

Plans for 'seven-day' NHS *Where will the money come from?*

Review by **Steve Fouch**
CMF Head of Nursing

In May, the Government announced a move towards a fully seven days a week service in hospital and primary care.¹

This proposal sounds good in theory. Running GP surgeries seven days a week would increase equity of access and reduce pressure on overstretched A&E departments. Meanwhile mortality rates for patients admitted to hospital at the weekends can be up to 16% higher than those admitted on weekdays,² so running the same standards of staffing and services at weekends also sounds sensible. The major problem is cost. It will require more staff, paid at higher rates for working unsocial hours, the running and maintenance of complicated medical equipment, heating and lighting. However, with the NHS needing another £30 billion a year by 2020 just to maintain services,³ where is the extra money going to come from?

The second issue is staff. Initially we could recruit nurses from overseas, but we are not going so readily to recruit more consultants and GPs. The current intake of GP trainees is running at 70% of capacity – and the gap

widens year on year. Newly qualified doctors are put off becoming GPs as they see all the non-medical work and stress it now entails.⁴ Yet to reach the Government's target of 5,000 new GPs, half of all medical graduates would have to train in family medicine.⁵

Many nurses, living with long term wage freezes and possible cuts to overtime pay, are getting weary and angry enough to consider industrial action.⁶ Others are leaving the profession; projections suggest a decline in the nursing workforce of 0.6 to 11% between 2011 and 2016.⁷

The general election campaign showed that none of the parties were addressing the critical challenges facing the NHS. Staffing and funding are just two of many issues, including an ageing population with growing expectations, increasingly costly medical technologies, and a rise in chronic diseases often brought on by poor lifestyle choices. The NHS was founded in the forties to address very different needs. We need a major rethink of what kind of health service we now need, and how we fill the gaps left behind.

The church could be a key part of addressing some of these gaps. Much of the psychosocial support now given by GPs is what local ministers undertook in the past. Churches already promote health through clubs for the elderly, parent and toddler groups and Parish Nurses.⁸ Can the church reengage in other areas of primary healthcare, as it has done so successfully with debt counselling, food banks and street pastors over the last few years? Maybe it's time for church and state to rethink our roles?

references

1. Speech: PM on plans for a seven-day NHS. 15 May 2015 bit.ly/1AX7VE9
2. Sunday hospital admissions 'a bigger risk'. *NHS Choices*, February 3 2012 bit.ly/1AX9D8w
3. Five year forward view. NHS England, October 2014 bit.ly/1AXd9zH
4. Fouch S. Primary care in crisis. *Triple Helix*; Summer 2014 cmf.ji/1AX8AFG
5. David Cameron renews NHS funding pledges. *BBC News*, 18 May 2015 bbc.in/1F42u12
6. Jeremy Hunt attacks nursing union for 'ridiculous' strike threat over seven-day NHS. *Telegraph*, 18 May 2015 bit.ly/1RY0Veh
7. Future nursing workforce projections: Starting the discussion. Centre for Workforce Intelligence, June 2013
8. Wordsworth H. Parish Nursing: Filling gaps in NHS care. *Triple Helix*, Summer 2014 cmf.ji/1RY1V1s

Assisted suicide bills *One down, one to go*

Review by **Peter Saunders**
CMF Chief Executive

One assisted suicide bill has been defeated and another resurrected in six weeks of roller coaster activity in British parliaments, keeping the debate very much alive. Patrick Harvie's Assisted Suicide (Scotland) Bill¹ was defeated by 82 votes to 36 in the Scottish Parliament on 27 May.²

Harvie proposed an 'Oregon-type system' with trained 'licensed facilitators' but with a wide scope for mentally competent adults (>16) with a 'terminal or life-shortening illness' or a 'progressive and terminal or life-shortening condition'. The bill was heavily criticised for its relativistic definitions, poor reporting provisions, minimal penalties, a 'saving' clause protecting doctors acting in 'good faith', no specification of 'means' of suicide and the absence of a conscience clause.

Scottish First Minister Nicola Sturgeon had already signalled that she would not support the bill.³ In addition over 15,000 Scottish people had signed a petition⁴ against it.

After winning the Private Members' ballot, Labour MP Rob Marris has resurrected Lord Falconer's Assisted Dying Bill in the House of Commons.⁵ His bill should come forward for a second reading debate on Friday 11 September. Marris's bill, essentially identical to Falconer's, would allow assisted suicide, for mentally competent adults (>18) deemed to have less than six months to live, subject to a series of 'safeguards' including a final decision by a High Court judge.

Elsewhere in the UK, elected representatives have repeatedly refused to consider a law which would undermine the position of disabled, elderly, sick and vulnerable people in society. In December 2014, members of the Welsh Assembly rejected a motion in support of Lord Falconer's bill by 21–12.⁶ And in February 2015, members of the House of Keys (lower chamber of the Isle of Man's Tynwald) declined to consider an assisted suicide bill by 17–5.⁷

In spite of wavering public opinion the legalisation of assisted suicide is opposed

by those who would be most affected, not least disabled people and healthcare professionals, on the grounds that such laws steer vulnerable people who perceive themselves to be a burden toward suicide. Such a change in the law is unethical, unnecessary and uncontrollable.

For Christians the matter is even simpler – all human beings are created by God in his own image,⁸ and it is written 'thou shalt not kill'.⁹ The current law is clear and right and our priority should be care, not killing.

references

1. Assisted Suicide (Scotland) Bill. Scottish Parliament. bit.ly/1fbgzir
2. MSPs reject Assisted Suicide Scotland Bill. *BBC News*, 25 May 2015 bbc.in/1Au8VQ2
3. First Minister rejects AS Bill. *Care Not Killing*, 6 March 2015 bit.ly/1E1LoB8
4. 10,000 sign Scottish petition. *Care Not Killing*, 27 February 2015 bit.ly/1E9xpnc
5. MPs to debate assisted dying bill. *Politics Home*, 9 June 2015 bit.ly/1BVZpjz
6. Welsh Assembly rejects Falconer. *Care Not Killing*, 19 December 2014 bit.ly/1cLJspD
7. Isle of Man's assisted suicide No. *Care Not Killing*, 6 February 2015 bit.ly/1B6ii4G
8. Genesis 1:27
9. Deuteronomy 5:17



Fears grow over HPV vaccine

How safe is it?

Review by **Philippa Taylor**
CMF Head of Public Policy

Recent reports¹ have added to an evolving story of inadequate research into the HPV vaccine that almost every teenage girl in the UK has been given since 2008.² Apparently, thousands have endured various debilitating illnesses after receiving the routine injection. Interestingly, Japan stopped recommending this vaccine in 2013 because of side effects. Concerns have also been expressed recently in Australia.³

This issue presents a dilemma. Vaccination always involves balancing risks and benefits. Risks from mass vaccination of young girls must be weighed against the increasing incidence of cervical cancer, which claims thousands of lives worldwide. A vaccine that helps prevent this is to be welcomed. To deny it could be foolish, and potentially very harmful to many young girls at risk.

But there is still little long-term research on the effects of the vaccine. One study stated in 2008, when the vaccination programme started in the UK: *'There were definitely promising results... but more long-term studies were called for before large-scale vac-*

ination programmes could be recommended'.⁴

A BMJ case study on ovarian failure in a teenager led to concerns about compromised research on vaccine safety.⁵ These included: underrepresentation of the target age group, incomplete and short-term follow-up, and non-reporting of new medical conditions after seven months. This all: *'...compromised safety studies' observation of ovarian health'*.⁶

30% of cervical cancer can still occur in vaccinated individuals. This means screening is necessary for sexually active women. So is there any advantage over routine screening? Could it increase risk taking amongst adolescents who consider themselves protected, especially since the primary cause is downplayed (that girls are only at risk once they become sexually active)? Will vaccinated girls be less likely to pursue vital screening?

I am not against the vaccine *per se*. But I am concerned about inadequate research on safety, unreported side effects, lack of information about risks and young girls making decisions at an impressionable age. This, together, undermines principles of informed consent. Importantly, the context in which the

vaccine is promoted fails to advocate any preventative approach, namely sexual abstinence and faithfulness. While I support its use for those at high risk, should it be imposed on all girls (which it effectively is), particularly when regular screening could prevent 90% of malignancies?⁷ Christians have a responsibility to promote premarital abstinence and marital faithfulness. Parents will have to weigh up the issues carefully, in discussion with their daughters, to decide whether they should be vaccinated, to protect them from their or indeed others' sexual immorality.

references

1. *Independent*, 31 May 2015 ind.pn/IRB6iQz; *Telegraph*, 12 September 2009 bit.ly/1cLupfA
2. HPV vaccine. NHS Choices bit.ly/1o17Ujm
3. Japan withdraws HPV vaccine recommendation for girls. *Medscape*, 25 June 2013 wb.md/1FLJ1ET; How safe is Gardasil for young girls? *Merconet*, 4 May 2015 bit.ly/1E3vOFM
4. Haug CJ. Human papillomavirus vaccination - reasons for caution. *N Eng J Med* 2008; 359:861-862 bit.ly/1TaZkUa
5. Little DT, Ward HRG. Premature ovarian failure 3 years after menarche in a 16-year-old girl following human papillomavirus vaccination. *BMJ Case Reports*, 2012 bit.ly/1FRushk
6. Little DT, Ward HRG. Adolescent premature ovarian insufficiency following human papillomavirus vaccination. *Journal of Investigative Medicine* 2(4):2014 bit.ly/1F80bKg
7. *Ibid*

DNA editing

A case still to be made

Review by **Peter Saunders**
CMF Chief Executive

Manipulating the human germline has been off-limits for decades but new technology has brought it one step closer. A new tool called Crispr enables scientists to 'edit' the genome by adding or deleting DNA sequences.

In response to a growing interest in the field, two leading science journals issued statements aimed at curbing the practice. In *Nature*, Edward Lanphier, a leading figure in Crispr-related research, called for a voluntary moratorium on modifying the genome of eggs, sperm or embryos, saying that germline therapy 'could start us down a path towards non-therapeutic genetic enhancement'. A similar statement in *Science* by experts in Crispr urged that germline modification be 'strongly discouraged', 'even in those countries with lax jurisdictions'. These cautions echoed UNESCO's statement that germline interventions 'could be contrary to human dignity'.¹

However one month later Chinese scientists announced that they had used

Crispr to genetically engineer human embryos.² Researchers at Sun Yat-sen University obtained defective human embryos from an IVF fertility clinic and targeted a gene which can cause beta thalassemia, a serious blood disorder. The results were unimpressive. Of 86 embryos injected only 28 had successfully spliced the target gene and only a fraction of these contained the correct replacement gene. There was also collateral damage in the form of 'off-target' mutations.

More recently, researchers in California have used a DNA editing technique successfully to treat mitochondrial disease in mice.³ This new research involves injecting affected embryos with RNA which leads to the production of enzymes which specifically target and remove faulty genes.⁴ The treated embryos were transferred to female mice where they developed normally and resulted in healthy pups with low levels of the targeted mitochondrial DNA. These pups later gave birth to healthy offspring, demonstrating this is a viable approach for preventing transgener-

ational transmission of mitochondrial diseases.

Furthermore, it avoids some of the ethical problems associated with mitochondrial replacement techniques, such as cell nuclear replacement (cloning) technology, DNA donation and using DNA from three biological parents. Might this be an elegant and more ethical alternative to the controversial so-called three-parent embryo? As a technique it is certainly more about correcting a defect (restoration) than creating something altogether new (enhancement). Time will no doubt tell, but in the meantime there are big issues to address in the context of animal research, not least about safety.

references

1. Universal declaration on the human genome and human rights bit.ly/1JXT7Yw
2. Chinese scientists edit genes of human embryos, raising concerns. *New York Times*, 23 April 2015 nyti.ms/1d6zyzC
3. Saunders P. New DNA editing technique for mitochondrial disease may render three parent embryos redundant. *CMF Blogs*, 30 April 2015 bit.ly/1F8qY9u
4. Reddy P, Ocampo A et al. Selective elimination of mitochondrial mutations in the germline by genome editing. *Cell* 2015;161(3):459-469 bit.ly/1JKbLBY