital, PO Box 149, Luwero, Uganda. Tel: 077 588 606 Fax: 041 610132

Zimbabwe

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

Contact Dr Sharon Stone, Medical Superintendent, Bonda Hospital, Box 3896 Bonda, Zimbabwe. Email: kane@telco.co.zw

TeleMedicine

Teleserve provide Telemedical support to 'volunteer workers' in remote parts of the world. Currently 4 GPs act as gatekeepers for emails from individual workers or expatriate doctors. They are seeking to recruit Specialists and an additional GP to assist in other future projects **Contact** Dr Tim Lyttle. Tel: 01691 655795. Email: *tim@lyttle.org* or www.teleserve.org

EVENTS

The Residential Refresher Course 7-18 July 2003 at Oak Hill College in North London. The programme is on the website.- *www.cmf.org.uk* This year's course will include some interactive workshops on AIDS, paediatric, surgical and obstetric emergencies as well as the usual wide ranging coverage of medical issues. **If you or anyone you know is contemplating working overseas or you have mission partners home on leave, this is a 'not to be missed' opportunity to enhance your knowledge and skills. (Recognised by RCP for CME)**

MMA HealthServe Day celebrating 125 years of their existence will be held on 12 July 2003 in the midst of the Refresher Course and at Oak Hill College. Aimed at informing healthcare workers of the needs and opportunities overseas, there will be seminars and keynote speakers with a thanksgiving service to wind up the day. **Contact** *Steve@healthserve.org* for details

ITEMS WANTED

Sonicaid(s) urgently needed for Bonda Hospital in Zimbabwe. Please contact Dr Sharon Kane. Email *kane@telco.co.zw*

Medical and nursing textbooks to assist in stocking the Medical School Library at the University of the Transkei, South Africa. Texts accepted on pre-clinical, clinical, nursing and midwifery subjects at undergraduate and post graduate levels. The only condition is that they have been printed in the last ten years (exceptions can be made for anatomy). If you have books that you could donate please **contact:** Mr Peter Willson, Consultant Surgeon, Kingston Hospital, Gallsworthy Road, Kingston, Surrey KT2 QB. E-mail: *peter.willson@ntlworld.com*

Emmanuel Hospital Association are looking for a refurbished arthroscope for use in one of their hospitals in India. If you can help, please contact: EHA, PO Box 43, Sutton, Surrey SM2 5WL Tel: 020 8770 9717 Fax: 020 8770 9747

BOOKS

Anxious Christians. Psychological Problems and The Christian Faith

Kenneth Redgrave
SPCK 2002
£8.99 Pb 192 pp
ISBN 0 2810 550 7

This book consists of case histories about people with a variety of psychological problems and demonstrates ways of helping them. Subjects include: 'Shyness and lack of confidence', 'Chronic anxiety and difficulty in decision making', 'Sensitive children' and 'Difficulties in being able to forgive a former partner'.

Each case history receives half a dozen pages. The author brings a compassionate viewpoint that demonstrates his wide experiences as a psychotherapist and previously as a Church Social Worker, Deputy Children's Officer and Lecturer in Human Growth and Behaviour. Although not medically qualified, he shows an understanding of how physical and emotional problems are related, eg in the case of 'Sula', who had depression and hypothyroidism.

The author is strong on the psychological and psychiatric perspective and he derives a lot of his thought from the Bible. Much of the bibliography comes from the counselling literature but this is not an academic book. It will be of value to clergy, doctors, students of counselling and pastoral studies, but particularly to Christians who have emotional problems. As the back cover says, 'The reader is encouraged to consider whether the particular problem or worry they have may be a symptom of some deeper malaise or dysfunction - physical, mental or spiritual - and to feel comfortable about seeking the skills and empathy of a trained counsellor or psychotherapist.'

Dominic Beer is Senior Lecturer, Division of Psychological Medicine (Guy's, Kings & St Thomas' Institute of Psychiatry) and Honorary Consultant Psychiatrist in Challenging Behaviour and Intensive Care Psychiatry (Oxleas NHS Trust)

Journeys of Faith. Church-based responses to HIV and AIDS in three southern African countries

Gideon Byamugisha, Lucy Steinitz, Glen Williams and Phumzile Zondi
Strategies for Hope No 16, 2002
£4.50 Pb 109pp
ISBN 0 95430 600 7
Available from TALC, PO Box 49, St Albans, Herts AL1 5TX, UK. Fax: (+44) 1727846852 Email: talc@talcuk.org Website: www.talcuk.org

Many organisations and individuals in Mozambique, Namibia, South Africa and UNAIDS assisted the authors in writing this well presented and illustrated book. While defining 'faith based' as having 'a religious affiliation', the book focuses on the Christian tradition. The introduction states that growing numbers of secular leaders have come to appreciate the unique potential that churches and other faith based organisations have for preventing the spread of HIV. It continues, 'Yet Christians have lacked sufficient urgency' the main reason being 'the association in the collective mind... of HIV/AIDS with immoral sexual behaviour.' This has led to 'judgmental attitudes' reinforcing denial and secrecy on the part of people who believe themselves to be HIV positive.

Christians might accept this apology in a book that is largely practical. It describes how churches have pioneered care of those infected with and affected by the disease. It contains inspired ideas such as encouraging an infected mother to keep a memory box of photos, possessions, a book of memories and other documents that she can leave to her children. There are testimonies of how HIV positive individuals have responded by coming to faith in Christ and intensifying the quality of their care for others.

But not all practical ideas are harmless. There is considerable promotion of condom use, particularly in Roman Catholic projects. While there may be a place for their use by some married couples there is no clear warning of the many harmful knock-on effects of promoting promiscuity, whether intentionally or unintentionally. Much promotion of condom use elsewhere is based on secular humanist teaching that is opposed to biblical teaching and the Christian's good news.

I would only place this book in a library after warning potential, unsuspecting Christian readers of its hidden dangers that emanate mainly from the West. I would at the same time recommend its many excellent ideas and commend the readers to join in communal repentance for our sins of omission and commission that are contributing to this terrible pandemic.

David Clegg is a retired Consultant in Obstetrics and Gynaecology and formerly CMF Overseas Support Secretary

Building the Body: Transforming Relationships in the Local Church

Pamela Evans
Bible Reading Fellowship 2002
£7.99 Pb 192 pp
ISBN 1 84101 193 2

Do you want to grow as a Christian? Do you want to be a more effective witness? This book, written by an Honorary Lecturer in Epidemiology at the London Hospital, champions the biblical theme of building the body of Christ in the local church. It suggests that God-honouring relationships are an integral part of Gospel living that we have neglected to our detriment.

Paul's doctrinal teaching has been a tremendous resource for the church over the centuries but his teaching on relationships, which is also extensive, has been under-emphasised. This has resulted in an unbalanced and individualistic Christian experience that may make us frustrated with our failure to continue to grow and failure to witness effectively.

Despite years of belonging to church, we are likely to find that the biblical qualities of giving time, listening well, serving practically, offering encouragement, learning by apprenticeship and maintaining our walk with God by mutual accountability are not as evident in our fellowship as they might be. How refreshing it would be if we moved in such an environment!

This book points the way towards developing a Christian community that not only pays lip service to loving out brothers and sisters, but aims to live it out in the confidence of God's love and forgiveness for us all. Shared life actively strengthens sound doctrine but also provides a safe place to express doubt and admit struggle.

The eight chapters of this book may also be used for group studies, for which there are additional notes, and there is a helpful appendix on listening skills. By using many helpful and sometimes humorous stories and illustrations, the writer is not so much speaking out of success, but humbly sharing lessons learnt along the way. I found it often connected with my own experience of church and opened a way to make progress. It could do the same for you or your church.

Kevin Vaughan is a General Practitioner in Birmingham and immediate past Chairman of CMF

Culture of Life – Culture of Death

The Linacre Centre for Healthcare Ethics, London 2002
Ed: Luke Gormally
£17.95 Pb 352 pp
ISBN 0 90656 124 8

This book consists of 22 papers by historians, legal and political theorists, medical practitioners, pastors, philosophers and theologians, delivered at the International Conference on 'The Great Jubilee and the Culture of Life' held at Queen's College, Cambridge in July 2000. This was organised for Roman Catholics with an active interest in healthcare ethics in response to Pope John Paul II's invitation to celebrate the year 2000.

Luke Gormally, Director of the Linacre Centre for Healthcare Ethics, a Catholic think-tank, explains that this book deals with the 'Clash of orthodoxies' – contemporary liberal secularism versus Judaeo-Christian moral tradition, two cultures with deeply opposed understandings of human life. The cover picture, Gernt van Honthorst's *Christ before the High Priest*, symbolises the confrontation between the culture of death and the culture of life. It was Caiaphas, the High Priest, who uttered the prototypical consequentialist judgement, 'You do not realise that it is better for you that one man die for the people than the whole nation perish.' (John 11:50). Willingness to sacrifice the innocent for 'the greater good' is central to the philosophy of the culture of death. However there was prophetic truth in Caiaphas' words beyond their intended meaning. Christ's redeeming death brought a message of life and hope to the world. The ultimate source of the culture of life is our Lord Jesus in his life, death and resurrection.

Cardinal Winning's opening address identifies characteristic manifestations of the culture of death: abortion, embryo experimentation and imperialist imposition of contraception and abortion policies on developing countries. The root of this culture is 'the eclipse of the sense of God and man'. Among four chapters on the culture of death, is a fascinating one about the de-Christianising of England. This one traces the evolution of secular philosophy that has profoundly influenced contemporary medical ethics eg from key thinkers such as JS Mill. In her report on Human Fertilisation and Embryology in 1984, Baroness Warnock appeals to Mill for her justification of relativism. Chapters on the culture of life deal with its theology, promotion, politics and medicine in the developing world. Examples of Christian initiatives bringing hope to destitute mothers, combating the spread of AIDS and caring for AIDS victims are eloquently described. Supplementary papers deal with eugenic genetic engineering, stem cell research, contraception and 'quality of life' ethics.

This Roman Catholic publication inevitably refers to classic papal encyclicals and traditional Roman doctrines without scriptural foundation such as the ban on 'artificial' contraception, the celibacy of priests, the 'sacrifice' of the Mass and human suffering sharing in the redemption accomplished by Christ. Some of these will appear to evangelicals to detract from the glory and uniqueness of Christ's atoning work. Nevertheless, read with discernment, there is much here that is valuable, thought provoking and consistent with a true biblical medical ethic, to interest, stimulate and challenge the Christian doctor.

Stephen Browne is a GP Principal in Birmingham

Doctors and Patients: an anthology

Ed: Cecil Helman
Radcliffe Medical Press 2002
£19.95 Pb 176pp
ISBN 1 85775 993 1

Analysis of the current trend in narrative-based medicine reveals, as the writer of Ecclesiastes indicated, that there is nothing new under the sun. The increasing number of books and articles on the role of narrative and the use of the arts in medicine is rooted in history and not in post modernity. It is part of this heritage that this book explores. Edited by Cecil Helman, General Practitioner, Medical Anthropologist and creator of Helman's folk model used in consultation skills, this anthology brings together a selection of narratives from the perspective of doctors and patients, as well as from the clinical encounter itself. Some of these stories are fictional, some true but all are rooted in an experience of health and illness. Contributors include world famous authors like Franz Kafka and A J Cronin, who wrote Dr Finlay's Casebook, and more modern, less well-known writers.

The collected narratives relate many key issues that doctors and patients meet in day- to-day life. The reader is drawn into the story and comes to understand the value of experiential learning, the difficulties in telling and hearing the truth, the problems of managing uncertainty and of the hurts caused by dysfunctional communication. The reader experiences an emotional roller coaster, moving from laughter to tears in a few short sentences in the world of terminal and chronic illness.

The anthology also acknowledges the time spent in health care by people who are worried but well, people who attend frequently and people who have problems with addiction. Their stories encourage empathy and challenge the reader's prejudices and preconceptions. Overall, the book encourages reflection on the whole person – physical, emotional and spiritual.

To quote Oliver Sacks, neurologist and author of 'The Man who Mistook his Wife for a Hat', from his contribution to the book about a young lady called Rebecca: 'A child follows the Bible before he follows Euclid. Not because the Bible is simpler (the reverse might be said) but because it is cast in a symbolic and narrative mode.' This book, being full of stories, is simple to read but within it lie many challenges to us both as doctors and Christians. With the increasing secular medical interest in narrative, it is worth reading to increase awareness of current trends in the medical world. I would also recommend this book for those involved in teaching communication skills or in medical education generally.

Rhona Knight is a General Practitioner in Hampshire

LETTERS

The Morning-After Pill

***Hilary Cooling**, who practises and teaches family practice in Bristol, takes issue with Phil Howard.*

In his article 'The morning-after pill - how does it really work?' (*Triple Helix* 2002; Autumn: 8-9) Phil Howard confuses the terms 'post-fertilisation' and 'post-implantation', and uses complex arguments of extrapolation to arrive at his conclusion that the evidence 'strongly suggests that [the morning-after pill] can disrupt implantation'. He gives the impression that he wishes the evidence to support his view, which was recently rejected by the High Court in the UK.

Has Howard taken his arguments to a journal such as the *Lancet* for robust debate? In the interests of intellectual honesty, how about inviting a response from Horaciao Croxatto, author of 'Emergency contraception pills: how do they work?' (*IPPF Medical Bulletin* 2002; 36:6, *www.ippf.org*). His conclusion acknowledges the uncertainty about precise modes of action. You could also ask Schering Healthcare since their deputy medical director is quoted, or one of the investigators in the UK arm of the WHO study.

***Phil Howard** replies.*

In the Judicial Review of the morning after pill (MAP), Mr Justice Munby held that MAP could not be abortifacient as 'if it is to be effective, [it] has in any event to be taken at a time – no later than 72 hours after intercourse – when implantation will not have begun'. The court accepted that implantation began around 4 days after fertilisation.

This ignores two points. First, the 72-hour period is the time *before the pill* is given and this lag time must not be confused with the duration of action *after drug ingestion*. Moreover, this refers to the first dose, the second being taken 12 hours later. Following ingestion, levonorgestrel will say in the blood for up to 25 hours and will act through de novo protein synthesis. Hence, its effects will last for days. Second, MAP can actually be given up to 120 hours after unprotected intercourse and still be effective. While it remains clear that MAP cannot cause an implanted egg to de-implant, this does mean that MAP can be active during the period of receptivity to disrupt implantation.

Hilary Cooling rightly draws attention to the WHO trial published in the *Lancet* in 1998. At entry to this trial, urine or blood samples were taken for pregnancy tests but there was no requirement for these samples to be analysed prior to enrolment - contrary to the usual canons of research ethics. It is therefore likely that some women were in the early stages of pregnancy at enrolment. Only the samples of women found to have sustained a clinical pregnancy during the trial were analysed, so we cannot know how many women lost early pregnancies. Moreover, we know that up to a third of women continued to have intercourse after taking MAP (in breach of the trial protocol), so its effects were almost certainly on more than one act of intercourse. As far as I am aware the ethics of this trail have not been publicly challenged.

For many with a conscientious objection to the use of abortifacient pills, the moral objection is not the interruption of pregnancy, but rather the destruction of early human life. There is a 'molecular dialogue' between the embryo and mother starting within hours of fertilisation. This 'cross-talk' prepares the endometrium for implantation. Surely, to prevent implantation from occurring is no different to disrupting implantation once it has occurred? MAP is destructive of human life at any time after fertilisation, when human life starts.

'From Medicine to Miracle' by Dr Mary Self

***Deborah Pitt**, Staff Grade Psychiatrist in Glamorgan, finds the criticism in Dr Peter May's book review rather harsh.*

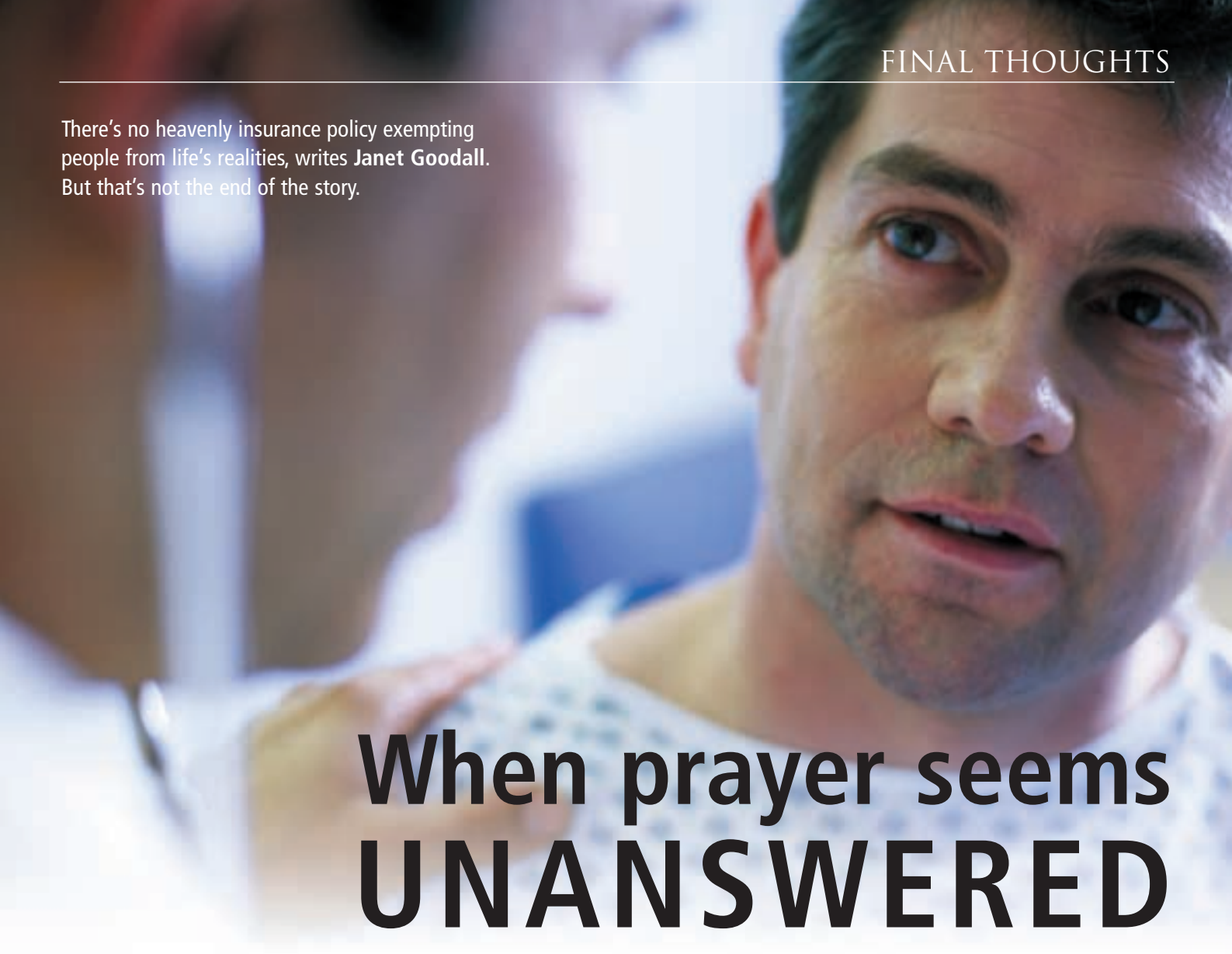
Having read the book by Dr Mary Self 'From Medicine to Miracle' and Dr May's review (*Triple Helix* 2003;Winter: 19), I thought his criticism rather harsh. It is reasonable to highlight any inconsistency in the details of the healing from cancer that Dr Self received, and which she attributes to her faith in Christ. Nevertheless, I was concerned about his reaction to her style of relating the diagnosis of bone cancer and the subsequent development of her faith. Perhaps such stark honesty and raw emotion is unfamiliar to Dr May, and I found the book sometimes uncomfortable reading. However, he was so dismissive of the reality and anguish of her suffering and desperate search for God that he appears to have missed the point. Dr Self's story is essentially one from rebellion and ambivalence to faith and trust in the Lord and is more valuable for her 'warts and all' portrayal.

***Christine Walter**, CMF member from Blackburn, agrees.*

When I had finished reading Dr Self's account of her illness and healing, I wrote to her to thank her for her honesty about her feelings. I found this insight particularly helpful as I too was experiencing 'an endless roller-coaster ride of emotions'. I was quite taken aback that Dr May found this 'tiresome'.

On a more serious note, I was shocked to read Dr May accusing Mary of not telling the truth about her illness. Mary was facing death from an untreatable metastasis, as diagnosed by her oncologist. Now she is well and enjoying life with the children she was told she would never have. As well as being healed from cancer, she was set free from fear and experienced God's love in a new and powerful way. I believe it was a miracle and I expect the 10,000 people who were praying think so too.

There's no heavenly insurance policy exempting people from life's realities, writes **Janet Goodall**. But that's not the end of the story.



When prayer seems UNANSWERED

In *Disappointment with God*, Philip Yancey reflects on those whose faith in God is seriously shaken by seemingly unanswered prayer.[1] Although earnestly asked to intervene, the Almighty still allows devastating wars. Disabling accidents or overwhelming illnesses arrive that prove fatal, despite prayers for and even claims of healing. The catalogue of permitted evil seems endless: child, drug and trust abuse abound, famines and earthquakes persist, terrorism and torture continue. We may be involved personally in some of these traumas. There is no heavenly insurance policy protecting Christians against strained or sundered relationships, failed examinations, poverty or homelessness; we are not immune to the constant strain of hope deferred. Where is God? Why does he seem so distant and deaf?

There aren't any easy answers. Throughout the Bible, God's people were kept waiting, their faith tested yet strengthened in the process. Abraham was 100 years old by the time God's 25-year-old promise was met in Isaac's birth.[2] Joseph was in his thirties when he was catapulted from prison to premiership and saw his teenage dreams realised.[3] Moses was 80 years old when he found his true vocation and spent another 40 years struggling to fulfil it.[4] Amongst many others, Job, Jeremiah and Hosea all knew painful times of great darkness and distress.

Our Lord Jesus Christ knew dark times. On the cross, he cried out, 'My God, my God, why have you forsaken me?'[5] By carrying infirmities, sorrows and sins to the cross, he was able to offer us his liberating, guiding and energising Spirit.[6] Still, he neither exempts us from pains and perplexities nor readily explains them to us.[7] Yet Paul spoke of delighting in his lengthy list of afflictions.[8] He had confidence in the Lord's personal promise, offered in the midst of pain, 'My grace is sufficient for you, for my power is made perfect in weakness'.[9] Good reasons for holding onto God's promise: 'Never will I leave you; never will I forsake you'.[10]

Fear not, for I have redeemed you; I have summoned you by name; you are mine. When you pass through the waters, I will be with you; and when you pass through the rivers, they will not sweep over you. When you walk through the fire, you will not be burned; the flames will not set you ablaze…Since you are precious and honoured in my sight, and because I love you…Do not be afraid, for I am with you…(Isaiah 43: 1-2, 4-5)

We need to cling to these promises, anchoring unstable feelings in the unshakeable fact that our loving Lord is with us, come what may. With this assurance, may we emerge from our trials with faith strengthened and encouragement to share.

Janet Goodall is a retired consultant paediatrician

1 Yancey P. *Disappointment with God*. Grand Rapids Michigan: Zondervan, 1988
2 Genesis 12:2-4, 21:5
3 Genesis 37:2-7,26-28, 41:46, 42:6
4 Deuteronomy 34:7; Acts 7:23,30,36
5 Matthew 27:46
6 Isaiah 53:4-5; Romans 8:1-39
7 2 Corinthians 6:4-10, 11:23-29, 12:7
8 2 Corinthians 11:30, 12:10
9 2 Corinthians 12:9
10 Hebrews 13:5

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