TRIPLE HELIX

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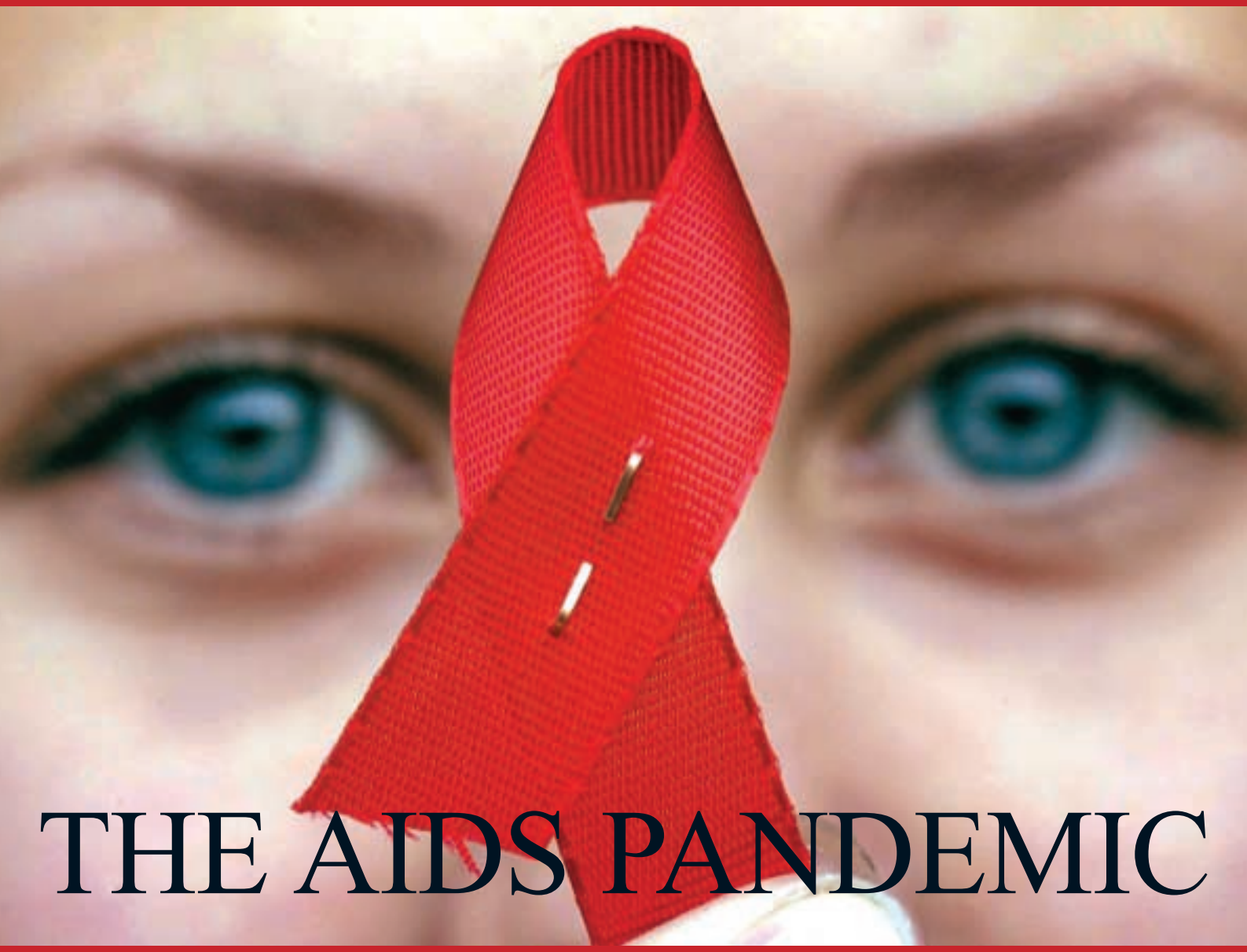
For today's Christian doctor



THE AIDS PANDEMIC

ABORTION FOR SERIOUS HANDICAP

SEX SELECTION

AROMATHERAPY

BULLYING

DOES PRAYER WORK?

FROZEN EMBRYOS

CONTRACEPTIVE PRESCRIBING

OVERSEAS OPPORTUNITIES

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CONTENTS

NO. 26. WINTER 2004

EDITORIALS

Abortion for 'serious handicap'

An important case to win


Photo: PA

On 1 December 2003 Joanna Jepson (right) was granted permission to launch a judicial review concerning a case of late abortion of a fetus diagnosed with cleft lip and palate. Miss Jepson originally approached the West Mercia police in October 2002, who declined to investigate the termination after obtaining a letter from the vice president of the RCOG in support of this decision.

Miss Jepson, a recently ordained Anglican curate, was herself born with a congenital jaw defect that was repaired in her late teens. Having endured the inevitable taunts of other adolescents, she has emerged – after three operations over two years – as the 'ugly duckling turned prom queen' and will stand in court to challenge the vacuity of a culture that worships physical perfection.

Ardent supporters of abortion see the case as a women's rights issue. Ann Furedi, Chief Executive of the British Pregnancy Advice Service (BPAS) claims that the law was, '…deliberately left…vague for the decision to be made between the woman and her doctors… what some people regard as extremely serious, and a condition they really feel they could not live with in a child, others would feel differently about.'[1] She has argued elsewhere that the choice to abort should be open to a woman at *any stage of pregnancy for any reason*.[2]

Others, like Jepson, see the case as challenging societal attitudes towards disability: 'I hope we shall succeed… and recognise once again the value and dignity of our common humanity, disabled or able-bodies, no matter what we look like.'[3] Her view of disability is informed by her own experience and that of her brother Alastair, who has Down's Syndrome – currently the most common fetal abnormality cited as grounds for abortion.

Questions about how 'serious handicap' should be defined were asked in the abortion debates of 1966, but left unanswered. They were asked again when the Abortion Act was amended in 1990 by the HFE Act to allow abortion up until birth on these grounds. Predictions that hare lip or a cleft palate might be included were described as 'a gross calumny on the medical profession' by Sir David Steel, and 'pure scaremongering' by others.[4] The on-the-record intentions of legislators are always to provide for extreme situations. I wonder whether, off-the-record, they are pleased or dismayed at the practical outworking of their regulations - are they surprised or had they expected it all along?

Regardless, this case provides a real opportunity to gain back some of the ground lost in the protection of the unborn since 1967. We must pray that it succeeds.

Jacky Engel is CMF Researcher in Bioethics

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HFEA ban on sex selection

The right decision for the wrong reason

The Human Fertilisation and Embryology Authority (HFEA) has advised the government to ban fertility clinics from using sex selection for non-medical reasons.[1]

More than 80% of respondents to the HFEA consultation document *Sex Selection: choice and responsibility in human reproduction* were opposed to using sex selection techniques for anything other than preventing the birth of a baby with a sex linked genetic disorder such as haemophilia.

The HFEA last held a consultation on sex selection in 1993, and in 1994 licensed sex selective PGD (pre-implantation genetic diagnosis) so that embryos affected with serious sex-linked disorders could be identified and destroyed. 'Social' sex selection was not permitted at that time, but since then techniques for sperm sorting, by gradient or flow cytometry methods, have improved.

Many CMF members will feel that sex selection, even for the prevention of severe disability, stigmatises, devalues and discriminates against vulnerable people who have as much right to care and protection as any of us.[2] But we can be thankful at least that the HFEA has advised a ban on sex selection procedures for 'family balancing' or 'personal preference'. Children are gifts not commodities. They are not designed to meet our preferences but given into our care as unique people with dignity and status who are worthy of the utmost respect. Sex selection offends that dignity and runs counter to the unconditional acceptance that each child deserves. Had social sex selection been approved, it would have led to some parents demanding the 'right' to choose 'designer babies' on the basis of biological characteristics other than sex.

Sex selection is a global issue. In some regions of India the ratio between the sexes is as low as 800 girls to every 1,000 boys.[3] Sex selection practices in China have resulted in a large number of men without wives, and a black market in women has resulted. The UK is a multi-cultural society, and some of our citizens live with cultural pressures that prefer children of a specific sex - we are not immune to the population effects that are witnessed elsewhere. But even if we were, our opposition to practices in China and India that favour male children would be hypocritical if we legitimised social sex selection here.

But, having said that, in apparently basing its ruling on public opinion rather than moral principle, the HFEA has made the right decision but for the wrong reason; and risks becoming future hostage to the shifting sands of consensus.

Peter Saunders is CMF General Secretary

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George Smith examines a popular alternative therapy

Photo: Wellcome Photo Library

Aromatherapy

KEY POINTS

Modern aromatherapy arose in the early 20th century and is an increasingly popular alternative therapy involving the application of aromatic oils, usually to the skin. The use of aromatic oils in relaxing massage is quite legitimate, but this use needs to be distinguished from their employment by New Age practitioners who attribute their 'healing' properties to 'balancing energy flows'. Systematic reviews do not so far support aromatherapy's therapeutic efficacy. Although some sickness may indeed require 'spiritual' treatment, for Christians, this should be based on biblical guidelines and led by God's Holy Spirit. Examination from both medical and Christian perspectives indicates that aromatherapy is not generally to be recommended.

Amongst the 150 or more alternative therapies available today, aromatherapy is high on the popularity list. There are over 6,000 aromatherapists in UK with varying amounts of training and experience.[1] Recently the *Daily Telegraph* reported that women were spending £670 million a year on various spiritual therapies; massage techniques such as aromatherapy were in the top five best sellers.[2]

It is important to distinguish between the valid use of aromatic oils in cosmetics, perfumes and medicines, and holistic aromatherapy as a healing technique. Some products (such as lavender sachets and perfumed candles) may be labelled 'aromatherapy' but are not significant elements of holistic aromatherapy.

Aromatherapy aims to promote and maintain holistic good health by the correct use and application of so-called essential oils obtained from plants. These are usually applied by massage. The word *aromatherapy* is something of a misnomer as its practice is not exclusively dependent upon effect on olfactory nerves. A more precise term would be *aromatic oils therapy*.

Origins

Aromatic oils were widely used in ancient Chinese, Egyptian, Greek, Indian and Roman civilisations for cosmetics, fumigation, embalming as well as medicines and religious rituals. Perfumes and medicines were prepared in temples and there was a Greek temple of aromatherapy.[3] Aromatic substances were burnt to appease gods and channel divine knowledge. The Greeks ascribed divine origins to aromatic plants. The word *perfume* is derived from the Latin *per* (through) and *fumus* (smoke).[4] Breathing in wood and resin aromas was believed to drive out demons. Hippocrates (460-370 BC) commended aromatic baths to prolong life and Pliny (AD 23–79) recorded therapeutic aromatic oil massages.[5] In the Middle Ages, incense and aromas were used during rituals, as perfumes and disinfectants, especially during plagues.

In biblical times, frankincense, spikenard and myrrh were used for anointing, incense and other religious rituals – quite unlike current holistic aromatherapy. The Good Samaritan's oil was more likely to have been olive oil than an aromatic preparation.[6]

Recent developments

Present day aromatherapy can be traced back to the work of Professor R M Gattefosse who first used the term *aromatherapie* as the title of his 1928 book. His theories were based on personal experience: following a laboratory explosion, he plunged his injured hand into lavender oil and obtained immediate pain relief and rapid healing.[7]

During World War II, French army surgeon Jean Valnet was impressed with the value of aromatic oils in wound treatment and began using them more widely with psychiatric, diabetic, tuberculosis and cancer patients. The use of dilute aromatic oils by massage (rather than orally with potentially serious side effects) was popularised by Austrian born chemist Marguerite Maury: she used two to three percent dilutions in plant oils (such as olive and almond) on the skin.[8]

Robert Tisserand (founder of the Tisserand Institute for Research and Education in 1969)

introduced aromatherapy to Britain. His book, *The Art of Aromatherapy* is a standard reference book. UK aromatherapists usually belong to one of several associations; there is a register but no current statutory requirements.

Essential oils

Essential oils are highly concentrated substances (such as clove and bergamot) extracted by expression, absorption or distillation from plants and trees. They are labelled essential as they are considered to have a particular, essential relationship with their parent plant. Implications that they are essential for good health are unjustified. Prominent aromatherapists, however, believe that they contain essential vital force, life energy or universal cosmic energy, which have New Age and Eastern religious and cultural associations. Tisserand maintains, 'Natural aromatic substances are better than artificial ones which do not contain any life force'.[9]

In *Practical Aromatherapy*, Penny Rich concludes, 'Essential oils are so complex and magical that no one knows what they are. Romantics and enthusiasts say they are the life force of the plants similar to the human spirit. Researchers say they are mixtures of organic compounds such as ketones, terpenes, esters, alcohols, aldehydes and other molecules too small and complex to classify under a microscope'.[10]

Essential oils are recommended for many conditions, ranging from asthma to cancer and tuberculosis. Therapeutic indices, apparently based on tradition and experience, list up to 200 medical conditions that may benefit from one of approximately 150 oils.

Medical checklist

How are they said to work?

There does not appear to be a rational scientific basis for this therapy. It is described as working by releasing neuro-chemicals, balancing hormones, stimulating the immune system, reducing toxins or influencing psycho-neuro-immunology; little explanation or scientific evidence is offered. Others claim that benefits depend upon balancing the bodies' vital energy, cosmic energy or life force. Gattefosse stated: 'Essential oils can be used to balance the energy flows of the body in a similar way to acupuncture'.[11] Tisserand also maintained that aromatherapy was based on the same principles as acupuncture, herbal medicine and homeopathy - the balancing of life force or ch'i (yin and yang). He felt that aromatic oils were yin or yang in effect with astrological associations influenced by their ruling planets.[12] Some therapists use astrology and pendulum swinging as diagnostic and therapeutic aids.

Do they work?

The wide range of practices and techniques employed, from bath oils through to massage treatments, complicates the process of assessing aromatherapy's efficacy. In addition, dosage by most of these methods must surely be imprecise.

Few clinical trials have been attempted but Professor Ernst's *Desktop Guide to Complementary Therapies* includes two systematic reviews that do not reveal any conclusive evidence for efficacy.[13] A Consumers' Association investigation found, '…little evidence that the use of essential oils for massage provides any greater benefits than a pleasant smell'.[14]

Are they safe?

Professor Ernst recommends that these oils should not be taken internally or used undiluted on the skin.[15] Severe reactions can occur. Some oils have carcinogenic potential and others may cause photosensitive reactions. General allergic reactions, nausea and headaches have been reported. Some therapists warn against use in diabetes, epilepsy, hypertension, skin problems, pregnancy and cardiovascular conditions. More importantly, it can be dangerous to use an unproven therapy when effective orthodox treatment is available but rejected.

Christian checklist

The lack of scientific evidence for the efficacy of holistic aromatherapy, together with its potential side effects, indicates that it can hardly be used with integrity. Some therapists' diagnostic measures include pendulum swinging, divination and astrology, which are strictly forbidden in the Bible.[16]

Many aromatherapists associate holistic aromatherapy with the theories of life force, vital energy, meridians and chakras, all of which are rooted in Taoist, Hindu and other eastern philosophies and religions. Many alternative therapies are associated with New Age ideology and healing, based on the idea that God is a universal force or energy rather than the Christian belief in a personal God and Heavenly Father.

Conclusion

Careful distinction needs to be made between the legitimate use of aromatic oils and holistic aromatherapy. The popular idea of aromatherapy as a relaxing massage using pleasant, fragrant oils is very different from the holistic aromatherapy of leading exponents such as Tisserand, Rich and Price.

Claims that aromatherapy is effective in the treatment of sicknesses that have spiritual overtones (such as anxiety, depression, fear and guilt) raise serious questions for Christians.[17] Spiritual sickness may indeed require treatment with a spiritual dimension; yet, for Christians, this should be based on biblical guidelines and led by God's Holy Spirit. Examination from both medical and Christian perspectives indicates that aromatherapy is not to be recommended.

'Walk as children of light…proving what is acceptable unto the Lord.' (Ephesians 5:8,10 KJV)

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Peter Saunders reflects on World AIDS Day

The AIDS pandemic

Prevention is the cornerstone of an effective strategy

KEY POINTS

The AIDS pandemic continues to worsen despite concerted international action and better funding. A heavily publicised priority has been the '3 by 5' plan to treat three million people with antiretroviral drugs by 2005; but a comprehensive HIV strategy must address palliative care, orphan care and prevention as well. A condoms-only prevention policy based on Western ideology and experience will fail. The Ugandan experience of ABC – Abstain, Be faithful, Condoms – has been extremely effective in halving HIV prevalence largely through behavioural change. Christians still have a huge role to play at all levels, in palliation, AIDS care, orphan care and in influencing public policy.

In spite of two decades of research and action against AIDS the global pandemic is accelerating. About 40 million people, including 2.5 million children, are now living worldwide with HIV, 95% in the developing world. Each year five million people are newly infected[1] and the annual death rate has risen from just over two million in 1999 to three million in 2003. At current rates of infection there will be 45 million more with HIV by 2010; but 29 million of these could be prevented if a comprehensive set of measures were implemented immediately in the worst hit countries.[2]

At the release of the 2003 *AIDS Epidemic Update*, Dr Peter Piot, the executive director of UNAIDS (the joint UN programme on HIV and AIDS) warned that AIDS was tightening its grip on Africa and threatening other regions of the world: 'The world is mounting a greater response to AIDS through individual initiatives like the US government's emergency plan on AIDS and the Global Fund to fight AIDS, TB and Malaria. However it is clear that our current efforts remain entirely inadequate for an epidemic that is continuing to spiral out of control.'[3]

There are some signs of hope. AIDS spending in low and middle-income countries has risen almost 25-fold in the last seven years, from $200 million in 1996 to $4.7 billion in 2003. Money is now coming from a variety of sources: UN agencies, multilateral organisations and also private groups like the Bill and Melinda Gates Foundation, which has allocated $250 million a year for HIV/AIDS since 2000.[4] Reduced drug prices, more funding and a recent trade agreement to allow poor countries to import (or produce) copies of patented drugs have certainly helped. But there is still a huge way to go.

The challenges are four-fold: antiretroviral treatment, palliative care, care for AIDS orphans and prevention.

Antiretroviral treatment

On 1 December 2003 (World Aids Day) the WHO and UNAIDS launched their '3 by 5' strategy to treat five million people with AIDS by 2005.[5] Drug treatment tends to grab the headlines: especially as the cost of medicines has fallen dramatically. The cost of antiretroviral treatment in Western countries where pharmaceutical companies have patents is about $10,000 a year. This was also the cost to developing countries in 2000. But now generic copies made in India, where patent rules do not apply, are being sold to African countries for around $300 a year, and it is hoped that this price will fall by half by the end of 2005.[6] There are six million people with HIV/AIDS, but currently only about 300,000 people in developing countries receive the drugs at all; less than half of the 800,000 being treated worldwide. In sub-Saharan Africa, where 4.1 million people are affected, just over 1%, or about 50,000 had access to antiretrovirals at the end of 2002.[7]

South Africa, with 5.3 million HIV-positive citizens promised drugs to 'anyone who needs them' in November 2003 and aims to treat everyone with a CD4 count of 200 or an AIDS defining illness by 2009 (about 1.4 million people).[8] Currently only those with access to private healthcare (about 30,000 people) have been able to get treatment. India's health ministry has announced an initiative to supply free antiretrovirals to100,000 people in six states from April 2004.[9] But whether these promises will come to fruition remains to be seen.

Palliative care

In African countries palliative care for AIDS sufferers hardly exists; and millions are dying without any pain relief despite oral morphine being incredibly cheap. Legal obstacles to supply and the lack of trained professionals at community level explain much of the gap. Even in South Africa, home to 25% of Africa's AIDS patients, only 250,000 of five million with HIV currently receive home support and pain relief.[10]

Photo: PA

AIDS orphans

The number of children in sub-Saharan Africa who have lost both parents to AIDS related diseases is set to double to 20 million by 2010; and could then account for 12% of the region's children, according to a new Unicef report.[11] In countries worst affected (Botswana, Lesotho, Swaziland and Zimbabwe) a fifth of children will be without parents. Many households currently are headed by women and grandparents; and most affected countries still have no policy to deal with the growing needs of AIDS orphans who in addition to the legacy of bereavement, are also economically, educationally, medically and socially disadvantaged.[12]

Prevention

Like most international initiatives, President Bush's five year $15 billion Emergency Plan for AIDS relief focuses mainly on drug treatment, with only 20% ($3 billion) being allocated for prevention. At present it is unclear how this will be spent as some conservatives favour an 'abstinence-only' approach whilst liberals dismiss abstinence in favour of condoms. But as Green and Mlay[13] point out in a landmark article in the Washington Post,[14] exporting any kind of Western solution to Africa wholesale may be a huge strategic blunder.

Condoms are effective in slowing spread amongst those at greatest risk: people with infected partners, sex workers, their 'customers' and those customers' wives. But whilst condoms may arguably have reduced spread of HIV in the West, where AIDS is largely confined to those engaged in high-risk behaviour, they have proved inadequate where HIV is found in the general population. In fact the African countries with the highest levels of condom availability – Zimbabwe, Botswana, South Africa and Kenya – also have some of the highest HIV rates in the world.

It is now widely acknowledged in the secular press that Uganda has been the most successful country in combating HIV transmission. The data are clear and conclusive. HIV prevalence in Uganda declined from 21.1% to 9.7% from 1991 to 1998, continuing to fall to 6.4% among pregnant women. This was observed across 15 antenatal sites with greater declines among younger age groups; and these declines are repeated in other national datasets available at county level; army recruits and blood donors, as well as data from all strata of society, urban and rural.[15]

Uganda's AIDS Commission has adopted what it calls the ABC approach to reducing HIV: 'Abstain (from sex), Be faithful (together), or use Condoms'. This led to a wide range of sexual behaviour change including reducing partners, abstinence, faithfulness, marriage and increased condom use. Between 1989 and 1995 casual sex declined by 65% to levels 60% below Kenya, Zambia and Malawi, countries that had similar casual sex levels to Uganda in 1989.

Ugandans were quite clear about the way their behaviour had changed: 48% reported that they stuck to one partner, 11% of men and 14% of women said they had stopped all sex and 2.9% of women and 12.5% of men had started using condoms.[16]

The behaviour change was achieved through a social communication process that began with President Museveni and worked at community level through schools and churches. In the context of post-war poverty, the cheapest approach worked best: public education stressing abstinence before marriage and faithfulness after. 'Zero grazing' was the message repeatedly conveyed by faith-based organisations, prominent cultural figures, political, community and military figures, non-governmental organisations and care organisations.

Comparing condoms to penicillin, Museveni said, 'Just as we were offered the "magic bullet" in the early 1940s, we are now being offered the condom for "safe sex". We are being told that only a thin piece of rubber stands between us and the death of our continent. I feel that condoms have a part to play as a means of protection, but they cannot become the main means of stemming the tide of AIDS.'

Conclusions

The AIDS pandemic is a public health emergency out of control. Effective management has to be comprehensive – involving drugs, palliative care, care for orphans and prevention. Sacrificial and extravagant giving to the poor,[17] compassionate care for the sick,[18] care for widows and orphans,[19] and faithfulness in marriage[20] are right at the heart of God's priorities. Christians have a huge role to play at all levels in giving, caring, implementing prevention strategies and, perhaps most importantly, influencing public policy. The Ugandan model has worked because it based on the biblical principles of wise, strong leadership, responsible communities, generosity, unconditional care and sound community and sexual ethics. There are important lessons here for all concerned about the future of our planet.

Peter Saunders is CMF General Secretary

Photo: PA

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Mark Cheesman reflects on a growing problem

Photo: Wellcome Photo Library

BULLYING IN THE NHS

Hard-headed managers can cope with tears and shouting but are all at sea when someone returns blessings for curses, offers forgiveness unasked or gently resists evil

Wouldn't you think that, being such a grubby and cowardly business, bullying would quite ashamed to show its face? Yet it is alive and well, an integral part of NHS culture. It thrives on silence and secrecy but, brought out into the open, it looks altogether less frightening. Many people don't believe that reporting a bully would change anything except their own position for the worse. Bullying is evil and it's high time we confronted it.

Bullying is the abuse of another person by virtue of some sort of power over them. Power play is a part of most relationships but bullying is not the ordinary rough-and-tumble of two sinners trying to relate to each other. There is nothing particularly Christian about having a thin skin or a sensitive ego. Most of us get bumps and bruises in everyday life: we shrug our shoulders and have a cup of tea. Everyone has off-days, including us.[1]

You know the difference: the colleague who makes you feel cold just by being there; that loathsome, manipulative patient; your managers trying to horse-trade another encroachment on your peace of mind; the consultant who can't lead without humiliating others. Something isn't right but you're the one who feels guilty! Skilful, isn't it?

Humanists say that bullying is unacceptable because no one has a right to a life-style that degrades other people. Christians go further: when you degrade another person, you insult their Maker.[2] God most surely sees what you do.[3] It is not a light thing to anger him.[4] Indeed, one of the best thought correctives before undertaking a difficult conversation is to remember that the other person is precious to God who is sitting at your elbow as you speak and sees it all.[5]

Firm supervision or bullying?

Supervision and mentoring are meant to be formative. This may involve correction of mistakes and unhelpful or unprofessional traits. Yet mentoring should never be destructive: reducing self-esteem and ability have no place in a supervisory relationship. Most organisations believe that they have a duty to train and educate their workforce; they also have a statutory duty to safeguard the physical and mental health of their workers. Most NHS trusts have formal anti-bullying policies but these frequently go the way of all other well-meaning policy statements when push comes to shove.[6] In one study of junior doctors, 37 percent said they had been bullied in the last year, and 84 percent in their professional lives.[7]

What can you do?

WRITE – Strip the incident of emotion and record the bald facts. Write it down and then read it. Is it

reasonable to be upset by this? If you think so, take it to someone you trust and ask for their judgment. Write, time and date all such incidents: this will be invaluable if you decide to pursue things. It may also help you in praying and keeping perspective.

THINK – Try to separate the just from the unjust. We do need to learn from our mistakes even when the rebuke was unreasonable. If harsh words were justified, accept them with or without a tear. Then get up again. If you're feeling strong, a 'Thank you' will blow them away!

DECIDE – If it's not a big deal, go and talk to them.[8] Choose your time well: say what you think they did wrong without emotion and offer your hand. If they have any integrity, you'll go up in their estimation. Writing may be appropriate but has less impact.

If it is a big deal – repeated, malicious or sexual bullying – don't do anything on your own. Sift through your thoughts with a trusted third party - a chaplain, colleague or BMA representative. Together, explain to the bully why their behaviour is unacceptable and how you will respond if it's repeated.[9] Be well prepared, civil and as emotionless as possible. Briefly record the proceedings afterwards.

What will happen?

In either situation, a variety of reactions are possible. The bully may be astonished and apologetic. You might encounter cold resistance. Remember, it is not your job to produce repentance - you want the behaviour to cease. Express your commitment, refuse to sanction or acquiesce in evil. Tough? Maybe but not as tough as going on in a semi-conspiratorial silence that destroys your confidence and happiness.

What if they respond by trying to block your career? People are not uniformly spiteful. They may feel that they cannot lose face but still be quite struck by events. At any rate, you will have a record of what happened that could be used in any sort of future appeal.

The bullying patient

The principles are the same for a patient who abuses a relationship. Go away and reflect, write it down and maybe consult with someone wiser. If you are a junior doctor, go to your consultant first. Deliver an unemotional response, either face to face or in a letter, or think who should do so. If it is repeated or malicious, meet up with the person with a third party present. And you do, after all, have the power to end the relationship.

Bully boss

Some people are serial, hard-core bullies: they are identified in NHS folklore and people avoid working for them. Their superiors often know about it but are disinclined or afraid to confront them. They twist, turn and lie to avoid trouble. Such people are difficult to take on: isolating them by refusing to work for them may not be practical in a job-scarce market. Yet a serious allegation of bullying, fed through your educational supervisor, manager or regulatory body's visit may well precipitate action. Others are on and off bullies: enquiry of your peers usually helps you decide if this is the case. Knowing whether this is a deep-seated problem or a stumble by a hard-pressed clinician can influence what you do.

Going nuclear!

Like resigning, you can do this only once. Your 'superior' colleague has far more to fear from it than you do. A serious, evidence-based accusation of bullying is a devastating thing to face. It also effectively ends the relationship. Sometimes it might have to be done: for the sake of others, justice and the honour of your Lord. It involves putting in a formal complaint, backed by records and advice. It's unpleasant, destructive and causes significant collateral damage. The bully knows this too and will be just as anxious as you to avoid it. Threaten only once and then do it.

Pray

Prayer is a wonderful transformer - of us, promoting God's will on earth, not ours in heaven.[10] We can bring any trouble and ache to our Heavenly Father.[11] He gently wipes our tears away. The trouble is that we're prone to storm out at that point and re-join the fray. We shouldn't: casting our sorrows where we have cast our sins - at Jesus' feet - should be the start of a time with God.[12] Sitting in silence with God is transforming. Slowly, we gain heaven's perspective on the situation: then it's relatively easy to pray for the most disagreeable person.[13]

Evangelise

God's grace is more powerful than anyone's sin.[14] Jesus' name can bring down extraordinary barriers.[15] Hard-headed managers can cope with tears and shouting but are all at sea when someone returns blessings for curses, offers forgiveness unasked or gently resists evil.[16] Bullies do not know how to cope with the kingdom of God. Nor do they realise, when viewed from a kingdom perspective, how vulnerable they really are.[17]

The power of 'No'

Most of us worry too much about refusing to be abused. As I have progressed as a consultant, I have been struck by how few adverse events there are when you say 'No'. After all, the only person we have no right to say this to is God. Now, your manager is not God.

Mark Cheesman is CMF chairman-elect and Consultant Geriatrician at Southmead Hospital in Bristol

KEY POINTS

Bullying is abuse through the misuse of power; and is alive and well in the NHS. Supervision and mentoring are meant to be formative, but can be destructive when they demean abilities and undermine self-esteem. When we are bullied we should carefully record the facts, determine whether the criticism was unjust, and confront the bully, perhaps with a supportive third party, in a civil and polite way. If an apology and change in behaviour is not forthcoming; then it may be necessary to proceed to a formal complaint. Whatever happens everything should be approached in an attitude of prayer, forgiveness and love.

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Medical facts and biblical principles should shape prescribing argues **James Tomlinson**

Conscientious contraception

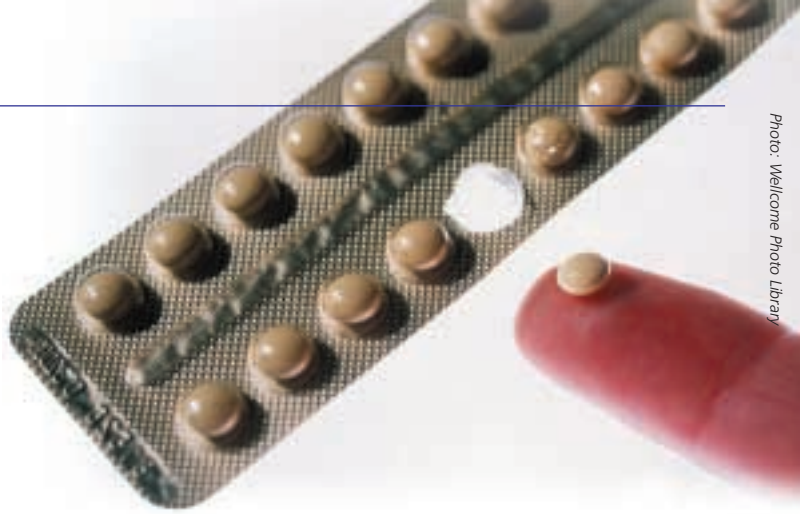

Photo: Wellcome Photo Library

A recent House of Commons inquiry declared the nation's sexual health to be in increasing crisis.[1] The committee made a number of recommendations: sex and relationship education as a core part of the national curriculum; prioritisation of contraceptive services; increased open access for terminations; performance management of primary care trusts against sexual health standards.[2]

General practitioners are on the frontline of a government strategy on sexual health that has 'safe sex' advice and the provision of contraception - including the Morning After Pill (MAP) - at its heart.[3] Under the new GP contract, practices will receive quality payments for having a policy on the provision of emergency contraception that ensures delivery.[4] However, Paul exhorted Christians not to conform to the pattern of this world but to be transformed by the renewing of our minds.[5]

I am on an ongoing journey: integrating my faith and practice in the area of contraception and sexual health. I remain convinced that (from both biological and biblical perspectives) the human embryo should be considered a human being from fertilisation.[6,7,8] Quoting John Wyatt, 'If we recognise a deep uncertainty and ambiguity about the moral significance of the embryo or early foetus, we have to ask: "What is an authentically Christian response to this deep ontological uncertainty?" Surely an appropriate response is to vote in favour of protection and against intentional destruction.'[9]

Accordingly, I avoid prescribing any contraceptive that may act after fertilisation. However, obtaining and assessing relevant information on the mechanisms by which contraceptives act is difficult. I have been guided by Professor of Family Planning John Guillebaud's recent review of methods he considers to act before fertilisation: combined oral contraceptive pill (COCP), *Cerazette* - a new progesterone only pill (POP), *Implanon*, *Depo-Provera* plus barrier methods.[10] His conclusion that these hormonal methods operate prior to fertilisation is on the basis that they *effectively* prevent ovulation as well as act on the cervico-uterine mucus to reduce sperm-penetrability and therefore block sperm migration. He supports the use of *Cerazette*: 'It is as effective as the COCP at blocking ovulation'. However, a recent review of *Cerazette* (desogestrel 75mcg) by the *Drugs and Therapeutics Bulletin* concluded only that it inhibits ovulation more frequently than a standard POP, since there aren't any published trials comparing *Cerazette* and COCPs.[11] In a double blind trial comparing desogestrel and levonorgestrel, ovulation occurred in 1.7% of desogestrel cycles compared to 28% of levonorgestrel cycles. (Ovulation was assessed by ultrasound and serum progesterone concentration.) Given that *Cerazette* acts both to block ovulation and thicken the cervico-uterine mucus, Professor Guillebaud's assessment that it does not act post-fertilisation seems valid on current understanding.[12]

As I feel that they may act after fertilisation, I will not prescribe (first-time or repeat) the MAP, POPs (except *Cerazette*) or intrauterine contraceptive devices (including *Mirena*).[13,14,15] Even in a patient-centred consultation, where treatment options are shared and the patient chooses her treatment, I am still responsible for what I sign. To prescribe a contraceptive that works after fertilisation is to participate in the potential destruction of human life.

I have sought a management pathway that shows compassion and respect for my patients whilst not compromising my convictions. If my beliefs may affect the advice or treatment I provide, I should explain this to my patients, telling them of their right to see another doctor.[16] When patients request contraception, I discuss how the different contraceptives work. I explain that some people believe that life begins at fertilisation and explore their thoughts about this. If they choose a method that acts after fertilisation, I explain that, due to when I believe life begins, I will not prescribe this for them but can refer them to another doctor. If they are already on a POP other than *Cerazette* and have attended for medication review, I check they understand the implications of its mechanism of action and discuss whether they wish to continue it. I have found that a number of my patients will only accept contraception that acts pre-fertilisation.

Reassessing my approach to contraception is painful and challenging. Reading relevant articles, attending conferences (such as 'Turning the Tide' and 'Handling Ethical Conflicts in the Consultation') and talking to Christian colleagues have all helped.[17] Compromise lies in pragmatically prescribing all contraceptives regardless of their mode of action. I choose to practise what I believe about the status of the embryo whilst continuing to engage with patients caught in society's sexual crisis.

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Peter May analyses a recent *Everyman* programme on the Mantra study [1]

Does prayer work?

One of the biggest, multi-faith, prayer experiments ever devised has concluded that prayer made no significant difference to the outcomes of the cardiac patients involved. A pilot study had suggested that prayer could have a measurable effect on the outcome of patients who required angioplasty, a surgical procedure to unblock diseased coronary arteries.

To test the hypothesis, cardiologists at Duke University Medical Centre in the American 'Bible belt', set up a three year trial, known as the Mantra study, to see if patients made better recoveries if they were prayed for. Statisticians advised them that they would need 750 patients to reach a statistically significant conclusion.

Enrolling the help of 26 prayer groups across the world, patients were randomly allocated into two groups. One group was assigned for prayer, the other group wasn't. Neither doctors nor the patients and their families were told which patients were being prayed for – in other words, it was a 'double-blind' trial.

The praying groups included Christians in Manchester, Buddhists in Nepal, Sufi Muslims and Carmelite nuns in America. The Cardiologist who led the study was a practising Jew but was inspired by Hinduism.

Questions about the study

The study appeared to be done to the highest, scientific standards. It was a prospective, double-blind study, where an appropriately large number of patients were randomly allocated into the two groups. There was however a major flaw. It assumed that no one prayed for those in the non-prayer group, or that the sheer volume of prayer for the other group from around the world rendered any such prayers inconsequential.

They could not rule out that members of the patient's family might have prayed for those in the non-prayer group, or that those patients, who did not of course know which group they were in, might have prayed for themselves! After all, they lived in the 'Bible belt'. The assumption made was that the 'amount' of prayer was the most important factor.

The researchers claim that after the events of 9/11, due to an apathy that threatened to end the study after only 500 patients had been entered into the trial, more groups were called upon to pray. We are told the figures 'suggest' there may have been a greater benefit after 9/11, when the prayer was increased. However, we were initially told it would need 750 patients to produce significant results, so to claim benefits for the remaining 250 patients has to be considered 'special pleading' and was not statistically significant.

Questions about testing God

Moses said: 'Do not put the Lord your God to the test.' [2] This is the text that Jesus repeated during his temptation in the wilderness, when asked by the devil to throw himself from the top of the Temple. [3]

Questions about prayer

Christians believe they are speaking directly to the loving Father in heaven who created them. But what do Buddhists believe about prayer? They do not believe in a personal, creator God, whom you can talk to in that way. Prayer is a different concept for them.

THIS STUDY REVEALS A SLOT-MACHINE ATTITUDE TO PRAYER, VIEWING IT A MECHANICAL BUSINESS, WHICH IS MORE EFFECTIVE IF YOU PUT MORE ENERGY INTO IT

I suggest this study reveals a slot-machine attitude to prayer, viewing it a mechanical business, which is more effective if you put more energy into it, and which works the same whether you believe in God or not? It reminds me of the famous Old Testament power contest where Elijah mocked the 450 prophets of Baal, taunting them to pray louder in case their God was lost in deep thought, was busy, travelling or just asleep? They prayed all day, without success. Elijah, however, then saw an immediate answer to his single, short prayer. [4]

James reminds us that there is a moral factor in prayer. He said the prayer of a righteous man is powerful and effective and cites the prophet Elijah as an example. He implies that he had no special powers but was 'a man just like us'. [5]

Jesus offered a similar warning in the Sermon on the Mount: 'When you pray, do not keep on babbling like pagans, for they think they will be heard because of their many words. Do not be like them, for your Father knows what you need before you ask him.' [6]

The Scriptures offer many examples of great prayers. They are not shopping lists for 'goodies'. They have to do with the relationship of God to his distinctive people. Consequently, they are concerned with asking for forgiveness, wisdom, courage, mercy, understanding, guidance, discernment and strength to do the right thing.

Yes, we are told to cast our cares upon him, knowing that he cares for us. [7] But we don't expect immunity from ill health, the avoidance of suffering, guarantees of a long life or exemption from physical death.

The apostles were beaten, stoned, thrown to wild animals and killed. The great apostle Paul cried out to God to be rid of his 'thorn in the flesh' (could it have been angina?), but it was not removed. Instead it taught him humble dependence on the grace of God – and God used him mightily as a result. But he didn't live into old age.

Jesus taught that fundamental to authentic Christian prayer is the desire 'Your kingdom come, your will be done', [8] implying a concern for and an openness to accept God's sovereign purposes.

Can people be randomly allocated to the love and care of God? That is an appalling concept. We need a deeper understanding of prayer.

Peter May is General Practitioner in Southampton

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The tragic high profile case of two women, who were denied use of their frozen embryos by the High Court on 30 September 2003, raises a host of legal and ethical issues.[1] **Peter Saunders** digs deeper

Frozen embryos – The tip of a huge iceberg

Human embryos are amongst the weakest and most vulnerable of all human lives, and yet are being sacrificed in huge numbers in this country under the provisions of an Act that is desperately overdue for major review

Natallie Evans, 31, of Trowbridge, Wiltshire, who had her ovaries removed after being diagnosed with cancer, previously had six embryos created and frozen, before breaking up with her boyfriend Howard Johnston. Lorraine Hadley, 38, from Baswich, Staffordshire, who had a 17-year-old daughter from a previous relationship, had two embryos previously frozen using her eggs and the sperm of her ex-husband Wayne. Under the 1990 Human Fertilisation and Embryology Act (HFE Act), both parties must consent to the storage and use of embryos at every step of the IVF process, but both former male partners had refused to give this consent.

The legal judgment

Lawyers acting for the women had argued that destruction of the embryos violated their rights under the 1998 Human Rights Act.

Under articles 8 and 12 they said they had a right to 'respect to private and family life' and to 'marry and found a family', but High Court Judge Justice Wall said these rights applied equally to their male partners who did not want the embryos implanted. They further argued under article 2 that their embryos, had a 'right to life' but Wall ruled that embryos are not persons with rights in UK law. He also ruled that article 14 ('prohibition of discrimination') did not apply in this case as the HFE Act itself does not discriminate against women who are unable to conceive without undergoing IVF treatment.[2]

Justice Wall in conclusion, whilst saying he had sympathy for the women's position, could not overrule the law as it stood, and said it was up to Parliament to decide whether the law should be changed. He ruled that the embryos should be destroyed. Natallie Evans has since applied to the Court of Appeal, but Lorraine Hadley has abandoned further legal action.[3] It remains to be seen whether the present legislation, which seemingly allows for no exceptions even in hard cases, will be found too rigid to survive a human rights challenge in higher courts.

Most official opinion appeared to back the High Court decision. BMA Ethics Committee chairman Michael Wilks commented: 'Whilst empathising with the situation of both women we feel it would be a dangerous step to change the rules on consent retrospectively.' Suzi Leather of the Human Fertilisation and Embryology Authority said: 'The judgement is clear, the law has been clear since 1990 when it was passed by Parliament – but I don't think that takes away the pain for the women involved.' Justice Wall commented further, that had the embryos been re-implanted, the former male partners would have become the biological fathers of children for whom they would be financially responsible, but with whom they could not enjoy any form of natural parental relationship. He added that no one would have expected a mother to have frozen embryos implanted without her consent just because her partner wanted it, and that the law applied to both partners equally.

The case did however highlight an anomaly in the present legislation. Professor Ian Craft of the London Fertility Centre, said: 'The irony here is that in a natural conception a woman has absolute rights, but she apparently does not have absolute rights in IVF.'

Expendable embryos

Understandably most of the legal and ethical

Photo: PA

discussion in the case has centred around the respective rights of the parents, but Lorraine Hadley crystallised another key issue beautifully in her comments after the trial, in speaking of her despair at the decision: 'An embryo is not a possession to be divided up in the divorce proceedings. It is a baby in the making. I fully accept that men have rights too. But I find it abhorrent that we should be able to create these little human beings – and then flush them down the toilet on a whim. Why should one of us have the right to say the embryos should be destroyed simply because it doesn't suit them any more?'[4]

The short answer is that both law and public consensus in this country regard the human embryo only as a potential human being (and hence without rights) rather than a human being with potential.

Since 1990 about 250,000 embryos have been frozen following IVF treatment in Britain. In March 1999 there were 51,346 embryos stored. This had jumped to 97,719 in March 2001 and 116,252 by March 2003, more than doubling in four years.[5] Around eight embryos are created in each IVF treatment cycle but only a maximum of two can be implanted, meaning that there are always spare embryos to be frozen, donated, experimented upon or destroyed. Couples are allowed to keep them for up to ten years for an annual storage fee of approximately £250. Some are re-implanted by those who want to 'try again' without re-harvesting fresh embryos after failed IVF, but most are allowed to perish at the parents' request. Some are donated for medical research, and some, but not many, are given to other childless couples. In 2001 there were just 189 cycles of treatment with donated embryos out of a total 25,000 IVF treatment cycles and only about 1,500 babies have so far been born as a result of donated embryos.

Infertility and adoption

The whole debate needs to be seen against the broader sociological background of rises in the incidence of infertility and falls in the number of babies available for adoption.

Infertility is increasing primarily because of delayed childbirth or tubal infertility. Couples are marrying later, or choosing to delay having children for career or personal reasons. Tubal infertility is increasing mainly as result of chlamydia infection, which currently affects 10% of women and is itself increasing 20% per year, largely as a consequence of unwise sexual choices.

In the mid 1960s there were about 15,000 baby adoptions per year but this has now fallen to around 200. This is in part because women who might previously have given their babies up for adoption are instead choosing abortion. In fact if adoption was more widely encouraged there may be many more babies available for adoption. In 1968 there were about 23,000 abortions in England and Wales but the total is now about 180,000 per year. In addition there is far less stigma now attached to one parent families, and about two million UK children live with only one parent.

About 8,000 IVF babies were born in 2001, the latest year for which figures are available. This is about half the number of adoptions that took place each year in the 1960s. Whereas clearly not all infertile couples would choose adoption above IVF, if more babies were available for adoption in the UK one would expect demand for IVF to decrease substantially.

IVF births now account for about 1% of all births. Since 1978 more than 68,000 children have been born through IVF, out of over 900,000 embryos created. Costs range from £2,000 to £4,000 per cycle and the success (live birth) rate for IVF patients of all ages is about 22%. In the UK about 40% of all IVF treatments are provided by the NHS,[6] but under new NICE guidelines all women up to 39 either with a clear cause of infertility, or three years unexplained infertility, will be entitled to three complete treatment cycles free. The estimated cost to the NHS is £400million or about 0.6% of the annual health budget.[7]

In the US a Christian adoption agency, *Nightlight Christian Adoptions*, has launched an embryo adoption scheme called 'Snowflakes',[8] whereby couples with spare embryos can donate them to another couple. They are seeking to introduce the service into the UK in the near future. 'Snowflakes' was created to rescue IVF embryos that would have otherwise been discarded, and has been responsible for the birth of 32 children in the US to date. Its procedures are similar to the traditional adoption process, including screening both sets of parents and allowing donor parents to veto adoptive parents they consider unsuitable.[9]

Better solutions

The frozen embryo saga highlighted by the cases of Natallie Evans and Loraine Hadley is just the tip of a huge iceberg. Human embryos are amongst the weakest and most vulnerable of all human lives, and yet are being sacrificed in huge numbers in this country under the provisions of an Act that is desperately overdue for major review. Christ gave his life for us 'when we were still powerless'[10] and it is a fundamental Christian ethical principle that the strong should make sacrifices for the weak. Christian doctors have a huge obligation to be at the forefront of a push for more humane legislation that treats human embryos with the wonder, respect, empathy and protection that they deserve as creatures made in the image of God.

But there are also far deeper sociological issues raised here: the promotion of embryo and baby adoption as alternatives to embryo disposal and abortion, and the prevention and proper treatment of the sexually transmitted diseases that account for so much infertility. A society that followed God's wisdom of 'one man, one woman for life' and which put service and family obligations above material gain would avoid much of the legacy of the sexual revolution that we are currently reaping.

We may never eliminate infertility, but even in an imperfect world there are more humane, wise, sensible and just solutions that those we have currently embraced.

Peter Saunders is CMF General Secretary

Photo: Wellcome Photo Library

KEY POINTS

The failed High Court appeal by Lorraine Hadley and Natallie Evans to save their frozen embryos against their partners wishes has highlighted the fact that current law offers protection for the rights of neither the mother nor her embryos in these circumstances. But the case also raises the deeper issues of the rising epidemic of chlamydia, the shortage of babies for adoption and the unavailability of non-high-tech solutions for childless couples. The Human Fertilisation and Embryology Act needs urgent review, but we cannot do so without also addressing our society's unbridled 'sexual freedom' with its legacy of infertility and abortion.

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HEAD T

Peter May and **Ruth Selwood** explain their contrasting positions.

Should we prescribe contrace

'Yes!' **Peter May** is a GP in Southampton

There are those - mainly girls in their mid-teens - who come for contraceptive advice before embarking on a sexual relationship. If she has not been prescribed contraception *before*, I ask about her intentions. Mostly, she has made her mind up already. Sometimes mothers attend along with their daughters, wanting them 'fixed up' before they start having intercourse.

Early in my career, I thought naively that I could persuade a young woman to change her mind: she returned within a few weeks requesting a termination. Now, when my advice is called for, I ask my patient to listen very carefully: 'I will say this only once!' If after due reflection, she still wants to embark on a sexual relationship, and comes back to me for contraception, I tell her that I will prescribe it without further discussion unless she initiates it. More often, these young women then go to a Youth Advisory Clinic instead and probably change to a GP with whom they feel more comfortable! The doctor-patient relationship is easily destroyed.

With gentle irony, I point out that there is a close, scientifically proven, correlation between intercourse and having babies. Of course, I warn of the risks of diverse infections. I point out the emotional dangers of multiple relationships, which statistically decrease the likelihood of entering into an enduring relationship in the future. I even talk about the wonderful joy and confidence that can be experienced in a unique relationship. Sex is fun from the beginning because you don't bring memories or hang ups into the relationship; it remains fun in the future because of the deep trust in each other's faithfulness.

It would be impertinent of me to discuss my faith unless it came up naturally in conversation: they have come to me for contraception not conversion. These discussions are always a challenge, especially when mother is present, as big questions can be raised about mother's values, lifestyle and the example she has set her daughter.

However, 99 percent of these young women have already begun a sexual relationship, so providing them with contraception is hardly facilitating their sin. My task is one of damage limitation. If they become pregnant, there is a very high risk they will have the pregnancy terminated. I would sooner that life was not created than that it should be destroyed. I am not greatly enamoured by the idea that they should get herpes, warts, chlamydia, cervical carcinoma or something even worse! Therefore, I teach them about these risks and encourage them to use condoms, which I provide if asked.

If I was to take the moral high ground and wash my hands of their iniquities, I guess I would not stop there. I wouldn't be able to give safe-sex advice to homosexuals. I would be tempted not to prescribe for anyone with a self-inflicted illness. Woe betide smokers with ischaemic heart disease: 'Buy your own aspirin and nitrate sprays!' I'd have to give short shrift to alcoholics with high blood pressure. Insomniacs with troubled consciences would remain tired: 'Do you expect me to give you a drug-induced peace, when you have no peace?' Obese people wanting Orlistat: 'Just eat less!' An injured hang-glider requesting analgesia: 'What! If God wanted you to fly, he'd have given you wings!' Such an approach would shift an intolerable workload onto my long-suffering partners!

PEOPLE CAN BEHAVE APPALLINGLY BUT WE ARE CALLED TO FOLLOW ONE WHO ROLLED UP HIS SLEEVES AND GOT ALONGSIDE THEM

No, it's a messy old world. People can behave appallingly but we are called to follow one who rolled up his sleeves and got alongside them. Jesus didn't come to condemn the world but to save it;[1] that judgement was God's business, not ours.[2] As guilty sinners who have found God's forgiveness, we should not be overly preoccupied with own moral purity. Jesus told the story of the religious priest who walked by on the other side, while a wretched Samaritan outcast rushed to a poor man's aid.[3] Much misunderstood, Jesus became the friend of sinners.[4] He helped without bullying them or overriding their decisions.[5] Such was his identification with lost people that he became sin for us and hanged on a gallows for our redemption.[6]

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O HEAD

eption for unmarried patients?

'No!' **Ruth Selwood**, former CMF staffworker, is a GP registrar in Birmingham

This controversial subject has been previously aired in CMF.[1] I fear we are kidding ourselves that extramarital intercourse with contraception is preferable to unwanted pregnancies with abortions.

Socially, the price of sex used to be life-long union with children, social and financial responsibilities; now it is free on prescription. Disintegration of the marital unit is the destruction of society itself. Divorce is more likely after extra-marital sex; cohabiting couples are more likely to split up. The illegitimacy rate has soared from five to over 30 percent since contraception was introduced. Fragmentation of homes can only perpetuate, as children grow up imitating their parents.

Physically, harm-reduction is mythical.[2] Despite sex-education programmes and free contraception, risk displacement is causing soaring teenage pregnancy and STD rates, whilst age at first intercourse keeps falling.[3]

Psychologically, contraception doesn't protect against emotional damage associated with multiple partners. Outside of a life-long trusting relationship, sex is a lie. Sexual body language communicates, 'I give you my all'; failure to set it inside a life-long commitment reveals, 'I am holding back'. I often use the illustration of gluing two pieces of paper together and then ripping them apart: little bits remain stuck to each other.

Spiritually, fornication is sin. We should neither impose our morality nor facilitate sin. Whilst not expecting them to conform to our standards, God's blueprint is still in our patients' best interests. It is illogical to argue that we should provide protection as they will have sex anyway. By providing the means, we heighten the motive, opportunity and exposure to the consequences. Suggesting, 'Shall we do evil that good may come?'[4] is unbiblical. I cannot imagine the Lord dishing out contraceptives to unmarried women. Jesus was non-judgemental yet uncompromising with the woman caught in adultery: 'Neither do I condemn you. But go, now leave your life of sin'.[5]

When a woman requests contraception for the first time, I certainly try to dissuade her. I explore issues of self-esteem, coercion and whether she feels this is Mr Right. I discuss STDs, unplanned pregnancy and emotional damage. I explain I am unable to prescribe for her, as I don't feel it is in her best interests. I offer her the option of seeing another doctor, apologise if this creates difficulties and explain that I would be delighted to see her in the future.

I saw this approach working effectively as a gynaecology SHO. Following a termination, my registrar told a 14 year old girl that it was vital she take the pill in future. As she neglected the wider issues, I returned (with her permission) to discuss with the girl whether she had wanted sexual involvement, her feelings about the consequences, self-esteem and sex as communication. It emerged she had felt coerced into sex, was shocked by the consequences and didn't wish to have sex again. She was happy to go home and discuss everything with her mother.

> BY PROVIDING THE MEANS, WE HEIGHTEN THE MOTIVE, OPPORTUNITY AND EXPOSURE TO THE CONSEQUENCES

The hardened pill user is trickier. I ask whether she is in a relationship. If it's a casual affair, I discuss the physical and emotional risks of sex; if he's Mr Right, I discuss the greater likelihood of break-ups in cohabitating relationships. I then get my GP trainer to sign the prescription; although arguably, in so doing I may be leading a Christian brother to sin.

Believing that life begins at fertilisation, I also have reservations about contraceptive mechanisms of action. Many contraceptives act by preventing implantation and so are in reality 'abortifacient'.[6] Regardless of patients' marital status, I prescribe only methods guaranteed to inhibit ovulation - a subject of current debate (see my letter in this issue).[7]

Taking this line is not easy. My heart sinks in pill-request consultations. I fear losing popularity or appearing off the wall. Since I can't offer a full range of contraceptive services, I try not to prejudice the options I discuss with patients. I decided against placing a notice in reception saying I don't see pill requests: I value discussing patients' sexual lifestyles with them. I strive not to appear moralistic, but rather compassionate for my patients, desiring to save them from harm.

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What position do you take? Is there a particular issue that you would like featured in Head2Head?

Write in to **rachael.pickering@cmf.org.uk** and join in the debate. In the next issue, we will publish correspondence along with the next Head2Head.

how i'd handle it!

Dr Liz Walker – GP retainer in Farnborough and former CMF chairman – presents us with this sticky dilemma

Fasciculations

Frank, a rather anxious 59 year old, consulted your partner with tiredness and difficulty in walking. He had bilateral leg fasciculation and minimal right foot weakness. Pressed for the 'worst case scenario', your colleague mentioned motor neurone disease (MND) as a rare possibility and referred him to a neurologist.

A week later, you are called out to see Frank: he's having a panic attack and is convinced he can't breathe because of MND. It turns out that his best friend died of the same condition. Frank's son tells you that he is going to make a formal complaint against your partner for mentioning the possibility 'without proof'.

How would you handle this situation? What would you have done in your partner's shoes?

Resolving this situation would require competence, compassion and communication. Wisdom from the book of Proverbs is helpful: 'It is not good to have zeal without knowledge, nor to be hasty and miss the way'.[1] I wouldn't diagnose a panic attack before excluding other pathology such as a myocardial infarction. I would take a history and examine Frank. Treating him professionally would help him trust me - vital as panic attacks require reassurance!

I would choose my words carefully: 'Reckless words pierce like a sword, but the tongue of the wise brings healing'.[2] Frank wants to hear that he hasn't got MND but these would be reckless words from me. 'A cheerful look brings joy to the heart, and good news gives health to the bones.'[3] So, whilst acknowledging the worry of the possibility of MND, I would emphasise the good news: 'Frank, you're having a panic attack, not dying of a disease you may not have!'

I might find it difficult to prioritise helping Frank as opposed to trying to avert a complaint. 'Meddling in someone else's quarrel is like seizing a dog by the ears.'[4] I could avoid the issue, suggesting that Frank's son make an appointment to see my colleague. However, 'A patient man calms a quarrel'.[5] Given enough time and sensitively using all the communication skills I know, I may be able to defuse the situation. Most complaints could have been avoided by clearer doctor-patient communication. There are several useful questions my colleague could have asked: 'What do you think or fear may be going on?' and 'What would you like to ask?' He could then have tailored his response to Frank's worries and queries. Of course, once Frank's diagnosis is made, he has the right to be told. At this early stage, it may have been wisest to refuse to speculate on specific illnesses.

Malcolm Savage is on the Sheffield GP training scheme and a former CMF staffworker

When I was in medical school nearly forty years ago, the debate was raging over a patient's right to know. Even today, openness is not a universal medical standard. One overseas colleague told me: 'If you tell a patient they are dying, you take away the life that remains'.

However, patients' right to know bad news is now virtually enshrined in the NHS. Whether they should be told of every medical possibility is a different matter. We rarely give medication as a single bolus but feed it in sequentially. Information is a powerful drug that should be titrated against Frank's need and ability to assimilate it. This interesting differential diagnosis has spelt out a death sentence to Frank.

When a patient presses for a worse case scenario, he has often spent hours pondering about it or even surfing the net. A patient's rational conclusion may even help us towards a correct diagnosis. However, we should be ready to allay fears caused by unfounded conclusions. In retrospect, my colleague should have reflected Frank's question back and asked him what he thought may be going on. Frank may then have raised the MND possibility himself, allowing proper discussion. Instead, he simply heard the disease on my colleague's lips and seized upon it as confirmation of his fears.

The mention of litigation drives some doctors to sleepless nights and others to confrontational aggression. Neither reaction is helpful: Frank is a man in physical and spiritual distress, not our enemy. Leaping in to defend my partner may not help as my perceived alliance at this could harden Frank's son's attitude. I would tell him that neither he nor I was present at the consultation and so don't know exactly what was said. Of course, I would inform my colleague: no doubt he would try to put things right. Meantime, I would reassure Frank that his breathlessness was not due to advanced MND.

If MND is confirmed, Frank will need an intact doctor-patient relationship more than ever. Before seeing my next patient, I would offer a prayer to God 'the author of peace and lover of concord'.

John Geater was a GP in Hastings and is now Director of PRIME

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3. Proverbs 15:30
4. Proverbs 26:17
5. Proverbs 15:18

Do you agree or disagree? Do you have a scenario to discuss? Would you like to join our panel of GP contributors? Email rachael.pickering@cmf.org.uk

Key Points

MND has a prevalence of 7/10,000. Caused by neurone degeneration in the motor cortex, cranial nerve nuclei and anterior horn cells, it is usually fatal within five years.

Fear of choking to death has led some MND sufferers (such as Diane Pretty) to push for legalised physician assisted suicide. Yet, St Christopher's Hospice found that no MND patient choked to death and 94 percent died 'peaceful and settled': 'The term choking is both inaccurate and inappropriate…its use should be abandoned'.[1] Better information and explanation can help alleviate such fears.[2]

Online resources

- *www.hospice-spc-council.org.uk*
- *www.mndassociation.org*
- *www.lougehrigdisease.net*

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EUTYCHUS

Cannabis downgraded

Cannabis will be downgraded to a class C 'non-arrestable' drug on 29 January 2004. The House of Lords approved the move from Class B by 63 votes to 37 on 12 November 2003, putting cannabis in the same category as anabolic steroids, benzodiazepines and the 'date rape' drub GHB. The reform to the Criminal Justice Bill will mean that in most cases police will no longer have the power to arrest users for possession. A last-minute amendment did however acknowledge the fact that the change may 'risk the health of young people'. (*Evening Standard* 2003; 13 November:14)

Gun crazy

There are currently 639 million small arms in the world, produced by more than 1,135 companies in at least 978 countries: one gun for every 9 people on the planet! Firearms currently kill one person every minute, and eight million new weapons are produced every year, with their proliferation increasing since the September 11 terrorist attacks in 2001. Amnesty International and Oxfam, in their recent report *Shattered Lives*, have together called for an arms trade treaty by 2006 (like the Landmines Treaty), to prevent arms exports to countries where they are likely to be used 'to commit grave violations of international human rights'. (*The Times* 2003; 10 October:19)

Plans to stop 'eugenic' abortions

Prolife groups in the UK are proposing to use a clause in the proposed European constitution to mount a legal challenge to the abortion of disabled babies. Each year in Britain about 1,800 babies are aborted after tests show them to have any of 200 conditions including Down's syndrome, spina bifida and muscular dystrophy. The government is committed to signing the constitution, which would take primacy over UK law. It includes a new charter of fundamental rights, which has been declared non-negotiable and requires the 'prohibition of eugenic practices, particularly those aimed at the selection of persons'. (*The Times* 2003; 29 October:15)

Gay bishop controversy

The consecration of (the openly gay) Gene Robinson as Bishop of Hampshire has heightened fears of schism within the Anglican communion and left the liberal and conservative wings of the church 'in communion with Canterbury, but not with each other'. In a joint statement the primates of the Global South (which takes on most of the Church in Africa, Asia and the West Indies) said, 'We are appalled that the authorities within the Episcopal Church of the US have ignored the heartfelt pleas of the Communion not to proceed with the consecration of Gene Robinson…The consecration of a bishop who divorced his wife and separated from his children and is now living as a non-celibate homosexual, clearly demonstrates that authorities within the Episcopal Church of the US consider that their cultural based agenda is of far greater importance than obedience to the word of God'. The primates account for 50 million of the 77 million members of the Anglican Communion worldwide. The majority of the remainder are British Anglicans who rarely, if ever, attend a church service. (*The Times* 2003; 4 November:1)

Update to embryology law

The House of Commons Science and Technology Committee has called for the 1990 Human Fertilisation and Embryology Act to be updated to include new 'therapies' such as preimplantation genetic diagnosis, embryo research for therapeutic purposes and issues of consent on frozen embryos. The committee blames the Government for its lack of action on the issue, which has led to the current inquiry. (*Hospital Doctor* 2003; 20 November:18)

Belgian contraception vouchers

The Belgian government is planning to provide hundreds of thousands of teenagers with monthly vouchers from 1 January next year to help pay for the costs of contraception, in a bid to reduce the number of unwanted pregnancies. Each voucher will be worth three euros, the monthly cost of the second-generation pill and the total cost of the exercise will be 5.29m euros. According to Belgium's most recent statistics some 2,200 abortions were performed on girls between the ages of 13 and 19 years in 2001. (*British Medical Journal* 2003;327:945 (25 October)

Sperm and egg trading

Last August, the world's first internet sperm bank baby was born to a proud mother and her partner, an Apple Power Mac G4. This iMac-ulate conception was made possible thanks to British website *ManNotIncluded.com* (although you can apparently get much cheaper sperm on eBay!) 'The whole procedure is horrible,' said a spokesman for the charity Life: 'Children are far too important to be the result of sperm bought by email'. (*The Guardian* 2003;22 August) The Human Fertilisation and Embryology Authority (HFEA) is to review the practice of 'egg giving'- whereby a woman seeking in vitro fertilisation firstly goes through one cycle of treatment in which her eggs are harvested and donated to another patient before going on to have another cycle of treatment for herself at reduced cost. London fertility expert Professor Ian Craft, who pioneered the practice, was criticised for the commercial nature of his activity in BBC television's current affairs programme Panorama. Craft maintains that egg giving is not tantamount to trading in eggs, which is illegal in Britain. 'No money changes hands, and both the donor and the recipient get the best possible chance of success in their treatment cycle.' (*British Medical Journal* 2003; 327:250)

Queen's speech

The government intends to introduce a new *Civil Partnership Bill* which would enable same sex 'civil partners' to sign a document entitling them to the same rights as married couples. A *Human Tissue Bill* is intended to tighten up rules on when doctors can and cannot retain dead people's organs and tissue. A draft *Identity Cards Bill* will create a national register and powers for compulsory ID cards holding biometric data. A total of 23 bills and 7 draft bills included in the 2003 Queen's Speech are expected to come up for parliamentary debate over the next year. (*BBC News Website* 2003; 26 November)

BOOKS

Prayer Life. How your personality affects the way you pray

Pablo Martinez
Paternoster Press 2001
£7.99Pb 156pp
ISBN 1 85078 436 1

'I would like my readers to think of prayer without guilt…prayer should not be just one more burden in life, but a pleasure to enjoy' writes Pablo Martinez in his introduction. His book goes a long way towards meeting this aim.

Combining his psychiatric training and experience as a pastor, Martinez explores why people with different personalities pray in different ways. Personality types are categorised using two axes to represent four psychological functions: thinking-feeling and sensation-intuition. A primary and auxiliary function can be identified (one from each axis), giving eight types, which are then doubled by the extrovert/introvert classification. As Martinez describes the different types, it is easy to identify with them and consider the various pitfalls and strengths of your temperament.

This approach helps alleviate the guilt that many feel about the way they pray (or fail to pray), a feeling that is often augmented by comparisons with others' prayer lives. Martinez urges us to be more accepting of others and ourselves: 'We are not required to like our temperament, but to work through it for God's glory in our lives', and allow others to do likewise. However, Martinez also offers guidance to help us develop in prayer; having identified our areas of weakness, we are better equipped to overcome them.

He moves on to explore the therapeutic value of prayer. In the last section of the book he provides a defence of Christian prayer against the charge that it is mere auto-suggestion, or no different from Eastern meditation.

John Stott has written in the foreword to this book, 'Here is a psychiatrist who is committed to Christ, knows his Bible, rejoices in Christ's cross, has a lively sympathy for struggling Christians and has much wisdom born of rich pastoral experience…I cannot imagine any reader failing to be helped by it, as I have been myself.' This book is warmly recommended for personal reading, practice library and passing on to Christian patients or church members.

Peter Pattisson is ICMDA Regional Secretary for Europe and the former USSR

Prayers for healing: A Burrswood companion

Michael Fulljames and Michael Harper
Canterbury Press, Norwich 2003
£9.99 Pb 141 pp
ISBN 1 85311 503 7

After many years of experience at the Burrswood Christian Centre for Health Care and Ministry, the authors of this little book offer a series of morning meditations with relevant evening prayers to cover 31 days. As chaplain and doctor, their collaboration typifies the Burrswood aim for spiritual and medical care to go together when facing the mystery of healing and suffering. Situated near Tunbridge Wells, Burrswood is an independent hospital and outpatients' department that offers a variety of services including rehabilitation, counselling and palliative care, as well as Christian worship and healing.

We are taken through the sometimes raw emotions experienced by many sufferers at the onset of a disorder, or when awaiting diagnosis and prognosis, both favourable and fatal. A doctor's helpful or hurtful attitude is also made a matter for praise or prayer. Whatever the expected outcome, the sufferer is encouraged to move towards total trust in the God who, through the cross, has identified with human suffering and is able to use it to bring about wholeness of spirit.

There is no unrealistic insistence that healing and cure must go together, so different prayers express fear and acceptance of death as well as gratitude for recovery. Illness can produce many mood swings, yet not everyone experiences them all. If read by a sick person, this book would therefore be most helpful used selectively rather than sequentially. Alternatively hospital chaplains (or others) could mix and match to suit particular needs.

The many relevant marginal annotations and references said more to me than some of the prayers and meditations themselves, yet these are for use by the sick, not the healthy. The authors' intention is to speak 'the common language of suffering', used here to express their own reactions to personal affliction and to convey how others have felt in theirs. It is, therefore, a helpful exercise for any health worker to listen to such messages, realising afresh that in times of trouble God is there, ready to be a very present help and healer.

Janet Goodall is a retired Consultant Paediatrician in Staffordshire and former CMF President

Curing the heart - a model for biblical counseling

Howard Eyrich and William Hines
Christian Focus Publications 2002
US$15.99 Pb 204pp
ISBN 1 85792 722 2

'Biblical Counseling' (sic) is greatly influenced by Jay Adams, founder of 'nouthetic' counseling, which has core principles of 'confrontation, concern and change'. The 'cure' in this model is not necessarily to reach a stage of 'feeling better' (p58), as 'the chief problem to be dealt with is a severed relationship with God'. The primary goal is therefore 'for people to become more Christ-like' (p157), not to 'rebuild a... wounded personality' nor to 'help [clients] perceive themselves as a person having worth'(p162).

Eyrich and Hines outline two premises. Firstly, the root of the 'counselee's' problems is sin. Secondly, Scripture is sufficient to deal with all problems. The only reference to persecution relates to the counselor rejected by a client. One of the flaws of this approach is the risk of our shortfalls becoming red herrings in the counseling process. Proverbs 30:6 is used to warn against adding to God's Word 'with other traditions or modern theories'. I would suggest, however, that common

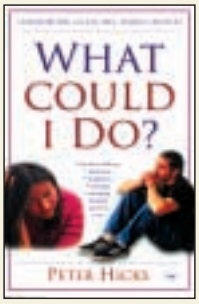
grace allows even secular studies to contain gems of knowledge about how we tick.

A checklist of problems given in a form to be worked through with a client seems arbitrary and haphazard, and problems 'with a physiological cause' are to be taken 'elsewhere', although there is no guidance as to which symptoms might suggest a physiological cause. The 'homework' task recommended for depression, would be near impossible for anyone with an affective disorder.

This guide is poorly structured, wearisomely repetitive and contains such mind-numbing statements as 'the age of the counselee can be an important indicator of the person's maturity or lack of maturity'. I agree that 'obedience and true discipleship must come before happiness and contentment' and that the challenge not to short-change our patients/clients is vital. However, more compassion, humility and cognisance of human suffering are required than can be found in this book.

Karen Palmer is a Staff Grade Psychiatrist in Glasgow

What Could I Do? A handbook for making hard choices



Peter Hicks
IVP 2003
£9.99 Pb 352pp
ISBN 0 85111 299 4

This book follows on from 'What Could I Say?' by the same author (*Triple Helix* 2003; Spring:19). While there is some overlap between the two books, 'What Could I Do?' shifts the emphasis to the hard choices we all face by seeking to offer biblical guidance on a variety of difficult areas. The diverse range of topics covered includes environmental issues, sexuality, money and the use of time. The initial section deals generally with decision-making and is probably the only part of the book that would be read as a whole; the remainder is more likely to be dipped into rather than be read in one sitting.

My main criticism of the author's approach in this book is that he appears reluctant to offer any definitive guidance. The introduction states, 'there's only one person who has the right to tell you what to do and that's God'. There is no mention of the authority delegated to others such as consultants, teachers, police and pastors. Therefore, in a messy and complex world, it all appears to come down to the individual Christian's personal view on the right course to take. To illustrate this, I was somewhat startled to see the following advice given to a woman facing an unwanted pregnancy: 'In the last analysis it is you who have the right and responsibility to choose to have an abortion or to have your baby.' Yet this appears to run contrary to the author's stated view that abortion conflicts with 'Christian morality and principles' (p191) and his use of the example of the misuse of abortion legislation when he argues against legalising euthanasia (p114). It is clear that he does not advocate abortion; it is just a pity that he hasn't stated this more clearly.

It would be unfair to write this book off on the basis of a CMF live issue – parts of it are excellent and in general the issues surrounding a broad range of topics are covered well. It is certainly useful to have a selection of compiled Scripture passages for each of the issues covered. Some readers will find that the range of options presented is a helpful approach; others, however, may be frustrated by this attempt to provide non-directional advice.

Tim Lewis is a former CMF staffworker and currently working with the Leprosy Mission in Nepal

The R Option

Michael Schluter and David John Lee
The Relationships Foundation 2003
£7.99 Pb 224pp
ISBN 0 9543879 0 2

'This book reminds us that it is the quality of our relationships that, more than anything else, determines our happiness, fulfilment and the sense of a life well lived.' (Jonathan Sacks, Chief rabbi).

Jonathan Sacks statement is powerful but counter-cultural one. As Schluter and Lee outline, our highly individualistic age assumes that we function first and foremost as individuals – our everyday encounters serving mostly in a contractual, and 'rights based' fashion. Thankfully as Christians and doctors, we are aware of the faulty philosophy of such a view. As doctors, we see the value in nurturing relationships as we struggle to maintain the doctor and patient relationship in an increasingly pressured working environment. As Christians, we realise our true nature – relational beings made in God's relational image. However, the reality of nurturing our relationships can be challenging.

Schluter and Lee outline a way of looking at life 'relationally' – that is analysing the impact of our lifestyle choices on our relationships, motivated by Christian thinking on the importance of relationship. For example, on lunch- if the time spent with our children over a meal is more significant than any committee meeting, we might do well to spend some time thinking about what we will discuss, how the discussion went and what was going on in the individuals' responses – as we would do for any meeting with colleagues. On money – consider spending money to develop relationships, perhaps a night out with friends, rather than buying a new gadget. On coffee breaks – see sociability at work as crucial to effectiveness and productivity. In this respect, I have particularly valued the daily midmorning break of 10-15 minutes in my current practice. Day to day events as well as clinical questions are shared and I believe the teamwork is more effective as a result. All nineteen chapters are short and readable covering areas as diverse as lunch, leisure, sex, forgiveness and schooling.

The beauty of the book is that the aim of developing relationships is not for personal satisfaction. The wonderful truth this book subtlety reveals is that fulfilment comes from putting other people's interests first. While this holds true for this life, it hints at an even deeper reality. As Jesus declared, 'many who are first will be last, and the last first.' (Matthew 19:30) I will try even harder not to miss the coffee break.

Liz Walker is a GP in Farnborough and former CMF chairman

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.

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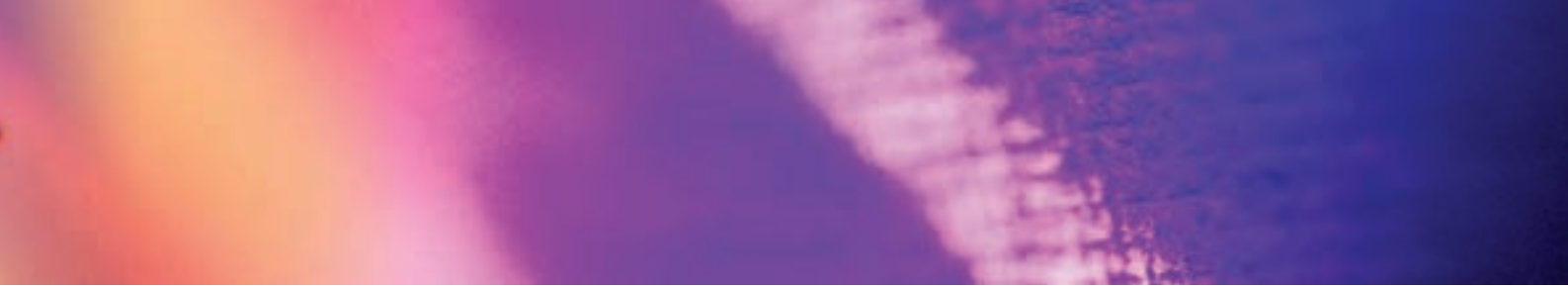
***John Guillebaud**, Professor of Family Planning in London, replies.*

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.

OPPORTUNITIES ABROAD

Specific Vacancies by Country

Posts usually require you to be **UK-based** with your own **financial** and **prayer** support. The contact details given are to enable you to research the post. For many other current vacancies visit the vacancies page at *www.healthserve.org* which is updated weekly or see previous issues of *Triple Helix*

Burkina Faso

Clinique Medico-Chirurgicale (ONG) require a general surgeon for this hospital to complement the work of a Government run medical centre. He/she will be mainly dealing with elective surgery - hernias accounting for the majority of cases. Would suit a retired general surgeon who also has some experience in O&G. French would be a distinct advantage. Accommodation is provided but otherwise the post is for three months (negotiable) and self funding. **Contact:** Dr Hui T Tan. Email: *htan@doctors.org.uk*

Ethiopia

A group of Ethiopian Christian Doctors have set up a clinic to provide a working base for medics of any specialty for whatever length of time they can offer – short or longer term. This could provide an ideal opportunity for the recently retired. **Contact:** Ergate Ayana. Tel: 01475 783101 for more details.

India

The Emmanuel Hospital Association (EHA) is looking for doctors in many specialties, especially female obstetricians & gynaecologists, to work in various locations as part of a team providing quality care to in and outpatients. Postgraduate specialist diploma required. Accommodation and approved work related travel expenses will be provided, otherwise self-funding is necessary. Posts are for 1-3 years. **Contact:** Hazel Whiting, Email: *info@eha.org.uk*

Kazakhstan

YWAM need a doctor to help pioneer medical and spiritual training for young central Asian doctors in English, though Russian an advantage. The post needs to be self supporting and of at least two years duration. **Contact:** Mathew Acker MD at mattlaura@trsutmail.org

Kenya

AIC Kijabe Hospital is looking for a consultant obstetrician to be part of a team at this busy 210 bedded Christian teaching and referral hospital near Nairobi. Duties include the supervision and training of junior staff. Colposcopy skills and an interest in research would be an advantage. **Contact:** MedDir.kh@kijabe.net for further details

Niger

A general surgeon and other doctors are still desperately needed at **Galmi Hospital** which is the only Christian hospital in the Republic of Niger, a mainly Muslim nation of 11 million people. The hospital treats some 200 outpatients daily. **Contact:** Roy Gamble, AIM Ireland Director or visit their website: *www.sim.co.uk*

Nigeria

Vom Christian Hospital in Northern Nigeria needs surgical specialists, especially orthopaedic and plastic surgeons, to carry out reconstructive surgery and provide training for local surgeons. There is also a need for paediatricians and physicians. **Contact:** TeleServe at *www.teleserve.org*

Pakistan

Kunri Christian Hospital is still 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.

Senegal

YWAM needs doctors for a project in Dakar where there is an outpatient clinic offering consultations, vaccinations, prenatal and dental care, plus evangelism and healthcare teaching to street children. In a second project in a rural area 150 kms away, there is a training centre for village health workers. A two year term is envisaged but shorter terms are possible. French, plus the local language would be necessary for long termers. The post is non salaried. **Contact:** Bryan Steele or Beatrice Marceau, Email: jemclini@sentoo.sn

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*

EVENTS

The **Developing Health Course 2004** (previously called the Refresher Course) will be held at Oak Hill College from 5-16th July 2004. Brochures are available from the CMF Office.

Student Elective Days will be held in **Leeds** at South Parade Baptist church on Saturday 6 March and in **London** at Partnership House on Wednesday 17 March 2004. Brochures are available from the CMF Office.

EQUIP offers a variety of useful courses including a three day course entitled ***New Directions***. It explores the practical issues of settling back in the UK after time spent abroad. The next course runs from 27-29 April 2004. **Contact:** The Administrator, Bawtry Hall, Bawtry, Doncaster DN10 6JH Tel +44 1320 710020, Fax: +44 1320 710027 or Email: *info@equiptraining.org.uk* Website: *www.equiptraining.org.uk*

All Nations Christian College offers **Refresh for Mission** - 5-9 July 2004 (same time as the CMF course I'm afraid). It aims to provide refreshment of spirit, mind and body for those involved in world mission. Pause for reflection on 12-16 July is a companion course designed to provide space and time for waiting on God, reflecting on past ministry and future possibilities Further info from *shortcourses@allnations.ac.uk* Website: *www.allnations.ac.uk*

COMET (Children of Missionaries, Education and Training). A Global Connection Forum. Has a list of resources relating to missionary kids on their website; *www.globalconnections.co.uk* or contact Global Connections at Whitefield House, 186 Kennington Park Road London SE11 4BT Tel: 020 7207 2156 Fax: 020 7207 2159

ITEMS WANTED

Medical and nursing textbooks (published within the last ten years ,exceptions made for anatomy), 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. If you have books that you could donate contact Mr Peter Willson, Consultant Surgeon, Kingston Hospital, Gallsworthy Road, Kingston, Surrey KT2 QB. E-mail: *peter.willson@ntlworld.com*

Peter Saunders reflects on the effects of a bad management decision

DEATH of a tea lady

When I was a general surgical registrar in Auckland, New Zealand the 'management era' was just beginning. Someone, who I expect had never worn greens and didn't know one end of a retractor from another, was examining the operating theatre budget in some office remote from the front line.

About $15,000 needed to be saved and in the mind of the 'micromanager' the deed could be done by one stroke in the expenditure column. The theatre tea lady was sacked. The next day a metal and glass substitute arrived and took its place in the corner of the theatre tearoom.

If a committee had studied the theatre environment for a decade in order to determine how to deal the worst blow possible to productivity, morale and efficiency for the minimal possible cost they could not have done better; because in value for money terms the theatre tea lady was the most important staff member in the department. I expect she graduated into her low-paid, low prestige role in the health service through managing to flunk her school exams and close the door to other possible career paths. Perhaps she chose her path willingly and cheerfully.

Regardless, she loved her job and considered it a privilege and pleasure to be part of the team – and in many ways her fussing, appreciation, smiles and sheer human warmth as she dispensed cake, sandwiches and cups of tea made to personal order were part of the glue that kept morale up. Despite her low status she had a gift for making everyone feel they were appreciated and valued. And I think that helped us in doing the best possible job. By contrast her sudden unannounced departure without a scrap of consultation just fuelled the resentment.

What the faceless bureaucrats failed to understand is that people perform best when they feel they are recognised and appreciated for the work that they do. The sacking of the tea lady was the first step in a long series of management blunders by people who in Oscar Wilde's words 'knew the price of everything and the value of nothing'.

Little things like clean on-call rooms, after hours meals for hard working staff, rubbish bins you don't have to empty yourself and tea ladies who smile and make you feel important make a huge difference to morale, self-worth and performance. But you have to rub shoulders with those on the clinical front line to appreciate it. And that takes a special sort of manager – regrettably seen rarely in the administrative corridors of the NHS or the Department of Health.

Jesus was that special sort of manager – entering our world at the lowest level, taking the form of servant, and bearing our burdens. We desperately need more of him in the NHS.

Peter Saunders is CMF General Secretary

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