LETTERS

Prolife movement at the crossroads

***Elizabeth McCullough**, Family Planning Association (FPA) Policy Officer in Northern Ireland, takes exception to Greg Gardner's article 'Prolife movement at the crossroads' (Triple Helix 2002; Winter:14-15)*

The outcome of recommendations made in Greg Gardner's article would be to coerce women into motherhood which they have not chosen. He would outlaw abortion, discredit providers and even shamelessly exploit what he characterises as the 'most powerful witness, the mothers who grieve after abortion'.

Clearly Greg Gardner doesn't want women to have a choice unless it is to give birth. A choice by definition involves more than one option; otherwise it is an imperative. Coercing women to give birth at all costs is the imperative that his position supports and its effects are enforced motherhood, the reduction of women to the position of incubators and the potential for generations of human misery. This approach has at its centre the endless subjection of women to biological determinism.

I think those of us who support a woman's right to bodily integrity and to make informed choices relating to it would be much more convinced by a 'pro life' lobby which took positive measures to reduce the need for abortion.

Of course the pro choice view is seen as the compassionate and thoughtful one, for the very simple reason that it refutes the old and long discredited view that you can impose things on people against their will 'for their own good' without attaching the label of tyrant to yourself.

***Greg Gardner**, GP in Birmingham, replies.*

In her letter Elizabeth McCullough accuses me of shamelessly exploiting mothers who grieve after abortion. The question is, who is exploiting whom? The abortion industry of which the FPA is a component part cannot claim to be there solely for the good of women. If it were, then women would be given comprehensive information at the time of the abortion decision so that a full and complete assessment of risks and benefits could be done. This would also include information about the procedure itself. There has been - and still is - huge resistance among abortion providers to giving women enough information - for the reason that too many of them might just choose not to have abortions. That people still refuse for example to inform a primigravid woman that she would increase her lifetime risk of breast cancer by choosing to abort is simply egregious. Valid choices cannot be made without information. The 'right to choose' is meaningless unless people know just exactly what they are choosing.

There is of course no evidence in any of the literature that abortion is good for women's health. The FPA and its associates have never produced a single piece of serious research that would support the view that abortion promotes women's health.

Elizabeth McCullough says she would be more convinced by a pro-life lobby which took positive measures to reduce the need for abortion. The fact is the pro-life lobby is about the only group doing this and the FPA are doing the opposite. Through its fierce antagonism to any idea of sexual restraint and its reluctance to inform young people about contraceptive failure rates it is an agency which is helping to spoil the lives of untold numbers of young people. Most abortion requests come about through failed contraception and most of these are among unmarried women. It is not a stretch to see that the FPA's 'non-directive' (ie. amoral) approach to sexual ethics is contributing to the demand for abortion, not reducing it.

When do contraceptives work?

*GP registrar **Ruth Selwood** takes issue with Professor John Guillebaud.*

In 'When do contraceptives work?' (*Triple Helix* 2003; Summer:12-13) John Guillebaud stated confidently that after 20 years of perfect use of a COCP, *Implanon*, *Depo-Provera* or *Cerazette*, there would not have been a single occasion when a post-fertilisation mechanism would have been utilised.[1] While there is added security in shortening the pill-free or injection intervals, I would welcome the clinical evidence for this absolute claim. Follicular ultrasound of the ovaries, +/- serum progesterone concentrations, is the only reliable means of monitoring ovulation inhibition.

The claim for *Cerazette* perfectly inhibiting ovulation is challenged in a recent *Drug and Therapeutics Bulletin*, suggesting that follicular rupture occurred in up to six percent of women per cycle, accompanied by progesterone rise in 1.7 percent.[2] Whilst better than a standard POP, where up to 40 percent of women show apparently normal ovulation and progesterone activity, this still represents a significant risk.[3]

Previously, incomplete ovulation suppression has been demonstrated with the COCP;[4] follicular development plus progesterone rise occurs in three percent of cycles.[5] A risk of a post-fertilisation mechanism operating in one out of 30 cycles is high. (Ovarian activity is significantly less in pills containing Desogestrel and Ethinyloestradiol, or Gestodene.) The degree of pituitary-ovarian axis suppression varies between women and from cycle to cycle. Breakthrough ovulation occurs in up to 5.2 percent of cycles.[6,7] 23 percent of women show significant ovarian activity by day seven.[8]

There have been a small number of surprise pregnancies in women on *Depo-Provera*, indicating ovulation towards the end of the three month gap.[9] Most cycles are ovulatory after one year's *Mirena* use.[10]

Moreover, John Guillebaud's assertion regarding 20 years of perfect use is unrealistic, given the practical problem of user-failure.

The other day a married Christian girl came to see me, requesting contraception that was *guaranteed* to work pre-fertilisation. I wish I had more clinical evidence at my fingertips to be able to reassure her.

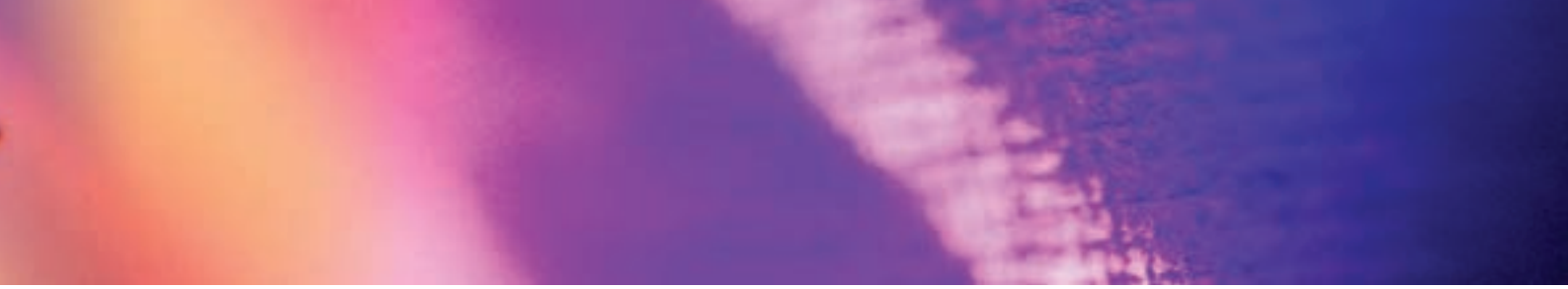
REFERENCES

1. *Triple Helix* 2003; Spring:12-13
2. *DTB* 2003; 41 (9):68-69 (September)
3. *Contraception* 1980; 21:87-113
4. *Triple Helix* 2000: Winter:20
5. *Contemporary Obstetrics and Gynaecology*. London: Butterworths, 1988:315-26
6. *Br J Fam Pln* 1987; 13:127-32
7. *Ob Gyn* 1994; 83:29-34
8. *Fertil Steril* 1989; 52:580-82
9. *Am J Epidemiol* 1991; 134 (8):804-811
10. *Fertil Steril* 1984; 41:52-55

***John Guillebaud**, Professor of Family Planning in London, replies.*

I have four points to make of which the fourth is the most important!

First, I only said I was confident, not that it was an infallible fact that 'there would not have been a single occasion when a post-fertilisation mechanism would have been utilised'. I added the important caveat that, having done everything humanly possible,



might not a believer (who - unlike me - believes that such mechanisms are off-limits for Christians) 'legitimately ask her omnipotent Lord to ensure that this would be so for her?'

Second, Ruth Selwood is unfair to demand absolute proof of a negative. If 10,000 sexually active women used one of the methods I highlighted over 10 years and it were proved that fertilisation never occurred, the following question would remain: 'What if we missed the even more rare breakthrough ovulation, with fertilisation but no conception, that might occur among 100,000 or a million highly fertile women?'

Third, although the DTB's Cerazette review was good, many in the scientific community disagree with their conclusion. Space limits a refutation here. Personally, I remain convinced that in the tiny 1.7% of cycles with potentially fertile ovulation, either the other major pre-fertilisation mechanism of action of Cerazette (mucus inhibition of sperm transport) would be effective or the method would fail altogether. Available evidence is against such a low dose of progestogen preventing pregnancy by interference pre- or post- implantation.

Fourth, as followers of Jesus we are not under law but grace. This implies trust about areas of uncertainty, as in my third sentence above. After 'thinking the Father's thoughts after him', we should apply the best available science without rigidity or legalism but with humility and love: during patient-centred consultations where all options are shared. The choice of action of contraceptive - like their own ethical beliefs - should ultimately be theirs.

9/11 tragedy – two years on

*Cardiff GP **Rob Wilson** concurs.*

I very much agreed with the editorial on the 9/11 tragedy (*Triple Helix* 2003; Autumn:3). Horrific though it was, the hypocrisy, self-centredness and political double standards of supposedly Christian nations is shameful. How can Americans, particularly Christian ones, and we British ignore, and in many instances cause, the suffering in the rest of the world. Please shout louder.

Sleeping with the enemy

***Iain Craighead**, GP with BMS World Mission, disagrees with Chris Richards' conclusions about the harm reduction approach to treating drug users.* (*Triple Helix 2003; Autumn:11-13*)

Both from personal anecdote, and reviewing the available literature I found ample evidence that a harm reduction approach does work for opiate users, reducing both mortality and morbidity amongst users. It is only for heroin addiction that effective substitution therapy exists. Addicts when they present for treatment are often, along with their families, at their wits end. They have almost all tried to go 'cold turkey' and failed and substitution therapy allows them the opportunity to step back from the brink. Methadone certainly reduces morbidity and mortality if it is appropriately prescribed. Buphrenorphine is also helpful in the final phases of withdrawal. However, many patients remain on a maintenance dose of methadone for many years, but this in itself does not inhibit their leading useful and active lives.

Second, we have to realise that opiate addiction is a relapsing-remitting disease and be prepared to deal with relapse when it presents itself.

Therefore I feel that quite the opposite approach is required for opiate users. I would suggest that we engage with and actively help drug users, treating them with respect and building strong therapeutic relationships. Second, that we treat patients according to the national and local guidelines ensuring the safe administration substitution treatments. Third, we must be prepared to accept relapse and deal with it compassionately.

The outworking of this approach is to see lives transformed and rebuilt and I feel an option we should as Christians embrace and not shun.

*Sheffield GP **Mark Houghton** takes issue with offensive illustrations.*

In recent years the presentation of *Triple Helix* has greatly improved making it a pleasure to hand around. But I felt uncomfortable about the photo of the couple making love at the beginning of Chris Richards' article. I have previously taken the *BMJ* to task for using sensationalist soft porn pics to grab attention and using this picture for this purpose undermined the message Chris was bringing.

*Cardiff GP **Rob Wilson** agrees.*

I was really surprised and very saddened by the illustrations accompanying Chris Richards' article. The two illustrations of people in bed were tasteless, unnecessary, and totally against the whole point of the article. Whatever happened to the idea of Christians not buying into the spirit of the age (or the techniques of Sun-type journalism)?

***Peter Saunders** replies.*

Fair cop and mea culpa! I take full responsibility for the insertion of the pictures and apologise for the offence caused.

Depression

*Leamington Spa GP **Peter Davis** writes.*

Paul Vincent has argued that Psalms 42 and 43 provide a good description of depression (*Triple Helix* 2003; Summer:), but there is a more accurate and useful account in Lamentations 3:1-20. If you substitute the word 'he' with 'depression', all the clinical features are then described.

It is also a passage helpful to Christians struggling with depression because of the famous verse that follows: 'Yet this I call to mind.....his compassions never fail. They are new every morning; great is your faithfulness.' (21-23)

*County Durham GP **Paul Vincent** replies.*

I am most grateful to Peter Davis for his helpful comments. The Lamentations were written after the fall of Jerusalem and the Exile and were formal acrostic poems for cultic expressions of sorrow. The people's situation was desperate: starving, held in contempt, no political leadership and either abandoned by God or subject to his righteous anger.

It is not surprising that the author feels in darkness, besieged, downcast, unable to escape, weighed down, mangled, not at peace, with a pierced heart and that prayer is unanswered.

These are many of the features of either clinical or spiritual depression. The author is reflecting a deep state of sorrow rather than depression, I feel, but the 'clinical' or observed, effect is the same. (I wonder if a state of sorrow is reflected in DSM IV?). And I agree, the solution, as in Psalm 42 and 43, is the same: not Prozac (although antidepressants certainly have their place in modern medicine) but a turning to the Lord, for even in the blackest situations 'there may yet be hope' (29). See also especially Psalm 77, 79 and102.