news reviews

Climate change, population and health

The problem is consumption, not numbers

Review by **Steve Fouch**
CMF Head of Allied Professions Ministries

The Copenhagen Climate Change Talks happen in December, and at the time of writing media comment suggests that the chance of meaningful agreement on curbing emissions rests on whether the West can persuade India, China, Brazil and much of the developing world to sign up.

At the same time, recent reports express concern about the role a growing population will have on climate change, poverty and development.[1] Many activists like Jonathon Porritt[2] are calling for drastic reductions in birth rates to save the planet. Others raise the concern that growing third world populations will not only add to climate change but set back development by spreading meagre resources too thinly.

This trend needs to be challenged. Recent research has shown that, far from contributing to climate change, the poor barely have any impact but are disproportionately affected.[3] The problem is not population growth, but the emergence of developing world middle classes who aspire to Western consumer lifestyles.

This raises two awkward questions. First, what sort of development do we want? Is it to turn Africa and Asia into continents that consume and pollute like Europe and America? And if not, then what right have we to deny them what we permit ourselves?

Calls to curb the population in the developing world smack too much of the rich trying to control and demonise the poor, while sidestepping the consequences of our own love of cheap credit and conspicuous over-consumption.

Climate change is happening – whether we can alter it is open to debate, but like the global economic crisis (which will swell the ranks of the poor by 100 million this year[4]), the poor are not responsible but are the first to suffer. Floods, droughts and forced human migration are real climate change threats to the health and wellbeing of the poor.[5] Jesus and the prophets warned strongly that sitting back complacently makes us culpable in the exploitation of the poor.[6]

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Assisted suicide

DPP guidelines currently cause concern

Review by **Peter Saunders**
CMF General Secretary

Since the 7 July defeat in the House of Lords of the Falconer amendment,[1] and after a final failed attempt to amend it by Lord Alderdice, the Coroners and Justice Bill has thankfully passed through both Houses of Parliament unchanged. It can now no longer be used as a vehicle by the pro-euthanasia lobby.[2]

However, on 30 July campaigner Debbie Purdy won her House of Lords case seeking 'clarity' about whether people taking 'loved ones' to Zurich to end their lives would face prosecution.

In passing judgment[3] the Law Lords required the Director of Public Prosecutions (DPP), Keir Starmer, to produce an 'offence-specific' policy outlining the 'facts and circumstances' to be taken into account in deciding whether or not it was 'in the public interest' in specific cases to prosecute under the Suicide Act 1961.

The DPP published his 'interim guidance' on 23 September, and after a consultation[4] lasting until 16 December, will publish definitive guidance in spring 2010.

The Care Not Killing Alliance (CNK), of which CMF is a founder member, and for which I act as honorary Campaign Director, published its comprehensive analysis[5] of the draft guidance on 15 November. CNK's position is that the guidance 'is not fit for purpose in its current form' and that there are 'serious defects both in its underlying principles and in several of the specific prosecution criteria proposed'. Of the 29 criteria six were deemed 'acceptable', 12 'acceptable only if amended' and a further 11 'unacceptable in any circumstances'.

Particular concern was focused on the following 'less likely to prosecute' categories which CNK believes 'pose serious dangers to public safety':

- the victim is disabled or seriously/terminally ill – despite Parliament having repeatedly voted against changing the law in this regard;
- the victim has attempted suicide before – even though this history often indicates mental illness and in prisons or hospitals is grounds for extra vigilance;
- the 'assister' is a spouse, partner, or close family member – even though elder abuse (physical, emotional and financial) often occurs within so called 'loving families'.

Meanwhile, Margo MacDonald MSP has obtained the signatures necessary for her 'End of Life – Choices' Bill to be debated in the Scottish Parliament. It could not progress through all its stages until 2010 at the earliest, but whatever happens in Westminster after the General Election, this would not affect Scotland which has devolved health powers.

Christian doctors should become informed about the current legal position and do all we can to prevent any legal sanctioning of assisted suicide.

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Abortion and mental health

More methodologically robust evidence

Review by **Dominic Beer**
Consultant psychiatrist in London

Until recent research from New Zealand [1] it was a medical *mantra* that it was safer for a mother's mental health to have an abortion than to continue with the pregnancy. I have twice reviewed this topic [2,3] and in further developments about abortion affecting mental health Fergusson *et al* [4] have extended the analysis and strengthened their earlier evidence. [1]

Data were collected on the pregnancy and mental health history of a cohort of over 500 female subjects in Christchurch, New Zealand from birth to age 30. Abortion was associated with a small increase in the risk of mental disorders. Women who had abortions had rates of anxiety and substance misuse about 30% higher than in other pregnancy outcomes like live birth, or unwanted pregnancy leading to live birth or pregnancy loss (miscarriage, ectopic or stillbirth). Even women without a history of mental ill health could have problems after an abortion. These findings persisted following extensive controlling for prospectively and concurrently measured confounders, and the study was therefore methodologically very robust.

Most recently Fergusson *et al* state that women reporting distress at having an abortion were 40-80% more likely to experience mental ill health than those not having an abortion. [5] They write 'the important implications of our research relate to the interpretation of the abortion laws in legislations such as those in the UK and New Zealand where the mental health risks of unwanted pregnancy are the principal grounds on which abortion is authorised'. [4] Their findings are the more significant because 94% of British abortions are signed by a doctor because of 'risk to mental health' for the mother.

The other important implication is that patients should be advised of this risk and what to do if they suffer any mental disorder following an abortion. The Royal College of Psychiatrists [6] has very sensibly called for discussion in the consultation, so the doctor can be assured a patient is fully informed before she consents. They also rightly called for other colleges and professional bodies to incorporate this evidence into their guidelines for women considering abortion.

Fergusson *et al* conclude: 'First, exposure to abortion is an adverse life event which is associated with a modest increase in risks of mental health problems. Second, the mental health risks associated with abortion may be larger, and certainly are not smaller, than the mental health risks associated with unwanted pregnancies that come to term.' [7] As Christians in medicine it is important we consider how to convey this far reaching evidence to our patients.

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Fatal distraction

Unqualified patient autonomy harms the heart of medicine

Review by **Andrew Fergusson**
CMF Head of Communications

At a resumed inquest in October, the Coroner ruled that doctors at the Norfolk and Norwich University Hospital had acted correctly in not giving any lifesaving treatment to 26 year old Kerrie Wooltorton when she was admitted in 2007 having suicidally ingested antifreeze. [1] It appears that she had done this up to nine times previously, accepting lifesaving treatment on every occasion, and this history might have been due to her 'untreatable' emotionally unstable personality disorder. [2] On this occasion, a few days before her death she had drafted an advance statement indicating she did not wish to be treated if the same circumstances arose in the future. They did. She drank antifreeze again, called an ambulance, was taken to hospital, and while conscious and said to be with full capacity consistently refused lifesaving treatment. (She called the ambulance because she did not want to die alone and wanted comfort measures only.)

October's publicity caused outcry, with most people's intuitions being that this was not what medicine is about; that attempts should have been made to save her. At first the case was seen to concern advance directives, given (mistakenly in CMF's view) full legal force in the Mental Capacity Act 2005. Health Secretary Andy Burnham said that the case took the law into 'new territory' which he did not believe had been intended by Parliament. [3] However, as Sheila McLean argues [2] it was the consistent, contemporaneous refusal with capacity of lifesaving treatment that meant the doctors, after consultation and with legal advice, were right to let her die.

That conclusion about capacity has since been challenged by two consultant forensic psychiatrists who state that 'depression and emotionally unstable personality disorder are mental disorders, which often impair a person's cognition and emotional health'. [4] Arguing that she could have been detained compulsorily and treated, they make the further point that, with a few exceptions, 'the Mental Health Act 1983 "trumps" the Mental Capacity Act 2005'.

The legal and ethical debate will doubtless continue, but even if the doctors acted correctly within the letter of the law, most have concluded they missed the spirit of it. The ideology of unqualified patient autonomy harms the heart of medicine.

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