Ethics & Medicine

A Christian Perspective

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Rutherford House
Medical Ethics Project

Aims: The aim of the Project is to develop a Christian mind on the complex and fundamental challenges posed to society by technological advance in medical science. Rutherford House is a research centre whose theological position is Protestant and conservative, but the Project is intended to draw together those with a common concern for a distinctively Christian approach to medical ethics.
The Project is currently engaged in publishing and in organising conferences, and hopes to be able to expand these and other areas as support allows.

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Editorial

'ONE IN 61 NEW YORK BABIES BORN WITH AIDS' reads the front page headline of *The Independent* on 14th January 1988.[1] A sub headline emphasised the point with these words 'RISK FACING HETEROSEXUALS ACCELERATES'. What can one say about the spread of AIDS which has not previously been said? What are the ethical and moral issues facing us as AIDS moves from being a disease affecting a minority group in our society to what is rapidly becoming an endemic disease in this country as in some parts of Africa?

If we hope to influence policy making in Government, or even just to convince our friends of our concern for our fellow men in this situation we must be clear as to our facts. Emotive language, video presentations with comments that 'could have been better expressed' and blatant homophobia all muddy the waters of debate. We must be aware of the facts. At the end of 1987 there were 1227 recorded cases of AIDS in the UK, double the number at December 1986. Of these cases the cumulative deaths were 697, compared with 293 at December 1986. These are the cases with the full blown disease of AIDS – there are 8,000 people known to be infected by the virus, but there are probably around 40,000 infected but not tested and so undiscovered. The Department of Health still estimates 4,000 deaths by 1990.

More than half of those infected in England and Wales are homosexual or bisexual, 300 are heterosexuals, 500 are intravenous drug abusers and 1,000 are hemophiliacs infected prior to adequate screening and treatment of blood products. About 85% of those with AIDS are homosexual/bisexual men. In England and Wales very few are women (about 3%) and they are drug abusers/prostitutes. The situation in Scotland is different with higher percentages of women, due to the greater incidence of drug addiction and the Edinburgh 'shooting gallery' shared needles. As a result more babies have been born in Scotland with evidence of infection with the virus. Currently there are 13 babies with AIDS and 23 with positive antibodies.

The headline quoted above is based on a study in New York in which every baby born in one month was tested for antibody to the virus at birth. This was done anonymously. 19,157 babies were tested, and the results showed great variation among the districts tested – the highest rates of infection being in babies born in Bronx, one in 43, reflecting the poor social conditions with a high rate of drug addiction, ethnic populations and poor uptake of medical services and counselling. These figures indicate the way AIDS is spreading from the homosexual population into the wider population via drug addiction, prostitution and promiscuity.

AIDS has always been a heterosexual disease in Africa, of course. The World Health Organisation estimates 150,000 cases worldwide in 1988, and in some areas of Africa AIDS is now more important than malaria as a cause of morbidity and mortality. The association of AIDS with other venereal diseases in Africa is thought to be at least partially responsible for its rapid spread.

These facts bring us now to the first of the ethical dilemmas to be faced in 1988. In order to treat AIDS effectively and to plan future resource allocation we need to know as a matter of urgency the extent of infection with the virus in the community. This can only be done by some form of screening procedure, and as the New York study illustrates, the results may well be startling.

The President of the Royal College of Physicians and other senior members of the medical profession have called for the institution of screening, particularly of pregnant women, but the Government has turned this down. The Royal Statistical Society has also called for testing in order to assess the epidemiology of AIDS and to provide forecasts of the future resources needed to cope with the vast numbers expected to be infected by the 1990s.

Population screening may be done in two ways. First, as in the New York study, samples may be taken as part of the assessment of the new-born, or the pregnant women, and sent for testing anonymously. This testing will result in no benefit to the individual or the unborn baby concerned and would be used only to provide a database for statistical analysis and forward planning. Since the taking of blood samples without informed consent is technically an assault on the person the blood sample would be taken ostensibly for some other purpose, such as blood grouping, testing for anaemia and Rhesus incompatibility. All of these are routine tests done on every pregnant woman. Similarly samples are taken from newborns for testing for various metabolic disorders. 'Spare' blood would be used for testing for antibodies to the virus. Since the samples are tested anonymously, and cannot be related to the individual patient permission for testing would not be sought. This was routine practice in medicine for many years – every woman was tested for syphilis antenatally, and every hospital patient was similarly tested on admission. Permission was not specifically sought for these tests which were done to protect the newborn from infection at birth, and to prevent infection spreading to medical and nursing staff. No one doubted the ethics of such testing, yet to do a similar procedure today is apparently unethical in the opinion of the House of Commons Social Services Committee. There may indeed be doubts as to the morality of such an investigation since no benefit will accrue to the 'victim' of the assault, the baby, or the health care personnel involved.

The second approach would be to ask permission of every patient to take a blood sample for AIDS testing, and to give the patient the option of knowing the result. This would provide statistical information and would avoid the problem of testing without permission. It provides another problem – what do you do with the patient who has a positive result? We do not know yet how many patients infected with HIV will develop AIDS; we do not know how long the incubation period or latent period of the virus is; we have no treatment available. If a person proved positive on testing, what advice do you give to him, his family, his colleagues? This is a particular problem for health care personnel, as the tabloid press made clear last year. As far as we know no doctor has spread the infection to a patient through clinical contact; but what is that doctor's moral responsibility and what can his clinical advisers do within the bounds of ethical confidentiality, as it is perceived in relation to moral responsibility?

Another dilemma in the morass that surrounds AIDS is a side effect of another issue *Ethics & Medicine* has considered – surrogacy. In the USA surrogate mothering is allowed, and in the preparation for the artificial insemination procedure the semen donor is screened for HIV, to prevent infection of the surrogate and the baby. A recent case reported in the *New England Journal of Medicine*[2] illustrates the complexity, and the tragic outcome of such activity: a 32 year old woman acted

AIDS, Medicine and Moral Absolutes

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Introduction

One of the most cherished beliefs in Britain today is the belief that sexual behaviour is a personal and private option. No adult has the right to tell any other adult how to behave sexually, so long as there is mutual consent. Such tolerance was given legal backing in the Sexual Offences Act of 1967. Into the midst of this contemporary consensus has exploded the AIDS bombshell. Here we have an epidemic of fatal disease that is related to sexual lifestyle.

Nevertheless AIDS continues to be explained as consistent with sexual freedom. For example, the biology of the AIDS virus is explained as a freak accident of nature. The ecology of the AIDS virus is explained as everyone at risk. The control of the AIDS virus is explained as a problem for technology.

In this paper I will examine the facts concerning the biology, ecology and control of the AIDS virus. My thesis is that contrary to the contemporary view, nature is on the side of only one kind of sexual behaviour.

The Biology of the AIDS Virus

The human immunodeficiency virus, or HIV for short, belongs to the class of viruses known as retroviruses. Retroviruses have only been shown to infect human beings in recent years. However, there are many animal retroviruses and much is known about how these retroviruses behave. For example, retroviruses cause cancer in rodents and fowl. How this happens was a puzzle because retroviruses contain only ribo-nucleic acid or RNA. RNA is principally in the cytoplasm of cells. Cancer, however, is probably the result of changes in the DNA of the cell, located in the nucleus. How could an RNA virus produce changes in the DNA of the cell?

The puzzle was solved when these viruses were found to contain an entirely new type of enzyme. The enzyme was called reverse transcriptase. A transcriptase enzyme is an enzyme that produces one type of nucleic acid from another type. Normally RNA is produced from DNA. The enzyme was called reverse transcriptase because it produced DNA from RNA. This special enzyme was the means by which an RNA virus could produce a change in the heredity, the DNA, of the cell. In 1975 the Nobel Prize was given to the scientists who discovered reverse transcriptase, David Baltimore and Howard Temin.

The human immunodeficiency virus (HIV) contains reverse transcriptase. When a person becomes infected with HIV, the genetic information of the virus becomes ingratiated into the DNA, the hereditary chemical of the cells of the individual affected. This probably means that once a person has become infected with HIV, he will remain infected for the rest of his life. Persons who are infected are also capable of transmitting the infection to others. This state of infectiousness can persist for many years.

Is it possible to cure a virus infection of this type? The drugs currently being developed and tested for AIDS aim at stopping the growth of the virus, not a cure. The presence of the virus in the cell DNA probably means continuing treatment for a very long time, perhaps the lifetime of the patient.

Another example of an animal retrovirus is visna virus. Visna is also the name of a disease in sheep. Visna is a progressive, degenerative disease of the sheep brain and spinal cord. It produces abnormal head posture, paralysis, and eventually death. Visna virus is a typical retrovirus in containing reverse

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as the surrogate mother for her sister. Her brother-in-law was screened and was negative. She did not reveal that 3 years previously she had been an intravenous drug user, and she was not tested. Five months after artificial insemination, when she was pregnant, her drug history was found out and she was tested and was positive for HIV. Her sister and her husband were not told until the baby was born and found to be HIV positive. The baby was rejected by both the surrogate and her sister and brother-in-law! The authors asked in the article who, then, should bear responsibility for the child? Who indeed?

These issues cannot easily be resolved. There are no easy answers, and it ill behoves us to cast stones. AIDS is now a problem for the general population, not just the homosexual. Yet, it can be controlled (but not, I suspect, by condom adverts). It is, as the statistics show, associated with particular aspects of our social behaviour. Aspects which are related to the disintegration of society as it has slipped from a biblical morality into a free for all. This is reflected in the Government's official publication *Social Trends* produced by the Central Statistical Office.[3] In 1972 only 8% of children lived in single parent families; in 1985 13%. In 1986, there were 158,000 illegitimate births compared with 61,000 in 1976. (The director of the Family Policies Studies Centre is quoted as saying that the time has come to change the definition of illegitimacy![4]). In 1986 more than 30% of marriages were second ones.

The biblical pattern of sexual relations limited to one partner and confined within the context of marriage to a partner of the opposite sex is *the* answer to our crisis. Let us proclaim this answer fearlessly in 1988.

Ian L. Brown

Notes

1. *The Independent*, 14 January 1988.
2. *New England Journal of Medicine*, 1987, 317, 1351-2.
3. *Social Trends*, HMSO, 1988.
4. *The Independent*, 13 January 1988.

transcriptase. However, it is different from the cancer viruses I have already referred to in that it kills the cells which it infects. The nervous system disease produced by the virus is due to a destructive process.

It is now widely appreciated that the human immunodeficiency virus infects the central nervous system. It may cause acute inflammation of the brain and meninges or it may have chronic effects. Many patients with AIDS suffer from dementia, that is, loss of the higher cognitive functions of the brain. At death up to 75% of AIDS sufferers may show evidence of this effect of HIV. However, there are patients who have only signs of brain involvement without any other signs of AIDS.

The third example of an animal retrovirus is the cat leukemia virus. Its name implies an association with leukemia, but this is not the most common result of infection in cats. The virus affects the immune system and many cats die of immune deficiency rather than leukemia. The effect on the immune system is the chief hallmark of the human immunodeficiency virus. It is the feature which has produced the acronym AIDS - Acquired Immune Deficiency Syndrome.

I have emphasized these features of retroviruses to show that the human immunodeficiency virus is a typical retrovirus. It shares nearly all of its principal biological properties with other retroviruses in the animal world. Although such a micro-organism may appear mysterious, it is in reality just like other viruses.

There are, in fact, four human retroviruses now known to exist. Two of these viruses are associated with cancers of the immune system. The two remaining have been isolated from patients with AIDS. The existence of four human retroviruses makes it extremely unlikely that they have originated via a mutation or other misadventure. The probability of one such misadventure is very low and the probability of four such misadventures is so infinitesimally small as to be unworthy of rational consideration.

If human retroviruses are not new viruses, what prevented their earlier recognition? I believe there are two explanations. First, AIDS is a complex of diseases. It includes pneumonia, meningitis, and skin disease. Each of these is associated with its own specific micro-organism. No one would suspect that these different diseases and micro-organisms had something in common unless a large number of cases occurred in a place where accurate recognition and reporting could occur. These requirements were satisfied in the United States. Second, HIV infection is often fatal. This is the case when the micro-organisms causing death are only mildly pathogenic. Loss of immunity in parts of the world when the most common infectious pathogens are virulent is even more serious. Dead men tell no tales. A virus infection that hides behind more common pathogenic micro-organisms leaves no footprints.

In 1987 we are faced with a world-wide epidemic of AIDS. Why has this happened? What I have shown so far is that the epidemic is not due to a change in the virus. Like the rest of nature, the virus has stable and predictable properties.

The Ecology of the AIDS Virus

For an answer to the AIDS epidemic we must turn to ecology. Ecology is the explanation of how an organism and its environment are related. The ecology of AIDS is one of its most striking features. In the U.K. it is possible to give an explanation for every single case of AIDS. That is, it is known how every person acquired the infection that caused his disease. Such a high rate of explanation is unusual even among infectious diseases. Neither Legionnaires disease nor Salmonella food poisoning are so completely explained, for example.

The explanation for 90% of cases of AIDS is that people have had multiple sexual partners. This association with sexual lifestyle is fortified by three correlations. First, the chance of getting AIDS correlates with the number of sexual partners, both in homosexuals and in heterosexuals. The more partners, the greater is the chance. Second, there is a correlation with specific sexual acts. Third, the incidence of HIV infection correlates highly with the age groups who have sexual intercourse. In Africa, the lack of infections in children between 5 and 20 rules out virus transmission via casual contact, mosquitos, or inadequately sterilized needles.

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Is it true that everyone is at risk? For ecological purposes it is convenient to classify sexual behaviour into two types: lifelong exclusive sexual partnerships on the one hand and all other types on the other hand. Lifelong exclusive sexual partnerships, i.e. monogamous relationships, are not at risk of HIV infection. Other types of sexual partnerships produce a network along which the virus can be transmitted. Multiple sexual partnerships link human beings together in a way that permits transmission of infective agents that do not in any other way pose a risk. Multiple partnerships between homosexual men provided the earliest networks for spread in the United States and Europe. Multiple heterosexual partnerships produced spread in Africa. The possibility of heterosexual spread in the U.K., however, does not necessarily imply that everyone is at risk.

A number of factors no doubt cooperate in affecting the efficiency with which the virus is transmitted. The frequency with which individuals change sexual partners affects the speed at which the virus spreads. Sexual acts which produce bleeding and tissue damage increase the efficiency of virus transmission. The presence of other genital diseases may increase the efficiency of virus transmission. As more people become infected, the number of sexual partners associated with a risk of exposure falls. For example, when 30% are infected, only ten partners produce the same risk as 100 partners when 3% are infected. In this way the epidemic feeds upon itself. At some critical point a combination of these factors produced enough dissemination of the virus to result in clusters of cases of AIDS.

Do you think that my ecological model for HIV transmission does not take account of all cases? What about individuals who have become infected by means of blood products or through monogamous sexual contact with an infected partner? Ecologi-

cally speaking, infections in monogamous persons are a blind alley for the virus. Further transmission from these individuals does not occur. Spread via blood products is secondary to sexual spread. From a population standpoint, monogamous behaviour completely blocks virus transmission.

You are no doubt aware that I have not yet answered the question of why we have an epidemic in 1987. From the foregoing it would be correct to conclude that there have been changes in sexual practice. A few may be skeptical that this is so. They insist that the only change has been a willingness to be open about sexual behaviour. Social changes can be difficult to measure directly. However, there are examples where an infectious disease has unmasked social change. The early 1950s saw outbreaks of poliomyelitis in children and young adults. This was no new virus. Improved sanitation and living standards had interrupted the circulation of enteric viruses. A child's contact with the virus was delayed until a later age. Infection with polio virus at an older age meant an increased likelihood of clinical disease.

Similar events have produced an increased prevalence of glandular fever in young adults in this country. In developing countries this virus is transmitted early in life. Clinical disease in young children is uncommon. However, the chance of developing symptoms in adults is 50%.

The current outbreak of HIV infection is evidence of social change. However, the increased prevalence is not due to a shift in the affected age group. Rather, the social change that occurred was one which created the opportunity for transmission where such opportunity previously did not exist.

The Control of the AIDS Virus

Our society has a habit of resorting to technology when it is in trouble. The Strategic Defense Initiative is the answer to the threat of nuclear war. Abortion is the answer to a threat to personal freedom. Drugs are the answer to worry and unhappiness. The technological answers to AIDS are 'safe sex' in the short term and a vaccine in the long term.

'Safe sex' has certainly expanded our consciousness. 'Exchange of body fluids' is now a household phrase. We see lists of specific sex acts that make sex seem like a trip to Sainsburys. The condom campaign has given rise to its own genre of stories. Have you heard about the consultant surgeon and his junior assistant who were doing an operation on a patient infected with HIV? All the appropriate precautions had been taken to prevent cross infection. As they were putting in the final sutures, the junior doctor said, 'Sir, may I ask you something?' 'Yes, what is it?' said the consultant. The junior doctor said, 'Sir, may I take my condom off now?'

The Terrance Higgins Trust has a booklet on women and AIDS. They advise using a condom if there is a chance that your partner is infected with HIV. However, the booklet also says 'Do not rely on a condom as a method of birth control, but use some other form of contraception to avoid pregnancy.' If condoms do not prevent pregnancy, will they prevent HIV infection? If the government has a further 'safe sex' campaign, I suppose we'll hear of MPs buying shares in Durex.

'Safe sex' fails because it violates the very character of sexual experience. It presumes the detachment of a prostitute eating an apple while servicing her client. 'Safe sex' is not safe.

For the long term control of AIDS, the money is on a vaccine. However, the deployment of an HIV vaccine is beset by cruel dilemmas. What if the AIDS vaccine, like many vaccines, is only partly effective? Vaccination will stimulate the production of antibodies, but the antibody test is the only routine method of distinguishing between those who are infected and those who are not. Widespread use of vaccine could make the antibody test useless. Another dilemma is when to vaccinate. When does a person become a drug addict or a homosexual? These are not risks that can be predicted for an individual.

A drug that prevents the symptoms of AIDS from developing may not reduce a person's infectiousness. Will use of a drug be accompanied by changes in sexual practice? If not, the result may be an ever increasing pool of infected persons. Will vaccines and drug treatment be accompanied by changes in behaviour? Or will vaccines and drug treatment be a substitute for these changes?

One reason priority has been given to technology to control AIDS is that there is hostility to a public health approach. By public health I mean tracing case contacts and testing high risk groups. This hostility has two explanations: first, the issue of confidentiality and second, the use of the antibody test.

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The law in Britain makes special provision for confidentiality in sexually transmitted infections. There is a reason for this. If syphilis and gonorrhoea are treated, their transmission is interrupted. The special clinics exist so that social stigma does not deter people from obtaining treatment. However, there is no evidence that special clinics can prevent the spread of infections that are difficult or impossible to treat. Reports show increasing prevalences of the sexually transmitted virus infections like herpes, genital warts and HIV.

Confidentiality means restricted information to those with a *bone fide* interest in access to it. There is a natural right to privacy. There is also a natural right to information. General practitioners, dentists, and sexual partners have a natural right to knowledge about HIV status. Confidentiality should not be confused with secrecy. Human beings desire secrecy for their most unworthy and unfaithful actions. However, secrecy does not deserve the protection of the law. Secrecy in AIDS is a threat to public health.

There is hostility to using the antibody test. Current advice specifies that persons requesting the test should be counselled

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AIDS: Social and Pastoral Considerations

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1. As more information becomes available regarding the nature of HIV infection we are invited to examine factors influencing the general health of individuals in more detail – and to draw on information derived from other studies with other groups. At a recent conference in Washington, organised by the Society of Behavioural Medicine, Professor Baum and colleagues reported that an unemployed group had fewer white blood cells (T & B lymphocytes) and an increased level of the immune suppressant hormone, cortisol, when compared with a control group.

2. Further, a recent Health Education Council report confirmed that a significant relationship existed between the general health level of individuals and their social class status and, also, whether or not they were employed – demonstrating that status and psychological well-being strongly influence the person's capacity to cope with disease. Further studies focussing on the nature of HIV infection and the effects on individuals will also need to take full account of the nature of the social network in which the person has his being. Louis Pasteur, on his death-bed, acknowledged that disease progression is strongly influenced by the nature of a number of factors affecting the person's resistance to the 'germ'. He said 'it is the *terrain*'.

"Let us not repeat the mistakes we have made in the past – in essence, trying to deny or disown those expressions of humanity which frighten us and remind us of our own vulnerability and fragility."

3. I also want to state that the organisation which I represent is totally committed to the care of those infected with the virus. This is reflected in the extent to which we have made provision for a direct service response. But I want to look briefly at the needs of other groups – marginalised groups in our society – who have not received the recent concentrated attention paid to those affected by HIV. We think of the elderly with senile dementia – described as the 'silent epidemic', mentally handicapped and the mentally ill persons who need the opportunity to grow and develop in an accepting community; the devastating effects associated with alcohol mis-use in society and in the lives of individuals and those close to them. In all of these cases, we need to examine the nature of prejudice, blaming and denial in the development of services in their social and historical context, learn from such studies and apply what we observed to our examination of the question of AIDS. Why did we, in Scotland, place so many people in large institutions? – out of sight and out of mind!

4. My plea is therefore twofold: (a) Let us not repeat the mistakes we have made in the past – in essence, trying to deny or disown those expressions of humanity which frighten us and remind us of our own vulnerability and fragility; and (b) Let us be given the opportunity to study and record the nature of this new social phenomenon of AIDS – through adequate investment in research, so that we can work more effectively in the provision of social care and rehabilitation. We do not have to 're-invent the wheel' in relation to tackling AIDS.

The title of a book describing the wretched treatment inflicted on children placed in institutions in America is *Weeping in the Playtime of Others*. These forgotten, so called 'problem' children, were not the slaves depicted in *Uncle Tom's Cabin*, but young Americans in the 1970s – many of them used as captive control groups for new vaccines and contraceptive trials.

As we examine the question of AIDS in our society – involving concepts which are now tentatively taking root in our culture and connecting with professional frames of references – a reality which is constructed socially by us – we are faced with the need to examine the stereotypes we all carry and the manner in which we have valued and devalued persons. Recorded accounts, such as the above volume on the care of children in institutions, provide sharp reminders of past mistakes and the uncaring indifference of a society caught in pernicious collusion.

Social Work Aspects

My professional experience draws on work with troubled adolescents, families with particular reference to those affected by substance mis-use, and, for the past seven years, involvement in the provision of services for individuals affected by problematic drug mis-use. The Church of Scotland operates eight specialist centres in Scotland for persons with drug and alcohol mis-use problems. Three of these units are located within Lothian Region and we have therefore been involved with the principal 'at risk' group, in relation to HIV infection, within the city – intravenous drug mis-users. During the development of such services I have yet to meet a 'typical' adolescent, 'delinquent', drug addict, HIV carrier or AIDS victim! They have all resisted our tendency to place them in a mould. Most of them can be adequately described as individuals under various forms of stress and often ill-served by an adult society which has failed to support and guide them – in particular, in the field of personal morality.

For example, Jean was fourteen when her mother died of a terminal illness – the family did not explain the nature of the illness to Jean and she did not attend the funeral. She saw a relative taking anti-depressant tablets and asked if they helped – her aunt gave her some and they appeared to 'help'. She found other tablets prescribed for her deceased mother and experimented with these until the supply ran out. For further supplies she had to connect with a street culture with access to drugs. At sixteen she was pregnant and an abortion was advised. She

continued to seek the relief available through various tablets and eventually injected heroin. Jean is now HIV sero-positive and seventeen – and she would not be able to identify concepts such as bereavement and loss as contributory factors in relation to her present situation but she is currently working very hard and trying to understand the nature of her *feelings* – her reactions to stress – and finding meaning in her present circumstances.

I also think of a young man in a workshop in one of our centres. In his efforts to carve a wooden figure with a Stanley knife he grazes his thumb. I make a gesture to help and with relaxed assurance he says, 'It's okay. I haven't had the test yet and it's better that I put the Elastoplast on.' There is no tension in our encounter – and he shares with his fellow residents an increasing responsibility for self and, as a result, for others.

These brief snapshots illustrate two emerging features of our experience of providing care:

1. The capacity of individuals in this situation to engage with the *demands* of the *maturational task* if adequately supported.

2. Their capacity to be responsible – this in contradiction to a previously chaotic lifestyle.

In addition, I now want to examine significant features of our professional work at Simpson House – aspects of practice which have their roots in previous work with offenders and adolescents:

a. *Networking* – engaging the help and collaboration of others in an active and committed manner – G.P.s, social workers, specialist hospital units and, of particular importance, family or significant others – these links being established after comprehensive assessment.

b. Combining *health education* and *health promotion* in a context which has an established basis of relationship and trust.

c. Expecting *adult behaviour* rather than encouraging inappropriate *dependency* on agency or staff.

d. Maintaining reality contact through *social skills training* – work with DHSS and social security, legal help, housing *etc.*

e. Working with *contracts* – including acceptance by the individual of an obligation to help and assist others in the group.

f. Adopting a model of *total health* – holistic health – psychological, spiritual and physical.

g. Programme elements include individual *counselling*, family *therapy*, group psychotherapy with a specialist input on stress reduction and physical education.

h. Within this framework, we work with *goals and objectives* – based on regular assessment and review.

Our work with individuals who are, or suspect they may be, carriers of virus has been incorporated into this basic model – the model is built on a foundation of precise individual assessment and is person orientated. Our staff operate under very regular professional supervision and are involved in staff development programmes. In this respect we would acknowledge the substantial degree of professional co-operation which has emerged in the Edinburgh network of services. Suffering and difficulty in responding to need can often precipitate fragmentation and splintering of structures – whether in families or between organisations. Edinburgh currently has a coherent basis for service delivery to clients through a determined commitment to develop collaboration and skill sharing workshops. This framework now needs to be sustained, encouraged and elaborated.

The above approach to coping with HIV infection associated with a history of intravenous drug misuse in clients has emerged in acknowledging the particular case management problems of this group:

a. We have recognised the risks involved when agencies operate in isolation or when individuals take responsibility for cases without adequate professional supervision and support.

b. Staff frequently experience role conflict in relation to their task. Rehabilitation of individuals with a history of drug misuse has traditionally involved an approach with clients which is future-focussed and outwards – career planning, employment, laying a basis for an optimistic future. Supporting individuals who are infected by the virus demands a further set of skills – encouraging clients to accept present circumstances and an uncertain future. In this respect we grope for new skills, share information with others and redefine the nature of the task.

c. Staff frequently have to cope with difficult and often unpredictable behaviour. We can, to some extent, plot anticipated stages and phases in the maturational process in the person's life – stages of growth and development and reconciliation with friends and relatives as the person proceeds through the therapeutic programme. But in cases involving HIV infection, the possibility emerges that the individual has to cope with a serious life-threatening illness – sometimes after having made substantial progress in response to previous patterns of drug misuse. The classic descriptive model produced by Kubler Ross outlines the following stages in relation to a person being told that he/she has such an illness:

Denial and isolation – Anger – Bargaining – Depression – Acceptance

These stages have to be managed by staff, friends and relatives of the person concerned – the individual can experience such trauma at a critical stage in the rehabilitation process and a new process of adjustment is demanded.

d. Creating the conditions which enable persons to change their lifestyle and behaviour is difficult, demanding and cannot be maintained by techniques which are superficial and do not connect with the depth dimensions of the problem. In this respect, I would want to record that a critical factor in the life circumstances of many individuals who have successfully managed an alcohol or drug problem has been an enduring personal relationship with Christ – for them, a profound spiritual response has been viewed as essential.

Pastoral Care

Pastoral care can be defined as having four main functions:

Healing – Guiding – Sustaining – Reconciling.

Further, it is offered by Christian persons and deals with problems within the context of ultimate *meanings* and *concerns*. Young couples who have been involved in drug misuse, and may be infected with the virus, face ultimate concerns if the woman becomes pregnant – the 'solution' is frequently to advise that the child should be aborted. The ultimate concerns have to do with sexuality and death – taboo areas for many in such circumstances. Abortion is often fiercely refused – their opposition to an imposed 'technological' solution is often more intuitive than reasoned – they *feel* they cannot accept an abortion – they want *their* child.

Recent evidence produced by a group of American clinicians specialising in post abortion care would support their intuition – I refer to publications by Dr Vincent Rue of California and Dr William Warden of Harvard University on the post-abortive syndrome. In our introduction we referred to factors affecting the individual's immune system efficiency – the trauma following abortion in the above circumstances can often precipitate a return to drug misuse or depress the person's psychological responses to the demands of life to an extent that the person simply does not want to keep 'trying'. Women who may be HIV sero-positive and have continued with their pregnancy have often coped well with the challenge of motherhood, if adequate support is available.

As we connect with the ultimate concerns of life and death associated with HIV infection, we cannot be seduced by, or collude with, measures which do not acknowledge the need for a depth response in pastoral and professional terms. To quote Hesse: 'Now there are times when a whole generation is caught between two ages, two modes of life, with the consequence that it loses all power to understand itself, no standards, no security, no simple acquiescence.' We have no vaccine, no definitive drug-regime – we are forced to accept that some time may pass before adequate therapeutic tools are provided. We have therefore to focus on prevention but we draw back from the challenge which confronts us in relation to morality and lifestyle in the 'at risk' groups and the general population. Emery and Trist present three classic maladaptive responses to a 'turbulent (social) environment' as depicted by Hesse above:

"The possibility of finding meaning begins in Jesus crucified and forsaken – united to failure, sin, agony and shame."

a. *Superficiality* – denying the deeper roots of the problem and often characterised by *intolerance*.

b. *Segmentation* – the situation in which sub-goals become goals in their own right – often represented by *prejudice*.

c. *Disassociation*– denying the contribution made by others and represented by postures of *indifference* and *cynicism*.

For example, to base a prevention campaign on the precarious efficiency of a latex membrane is *superficial*. Further one suspects that, in a real sense, the efficiency of the person's immune system is also inextricably connected with the manifest sensitivity of the social responsiveness which the individual meets in seeking help – acceptance of the other, in its deep sense, becomes the critical element in this encounter. As Christians we are bound by an imperative to respond to the other – as children of the same Father.

Conclusions

1. If we enter into a depth involvement with this concern – to give *light* – we must, in Viktor Frankl's terms, endure burning. For these young people infected by the virus, it is insulting to be treated simply as a victim of circumstances – we may do this by being superficially sympathetic. They may choose to collude with such an invitation and we shall have blunted their will to change and denied their dignity as persons – we will also have denied the reality of pain, guilt and death. The work of Frankl, derived as an optimistic call to find meaning in suffering, with its roots securely based in the ultimate concerns of the death camp, will guide our pastoral care. Central to such a viewpoint is that suffering can have a meaning if it changes our life – this is the challenge to pastoral care services in responding to HIV infection in the lives of people.

2. To do this we must ensure that we combine sound professional practice with a renewed state of trust in God – to create conditions where death is seen as a door and not a wall. The possibility of finding meaning begins in Jesus crucified and forsaken – united to failure, sin, agony and shame. The cross remains the root of charity – concern for others which fully acknowledges their pain, does not judge and invokes a response which is sensitive to the person's needs. There is no resurrection without felt contact with the reality of the crucifixion – for those who seek to give and those who need to receive.

3. Dostoyevsky's wife tells the story of the writer examining Holbein's picture of Christ in a gallery in Basle – the body has been taken from the Cross and is abandoned to decomposition. Dostoyevsky seemed annihilated by the representation – he saw clearly that the painter had depicted the death of Christ in the hearts and lives of mankind; he stood in front of the picture and repeated the act of faith of the disciples. In witnessing the assassination of God in souls and history, he anticipated the later work of Solzhenitsyn in the final analysis of his examination of the picture. 'The West has lost Christ, and it is for this that it dies, for this alone.'

4. Finally, we face a substantial challenge in responding to the needs of the person who is infected with this virus – a challenge which we have to meet. We have neglected our young people in not representing the truth of the Gospel to them in a manner which respects them. It requires investment of time and skill and a capacity to understand their view of society. Chastity outwith marriage and fidelity within marriage represents the only sure basis of prevention, but to say this in isolation from a context of respect and mutual understanding will not suffice. As Christians we must accept the suffering associated with HIV infection as a collective suffering – shared and felt. Christ on the Cross is the key to profound solutions in the lives of the individuals in question and for society – as he acknowledges the extent to which we all can respond to life beyond the Cross.

When I shall be lifted up from the earth, I will draw all men to myself. (John 12:32)

Counsel and Care

BISHOP MAURICE A. P. WOOD
Formerly Bishop of Norwich,
Chairman of the Order of Christian Unity

First, the long term, and then the short term (so, if you aren't interested in the long term, you can have a bit of a rest now, and then we come to the short term in the second half of what I am wanting to say to you).

The Long-Term Approach

A clergyman said to me, 'I've only got about half-a-dozen really young people in my congregation' soon after he had become the new vicar; 'what do I do?' So, I said, 'Take the long view. Go back ten years, and then you will find those six teenagers may well have been part of the large Sunday School in your church, ten years ago. Therefore, start again at the base of the pyramid, build a really large Sunday School, a large family service, a good follow-up to your baptism programme; a good follow-up to the young families of the babies with whom you're in touch; and if you do that, then ten years later, because of the drop-outs, or peoples' movements, that very broad-based pyramid will have a very much stronger area at the top.'

So, with AIDS, prevention is better than cure, especially, tragically, as we know there is no present cure for the AIDS situation.

I. *The long term need to counsel and care for people in our churches and schools and families from their earliest childhood.* As we have here a Christian perspective, I'm keeping within those parameters of Christian and church life, in what I want to say. I believe that our Christian teaching, needs to relate to three main areas:-

1. The teaching of the moral law with the Ten Commandments. That is where the Christian community and the Jewish community are hand in hand in promoting the great moral insights and direct teaching of God right through Old and New Testaments; and I find that it's good to join common ground with those who are both Jewish and Christian in terms of the Commandments, the moral law.

2. Secondly, the example and the life of Jesus in holy living and in his teaching in the New Testament must be the shining light of holiness, and chastity and self control which mark every aspect of the humanity of Jesus, in his earthly ministry.

3. Thirdly, the promotion of the ideal of lifelong marriage as God's usual pattern for home and family. I give you an example: my wife, Margaret, and I were opening a basement Christian restaurant beneath a west-end church in London. A young woman had recently become converted to Christ and she sat down at a table in this Christian cafe, and said to us, 'I've only just become a Christian recently, but I've been welcomed to three different homes of young Christian couples'. Her eyes lit up. She said, 'You know, I've actually come to discover that Christian marriage is *fun*'. 'Well,' I said, 'you must come to our home and we'll tell you more about the fun of Christian marriage!' But there's so much attack on Christian marriage today that Christian marriage is in danger of becoming an endangered species, and it's important, again, to remember that marriage is a Creation ordinance, and not only a Christian institution. If you think that to talk about the Ten Commandments is rather a negative thing to do, not so: John, one of our sons, has just flown in from doing three months' parish experience in White Plains, New York, and yesterday he jumped into our car to drive Margaret, my wife, round the corner. He said to me, as I leant in to say goodbye to him, 'Dad, this has got no power-assisted steering on it.' 'No, John, it hasn't.' 'And what's more,' he said, 'it looks as though it's going to have to drive on the left hand side of the road (he'd been driving across the Golden Gate in San Francisco for a few days' holiday in the States). It's worth remembering that the law about driving on the left in England is not a pejorative, difficult, 'don't do it', negative matter; it's for our good, and for our health and for our safety. So, we've got to go back to the Ten Commandments. When I was a little boy, I was brought up in a Christian home and I thank God for this. I had Christian parents and Christian grandparents, and we are believers in Christian dynasties. My wife and I have got six children, and our eldest son has got six children, and so it goes on, and 'the Wood dynasty' is marching ahead. Establishing Christian dynasties is a good thing. Young people present, if you aren't yet married marry a Christian, much keener than you are yourself, and set about establishing a Christian dynasty yourselves.

None the less, I went to a children's mission as a little boy, though I had all the background of help from my Christian parents. I'd not seen the need for a personal decision for Jesus, and so, in that children's mission, they showed a picture of a bucket and a well and a chain with links on it; and the missioner said, 'you're in the bucket, the links are the Ten Commandments; if you break one of them, what happens?' And my simple childish logic saw I fell to the bottom of the well, and that helped me to understand Romans 3: 23 - 'All have sinned and come short of the glory of God.' I didn't find anything unsuitable about the challenge of the Ten Commandments, and I believe we need to reassess them and then reproclaim them. That's long term.

II. *There is the long term need to counteract the humanist, liberalist, hedonistic publicity of the present day.*
I like saying 'three cheers' for Mary Whitehouse, because I believe she's a fighter and a courageous one, and a good Christian person. She stands up and actually talks about these issues of standing against those sort of rather difficult situations that touch us today, and I happen to be a trustee of the Mary Whitehouse Trust, so, I'm fairly firm about morality, as I hope you would expect from a Bishop. Let me share an encouragement with you. I confirmed a man with a very remarkable face and moustache recently, and he had a very remarkable name, Gawn, and it wasn't a Christian name I had met before; he was a man in the mid-forties. The vicar said to me casually beforehand, 'Oh, he writes plays for television and he acts in them, and

his wife is the main actress in a programme finishing this Friday night'. It was a tremendous time confirming him and a great time afterwards, and I didn't know him at all. It was so encouraging to see him on the box again last night, and to see that that actual programme finished with (and he had written it) the husband and the wife both of whom had gone off into the wilderness to live with other people, actually coming together. The fade-out was a husband and wife coming together again. How exciting about that, how nice to think that there's a certain number of Christian people writing positive plays, and it just happened I met him on Wednesday because I confirmed him. Take courage, therefore, from the fact that, in our Arts Centre Group, in the creative world, for professionals in music, and art, and television and dance, there are real Christians who are seeking to reverse this long-term hedonistic, gloomy and discouraged approach that almost leads young people into the depressions of drug abuse and of sexual promiscuity of all sorts. Some of you may like to do some study on what actually does in fact come out in the papers. Did you know in our Order of Christian Unity of which I'm the chairman, and Angela MacArthur, our Administrator, that we produce an OCU information service, and every month we publish a press cutting document on all the major issues of a moral sort that crop up in our areas of the Order of Christian Unity: the family, education, media and medical ethics; its costs £15 a year as an annual subscription, but it's very useful, because it means that, at your finger-tips, you have the various areas of what people actually are saying in the world today; and some of them are really rather tragic; I quote:

> *A generation under threat: depressing news for the nation's youth.* The next phase of the AIDS Campaign is aimed at them. The latest news from New York: alarming escalation among sexually-active teenagers. And if ever a message is unwelcome, this is it. Our teenagers must be feeling marked down as the generation least likely to succeed; and now the shine is to be taken off their love lives.

As though to say that, if young people live a robust and holy and energetic and clean life, then the shine is taken off their love life. And then this sort of assumption in today's papers: 'Given that total abstinence is unlikely, if not out of the question, what will succeed in getting the 'safe sex' message across? It is likely that the majority of young people will be active by the age of seventeen', and so it goes on, and dividing young people between sexual adventurers and serio-monogamists, but not recognising that many young people are living controlled, chaste, Christian lives.

The atmosphere of the world is one of taking it for granted that young people are *not* going to live a life of positive chastity, and are *not* going to be encouraged and challenged to come 'pure' to their marriage. So, we have a long-term task of education; and, perhaps, it's more important than ever before. I quote again, this time from Caroline, Lady Cox, who is a 'bonnie fighter', in the House of Lords; but she's not just in the House of Lords. I met her, again, a month or so ago: she'd just come back from the Sudan where one of her sons is doing medical work, and she said to me, 'Well, a pair of nursing hands (she was nurse-trained) is useful in the Sudan'; she had just spent six weeks out there and had spent five hours on the back of a camel! She's been fighting in the area of education, and the education which is deliberately targeted *against* the family and *against* marriage; and, sometimes in this long-term business, Christians have got to get their hands dirty. I like using direct examples rather than more general principles. Get therefore the copy of the Evangelical Alliance current magazine and read the article about Roger Forster's work in his particular borough, where his groups of Christians, the Ichthus Fellowship, are simply seeking to highlight what his borough council is saying about the whole promotion of homosexuality. Among the policies promoted by this particular borough is to welcome lesbians and gays as adoptive and foster parents; to teach young people that homosexual feelings are to be welcomed as having the potential to enrich their lives; to open the way for those who oppose the promotion of positive images of homosexuality among children to be penalised in Council job interviews, and possibly even to lose their existing jobs. Here is long-term work to resist the very real pressures, which undermine the confidence of youngsters about the challenge and joy of holy living. I remember that it was nearly fifteen years ago, I was talking to somebody who was doing counselling work among schoolgirls of about twelve. She said to me, 'One of the girls I spoke to said to me, "Miss, the fact I don't sleep about means that my friends at school say I'm queer; am I really queer because I don't sleep about?"' These are the sort of terrifying pressures on the idealistic young and immature boys and girls, that the church needs to stand beside, care for and help: there is long-term need to counsel and care in these areas.

"The atmosphere of the world is one of taking it for granted that young people are *not* going to live a life of positive chastity, and are *not* going to be encouraged and challenged to come 'pure' to their marriage. We have a long-term task of education, and perhaps it's more important than ever before."

III. *The long-term need to encourage Government, Medicine and the churches to promote positive chastity and strenuous self-control.*

About three weeks or so ago, I had the great privilege of spending a whole day at Ealing, speaking at a Family Conference called by Harry Greenway, the Member of Parliament there. Cardinal Hume and Professor Tony Pinching, who is one of the experts in the AIDS field, were also speaking. The interesting thing was that the leaders of the ethnic communities, the Church leaders were there: we had five minutes from the Buddhist and the Muslim and the Sikh speakers, and afterwards, they came to us, the Cardinal and myself as representative church people, and said, 'Go on fighting for the family, because, if in Britain the family is at risk, then it's at risk through all our communities as well, and we need your help in fighting for the family'. The long-term need is to encourage Government, medicine and the churches to promote positive chastity, strenuous self-control and family life. I was interested to hear Tony Pinching saying, 'Of course, AIDS (HIV) is a very frail virus, and it can only really work by penetration, and' he said, 'I find that by going to schools and saying to boys and girls at school, if you don't enter into sexual relationships, then you won't get AIDS', they recognise the truth of the message. I know that, in Edinburgh at the moment, the AIDS situation is deeply involved in the very difficult drug situation, and also, of course, I know about the tragic third group of the mothers who, usually through drug addiction and needles, have caught AIDS and their babies

are being born with that. I know these tragedies. But in general terms, I believe that we have to seek to encourage the three great influences of Government, Church and medicine to work together and share the same message. From our Order of Christian Unity, we wrote this in the papers recently:

> The Government should not shirk in its advertising campaign from the explicit moral and medical fact that personal chastity, before, within and outside marriage (as the Bishop of Birmingham had said just a week or so before this was printed) is the main barrier against all sexually-transmitted diseases, and this call for a positive, unselfish and strenuous life of chastity for those of both heterosexual and homosexual inclination, should be at the centre of any national advertising campaign. Upon the good sense, personal discipline, and responsible marital relationship of our young people, the future of our Nation depends. The churches have a duty to warn against sinful behaviour, to promote healthy and happy family life, as well as to care compassionately for grievously sick people.

We have to seek to do this. At 'The Doctor of the Year Award' lunch, I was giving the final address recently. It is good to talk outside church life and in the medical world. I tried to say to them 'I believe we've got to think of some way of warning people about AIDS. Would this do? Sexual promiscuity, whether heterosexual or homosexual, should be seen in these ways: The Government says, 'it's dangerous'; the churches say, 'it's sinful', and the doctors say, 'it can be fatal'. There it is, I think: Government, Church and medicine; saying dangerous, sinful, perhaps fatal. I believe it is right and sensible to shock people towards chastity and self-control and holy living, not because we are old and 'fuddy', but because we are desperately concerned that the next generation of boys and girls and young people in the British Isles should lead a good life, as God provides it for us: 'a healthy mind in a healthy body.'

The Short-Term Approach

The short term needs to counsel and care for young people likely to be at risk.

1. The opportunities for a Christian voice, and especially a Bible-based, and, I believe, evangelically enlightened Christian voice, must be openly made in the Nation. I give you here just these further quick examples. I make no apology for the fact that I am speaking as the Chairman of the Order of Christian Unity, because I am so named on the programme and, presumably, that's why I've been invited to speak here; but we are seeking to make sure, through our publications, through our meetings and, particularly, through our Medical Ethics Committee, that there is counsel and care for young people available.

2. When one goes to schools, this voice must be heard. Again, let me illustrate. I was preaching at a big boys and girls school recently and, in the sermon, I said the sort of thing I've just said about Government, Church and medicine, promiscuity being dangerous, sinful, fatal. I had been confirming at that school the year before and we were having a Confirmation Reunion. There were four 16 or 17 year old boys sitting at one of the tables, and I was going round each table during tea at this reunion. One of the boys said to me, 'Thank you very much, Sir, that you said that in the sermon because', he said, 'we, sixteen and seventeen year olds, are told that we are the age range most at risk, and, frankly, it's a help to have something quite as blunt said to us as you said'. I think we have to be careful not to wrap up our advice in complicated words, but to help young people face the dangers *before* they experiment, rather than afterwards. The short term need to counsel and care for young people likely to be at risk, and, perhaps, if possible, to help them beforehand.

3. We have to resist some of the literature that comes out, which is not helpful in that way. I collected from the counter in a chemist's shop the November 1986 booklet of the Health Education Council, called 'AIDS, WHAT EVERYBODY NEEDS TO KNOW'. The Health Education Council, since producing that booklet, have been closed down and reformed in a different pattern. Pages 10 and 11 state, 'How can you reduce your risk of getting the virus?' It appears to say, 'here's some advice to help you to reduce your risk: the fewer sexual partners you have, the less risk'. 'The fewer partners your partner has too lessens the risk; the way you have sex also affects the risk.' Then (and I won't sully your ears with it) they set out a variety of sexual practices; on page 10, you can read it for yourself. There it *all* is! It is pretty frightful, because it's saying in effect, if you can drive your car as near the edge of the precipice as possible, you may *just* get round that corner. And I think we have to be willing to say to the new Health Education Authority that pages 10 and 11 of 'AIDS, WHAT EVERYBODY WANTS TO KNOW' *must* be revised in a positive and good way, because God has created us in his love to live in his world, and he's created us to live in his world in a reproductive way within the safety of monogamous marriage, and we Christians believe with the extra joy and privilege of Christian monogamous marriage for the continuation of the human race; and, if in fact we move into areas which are outside monogamous marriage, there's going to be natural dangers, perhaps disasters.

"Upon the good sense, personal discipline, and responsible marital relationship of our young people, the future of our Nation depends. The churches have a duty to warn against sinful behaviour, to promote healthy and happy family life, as well as to care compassionately for grievously sick people."

4. Short term Counsel and Care for those with Homosexual Tendencies. I use the word 'tendency' carefully: a homosexual tendency is *not* sinful, any more than a heterosexual tendency which is the normal tendency. It is giving way to the practice of sexual relationships outside marriage which is sinful. The homosexual tendencies can be sublimated, because there are good things in the creative qualities of those who find themselves with a homosexual orientation. They should not, therefore, cast themselves down as being themselves 'no use' to people; because, where people have a real and lasting homosexual tendency, then there are certain qualities of gentleness and of creativity which, harnessed again within exactly the same parameters of holy living, can be of help to the community. In just the same way those with strong heterosexual tendencies, harnessed within the life of positive chastity, have so much to give. And I think it is important for us to remember that we should not, therefore, let people wallow in a sense of self-defeat. Here is the specifically Christian truth that Christ can meet our needs, whether we have a homosexual tendency or a natural heterosexual tendency, and we can meet him in our weakness and find him in our need. One of the encouraging things today is to meet with born-again men of homosexual tendency who are

seeking by God's grace to live holy lives. They seem to have a special ability to help others who are not yet willing to live that disciplined life but know they need to. We should, therefore encourage people to count for good in life. We are to seek to love them for Christ's sake and treat them as individuals with tendencies, whether homosexual or heterosexual. It is very important for us not to talk about drunkards, not to talk about smokers, not to talk about homosexuals, but to talk about people whom Christ loves, who in fact face such problems and pressures.

"Not only we can, but we *must* pray, because prayer not only releases the power of God in a situation, but it illuminates the praying person, and encourages him to get into action."

5. What is our task as Christian carers? It is very important, as a Christian carer, and I suppose a parson is that, that he should be quite clear about the quality of sinfulness in wrong sexual relationships, and the quality of caring and reaching for those who are in this situation. But certainly, we *must* warn people against this word 'safe sex', because it just isn't so, as our doctors tells us, and so do our traditional moral theologians.

6. What of short term counsel and care for AIDS victims? That's where most Christians find themselves facing a very deep dilemma. This has become much more urgent now because it's all so very public. Twenty-eight people died last month of AIDS, bringing the total to 405 so far, last year, 80% of those of homosexual tendency. The Edinburgh situation is different with a high proportion of drug-addicts. I am thinking now particularly of the homosexual AIDS victim who is in a very desperate situation. He faces the diagnosis of AIDS, first of all, the fact of a no-cure situation; secondly, the fact of it becoming public, and the family rejection that many of these are subsequently facing; the fact that socially they are beginning to feel more and more 'pariahs', and the very sad fact (and I'm immediately up-to-date here) that, when our very brave and lovely Princess Diana went to visit the new AIDS ward at the Middlesex Hospital, the patients really didn't feel they could face the chance of even being identified by photograph. This is a very tragic thing. But I think that that particular picture of Princess Diana stretching out her hand to one AIDS victim who was willing to be seen, but with the photographer behind him, is, I believe, symptomatic of what Christians have got to do. We have got to take the initiative gently. In the New Testament lepers, for instance, were so cut off from people that no-one would touch them and nobody could heal them, and so they are a picture, a parable, if you like, of the task which the Church, and the medical world and, especially the Church and medicine together, are called to deal with. Christian action is the call today. I believe that all the 'pro-family' societies and the 'pro-life' societies need to be very close together, not fighting each other as rivals, but uniting as partners, because we are small groups. We in the Order of Christian Unity, though we are thirty years old, are quite small, though we have pretty high-powered people on the committees. Care Trust, which is larger and very good is also growing. This marvellous work Rutherford House is doing in convening this Conference, and Valerie Riches and her Responsible Society, work together. It's a thrilling thing that these great societies, though they're fairly small, are really concerned with the quality of living, especially in these rather tragic days. I suppose the most exciting news, really, is the work that the Mildmay Mission Hospital have started, though their first AIDS patients haven't arrived yet, but it's very good that we've got both the medical director and the new matron and representatives of the Mildmay Mission Hospital here, because here is obviously something we can 'home in' on in this work. For here is a Christian medical mission, saved from being closed (I remember giving the blessing at St Paul's Cathedral on behalf of the Bishop of London at our great Thanksgiving Service, not so long ago now) who feel God has called them to set about an AIDS project and an AIDS ward at the Mildmay Mission Hospital. Over lunch you must talk with representatives of the Mildmay who are here. But here is a very exciting situation, in which, in fact, we are moving into opportunities for actually caring for people who have AIDS.

But you, personally, aren't here just because you're interested academically, but obviously, you've come here today because you're interested personally. What can you and I do in the Christian perspective on AIDS?

1. *Praying*. Not only we can, but we *must* pray, because prayer not only releases the power of God in a situation, but it illuminates the praying person, and encourages him to get into action. Anyway, we never know how prayer works, except it does; and the older you are as a Christian (and I am now seventy), the more I know that prayer works and things happen gloriously when we pray determinedly. Pray on!

2. *Giving*. I do hope that, in some way or other, you tithe your money; how you do it, I don't mind. The simplest way is, if you're on a pension as I am, or if you get a monthly salary cheque, or however you get paid, you simply arrange for a percentage of your monthly cheque and salary to go to your No. 2 Missions Account, and then the money is there, ready for you to share, either through Charities Aid Foundation, or by direct giving or covenanting. But it is important that we should be really giving usefully to the areas where it's needed. That's good. I have a feeling that the Mildmay Hospital is going to be our Christian flagship in Christian response to AIDS in the coming years. I'm not being paid to say that, I just think it's important and I'm glad to say it! We must also support the pro-family and pro-life Christian societies of which I've just spoken, also.

3. *Thirdly*, seek vocations in the nursing world, the medical world, the social caring world, the MacMillan Nurses work. We know of this because Margaret, my wife, is on the National Council for Cancer Relief, and so we know a good deal about MacMillan Nurses, when we helped to get our own hospice going in Norfolk. What about the whole AIDS care situation? If God has given you an administrative mind, may God lead you to administration; that's a good thing too. I was out in Uganda doing a mission, a year or so ago, and I went to Katenga Hospital, under the Ruwenzon Mountains, and there there was a lovely, cheerful, young Ugandan administrator, very black-faced, very white teeth with a great big smile, a lovely young man, a real Christian and a fine administrator. Remember administrators get knocked all the time, but the word 'ministry' is actually built into the word 'administration'. He was showing me the new maternity hospital they were building there: very few resources, the lights went out at 8 every night because there wasn't enough

Aiding the Young

MRS VALERIE RICHES
Honorary Secretary,
Family and Youth Concern

By the nature of things, young people are particularly susceptible to influence. Were it not so, we should not be concerned, as we rightly are, to protect them from undesirable social influences and habits.

Whatever the strength of their own convictions, it is a great deal to expect boys and girls to reject information that plays on their own emotional and physical instincts, or conditions their thinking, by implying that it represents some kind of contemporary norm of behaviour.

We must be concerned about this, because certainly in the Western World, and more and more in the developing countries, young people are increasingly vulnerable, and at younger ages, to the influences of commercial and ideological interests, who see the importance of getting a grip on the developing mind.

Advertisers seek to influence the spending habits of the family through the children. There is an army of experts projecting their own (often unresolved) problems through the advice columns of the teenage magazine market. There are 'sexual minority groups' clamouring to plead the normality of their life styles to inexperienced and immature minds.

Then there is the media in general, especially television, endowing an aura of glamour to alternative life-styles; drugs, sex and violence, in a way which commands immediate attention: an all-commanding 'newness', for instant gratification.

All apparently seek to liberate children and provide them with full rights of sexual self-expression, with back-up supplies and services. In addition to this onslaught on the young, children in schools are now subject to the ministrations of a lobby, one of whose interests in sex education lies in ridding society of what they describe as 'archaic sex laws'. This public-funded lobby not only informs children about all means of fertility control (contraception, abortion and sterilisation) - except the most effective, *self-control*, but so fills their minds with the notion, that if they want to have sex of any variety, at any age, there can be no moral objection, provided only that they do not get pregnant, or get any one else pregnant. Pregnancy is regarded by this lobby, not as the glory of womanhood, but as the number one major disease of the 20th century, to be stamped out at all costs, just as the government now regards the problem of AIDS.

The same message is taken up by magazines specifically aimed at teenage girls; a relentless message. With frightening regularity, amoral attitudes to sex, appalling vulgarity, lack of restraint in visual material, and weird insinuations about the occult jostle for space with advertisements for abortion, crude fiction, and mendacious information about contraceptive drugs and devices. Our young people have a strong tide to swim against: a very strong tide indeed.

You may well ask how did this situation come about. I believe that to understand the problem underlying AIDS we need to look at some of the intellectual origins of the sexual revolution, and some of its consequences.

For nearly 2000 years in the Western World, there has been a basic commitment to the ideal, if not always the practice, of associating sex with love, and fidelity, in the context of monogamous marriage. However, towards the middle of this century, great changes took place, quite different in nature from previous periods of permissive sexual behaviour.

Among the most obvious contributing factors to this change was the publication of the Kinsey Reports in 1948 and 1953. Kinsey, a biologist, applied to over 12,000 humans the techniques he had used in studying over 2 million gall wasps. From the data he collected, he proved, to his satisfaction, that there was no such thing as 'normality' or 'abnormality' in sexual behaviour – no rights or wrongs. The validity of his sampling techniques was challenged as soon as the first volume appeared. The respondents were not a random sample of the population, but volunteers: it was only too evident that the results depended absolutely on the type of person who volunteered.

However, in spite of the inadequacies of the methods employed by Kinsey, the revelations in his reports quickly became fact, and were used by the media, 'sexual minority groups' and vested interests as an excuse for sexual freedom. These days it seems to be a fact of life that lies travel half way around the world before the truth has got its boots on. In any event, sex rapidly became a commodity to be exploited; and committed love a subject to be avoided.

It is impossible to over-estimate the far-reaching influence these frequently quoted reports have had on sexual attitudes and behaviour, and on sex education policies. In fact, the Kinsey Reports provided the blue-print for the sex-education missionaries – and the long-term effects on Western societies are now becoming painfully obvious.

There is no better example of the ideology lying behind the sex education lobby, than that contained in a book *Can People Learn to Learn*, by Dr Brock Chisholm, a humanist, and first Director of the World Health Organisation, and connected with population control lobby.

Chisholm was wedded to the idea of world government, and believed those who opposed him were neurotic, selfish or mentally sick. He believed that the most persistent barrier to developing a civilised way of life in the world was the concept of 'right and wrong' – a concept which he thought should be eradicated. Codes of belief, fixed rules or dogmatism were anathema to him. He saw parents as dictators and suppressors of the child's better nature, and believed that children must be freed from national, religious or other cultural 'prejudices' forced upon them by parents and religious authorities. He advocated sex education to be introduced at an early age, eliminating 'the ways of the elders' by force, if necessary.

Such ideas may sound extreme but they were merely confirmation of other concepts being advocated about the same period. For example, Rudolph Dreikus, another humanist, put forward the following theories:

- the sexes or sex roles should be merged or reversed
- that children should be liberated from their parents
- and that the family as we know it should be abolished

Now all these ideas are deeply embedded in the thinking and practice of the sex education missionaries and can be seen in many fashionable sex education publications and programmes.

Take the last first – The Family:
It is not possible to look at the problem of AIDS and how to help the young, without looking at the social context in which today's children live out their lives.

We face a crisis in family breakdown which has deep religious, political and social implications.

Religious: because we are a Judaeo-Christian civilisation which has for two thousand years preached that marriage is for life.

Political: because the family, formed by marriage, is the foundation for democracy and a barrier against excessive powers of the state. As the family breaks down, so the state assumes more of its functions including some of its most intimate family matters.

Social: because we now lead the European divorce stakes, with 1.5M children living in 1M one-parent families. Because, we now have about one in five babies born out of wedlock: if the present rate continues, there will be one in three by the turn of the century – not long after there will be more babies born out of wedlock than within it. Because, as these problems have increased there has been a moral decay with the rates of abortion, children in care and juvenile crime rising proportionately. The financial cost to the nation has been estimated as over £1,000M a year, and even more significant, there is widespread misery with 50% of second marriages breaking down.

"The family, formed by marriage, is the foundation for democracy and a barrier against excessive powers of the state. As the family breaks down, so the state assumes more of its functions including some of its most intimate family matters."

Youngsters born in the '80s can expect to follow these ten stages:

1. Live with both parents for several years, then
2. Live with their mothers after their parents' divorce, then
3. Live with their mothers and stepfathers, then
4. Live alone for a time in their early 20s, then
5. Live with someone of the opposite sex outside marriage, then
6. Get married, then
7. Get divorced, then
8. Live alone again, or with their children, then
9. Get remarried, then
10. End up living alone again after the death of their spouses. (American Insurance Council assessment for the year 2000).

If I go into a classroom, well over half the children will not be living with their natural parents. Many will be on their fourth set of grandparents, to say nothing of aunts, uncles and other relations. The discontinuity, fragmentation and disposability of relationships involved, the suffering and unhappiness entailed; the behaviour and mentality that lie behind this pattern, are all things we should be helping our young to understand so that they will know what the 'trivialisation of persons' means when bodies meet but minds and hearts are light years apart: the underlying cause of AIDS.

The disposability of relationships has become such that whilst in the 1950s it was appropriate to ask 'How many children does the average family have?', the more appropriate question in the 1980s is 'How many parents does the average child have?'

That forms the back-cloth for the theories I outlined earlier. Now to the sexes or sex roles being merged or reversed. I have to say here that it seems a good and positive thing that men are contributing more to the rearing and understanding of the needs of children. But what is of concern is the extent to which children are being indoctrinated into believing that homosexuality is entirely acceptable. I quote from a report of the National Council for Voluntary Youth Services:

> Every opportunity should be taken to communicate the message that homosexuality is no more and no less 'natural' than heterosexuality.'

That inaccurate and misleading theme runs through most sex education programmes and material. Children are also being persuaded that there are no differences between the physical and psychological make-up of male and female. This is contrary to even a child's perception of the obvious facts of life. But in order to achieve this fatuity, we have education authorities demanding an elimination of any stereotyped concept of the roles of men and women in all forms of education.

The fanaticism with which the libertarians seek to secure the suppression of 'stereotyped' material makes an extraordinary contrast with the resistance of many of them to countenance any control over material of an obscene or violent nature, despite evidence of its antisocial consequences.

With regard to liberating children from their parents, we are all aware of the sensational court cases which were pursued by Mrs Victoria Gillick, against the DHSS and her local AHA in an attempt to place the responsibility for the sexual welfare of children back where it belonged, in the hands of parents. Alas the case was lost. It is no coincidence that Chisholm's 'elimination of the ways of elders' has taken place in a number of countries through the ministrations of national family planning associations, under the auspices of the International Planned Parenthood Federation. This body has made no bones about promoting the 'right' of young people from the age of 10 to have full access to fertility control with guaranteed privacy and confidentiality.

It is a fallacious argument that the provision of contraceptives to teenagers solves the problem of teenage pregnancy. During the

10 months between the decision of the Court of Appeal and the judgement of the Law Lords, youngsters could not get contraceptives behind the backs of their parents, and the sex educators in the media and in schools, had to stop proselytising 'safe sex' for teenagers. There was a significant fall in attendances at NHS family planning clinics. Now despite hysterical claims from the birth control lobby that there would be an alarming increase in abortions and births, there was a fall in abortions and births resulting from that period.

This tends to show that parents hold the key to the responsible sexual behaviour of their adolescent children. In every state in America where parental consent for abortion had been re-instated, the indices of teenage pregnancies, abortion and births dropped dramatically.

Yet many people of goodwill in this country, brainwashed as we all are, still believe that the provision of contraception to adolescents without parental knowledge, is the only charitable and humane way to deal with the incidence of teenage pregnancy and now AIDS. There are lessons to be learnt from all this. When the adult world stops encouraging adolescents to have sex, they will be less likely to oblige.

"The fanaticism with which the libertarians seek to secure the suppression of 'stereotyped' material makes an extraordinary contrast with the resistance of many of them to countenance any control over material of an obscene or violent nature."

Now, despite incessant arguments that contraception, especially the Pill, solves the problem of unwanted pregnancy, abortion and illegitimacy, the government continues to grant large public funds to the promoting organisations. I cannot imagine any commercial enterprise continuing to fund plans or policies which failed so miserably.

Yet, ladies and gentlemen, we are going through the whole scenario again in regard to the AIDS epidemic: 'safer sex' with the condom as the quick technical fix instead of the little wonder drug, the Pill. Some years ago the Health Education Council produced what was known as the four-feet advertisement, with the caption, 'I wonder if She's on the Pill.' That advertisement was banned by the Advertising Standards Authority on the grounds that it would appear to encourage promiscuity. The same four-feet advertisement has appeared as part of the government's anti-AIDS campaign message to have safer sex with the use of the condom and to try and keep their partners down to as few as possible.

It is with regret that I must say that the government's present advertising campaign is doomed to failure.

It is claimed by some that AIDS is the leprosy of the West – a punishment on a sinful world. It is not for us to judge but to offer the victims our genuine compassion and care. What cannot be denied is that looked at objectively AIDS is the symptom of a malaise which accepts promiscuity as the norm. It is an inevitable result of that false ideology which overtook us and convinced us that there were no rights or wrongs in sexual emancipation as a positive virtue, and physical satisfaction in sexual relationships as a supreme goal in itself. We recklessly abandoned traditional values and standards in relation to personal behaviour and family life . . . . And that wreckage leaves us with AIDS.

Kick nature in the teeth, and nature bites back.

AIDS is as much a moral problem, as it is a problem of public health. The answer lies in primary prevention; the promotion of faithfulness in relationships.

Now that the first phase of the government's campaign has passed we must urge that the second and third phases will start telling the young the truth. Beyond necessary facts about the side effects of the Pill, abortion and early sexual intercourse, we must bring out of the archives that important concept of chastity. The young have been sold-short. They need to understand that self-restraint is a vital component in the life-long struggle for self-mastery. Given untarnished and unbiased information, in a moral context, with ideals to aim at, most sensible youngsters would refrain from entering into relationships, which may spoil their opportunities for a life-long committed relationship, to which most of them would aspire given the support. So many of them see the tragic toll on the quality of family life, the undeniable evidence of the 'disposable society'.

There is an urgent need for a radical change of political thinking on family policy in general. The Christian moral viewpoint is founded on human reason illumined by faith and the desire to do the will of the Creator. We have the benefits of scientific discovery but we are able to transcend its horizons and see it in the perspective of God's creation.

In discussing AIDS we have to look at the whole vexed question of sexual relationships and partnerships. The swiftness of the spread of the disease into all strata of society must mean a reappraisal of our attitudes and behaviour in matters of sexual behaviour and human relationships.

"In every state in America where parental consent for abortion had been re-instated, the indices of teenage pregnancies, abortion and births dropped dramatically."

We need to look at homosexuality and its causes. Most leading psychologists now agree that homosexuality is not innate and does not have any genetic connection. Dr Charles Socarides, author of a treatise most frequently used by medical scholars on the subject has pointed out that homosexuality is learned, acquired behaviour. As with other kinds of conduct, thoughts become actions, actions become habits, habits become a life-style.

It is therefore of great importance that the sex education lobby stop telling young people that homosexuality is a genetic condition and normal and natural. It is especially dangerous to impart

this message at a time when adolescents are going through what is loosely termed a homosexual phase: a condition most of us have been through when we get a crush on a member of our own sex, (often the most unlikely characters) but which passes on to the development of relationships with the opposite sex.

For this reason, it is an extremely unhealthy development in society to see the growth of gay teenage clubs funded by local authorities, where youngsters who think they may be homosexual, are integrated into the homosexual fraternity, rather than be allowed to develop normal teenage friendships.

In setting out the dangers of present teachings and practices, we must clearly set out the arguments against a promiscuous way of life. Sexual intercourse should be an expression of self-giving, selflessness and a communion with one's partner. This can only come to full fruition within the bounds of the marriage bond.

We have to start by reiterating some simple truths about human needs; truths that have been tragically forgotten in our pleasure-seeking society. One is that from the moment a mother takes her new born baby in her arms, the process of bonding begins. It is the first relationship the infant experiences, and it is crucially important that it should be of the highest possible quality because it affects the baby's adult nature and sexuality. Every contact between mother and child must carry a message that the baby is of the highest value, completely loved and lovable. These contacts will also affect the responsiveness of the baby to the way it is handled and spoken to and visually stimulated by its father and brothers and sisters.

It is through the bonding process that the baby develops its basic orientations towards trust, love, security and confidence to develop a deep sense of its own worthiness, from which its capacity to love can grow. These are things which our adolescents, boys and girls, should be taught so that they may provide circumstances in the future for the healthier rearing of the young.

Another basic need so tragically forgotten is that people need love and that it is in the family that we first learn how to love and relate to each other as unique human beings.

Adolescent girls and boys need to be convinced that sex alone will never bring them the personal commitment and acceptance of another, that they are really seeking.

There is much work to be done in our schools. But it is principally in the setting of the family that fathers who are secure in the love of their wives can show their sons, and mothers who are secure in the love of their husbands can show their daughters, how to live.

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oil to keep the dynamo turning to make the light last any longer. He showed me this new maternity block they were building. He turned to me in that lovely open way Ugandan Christians have and he said, 'whenever you see a beautiful thing, you see the face of Jesus'. Isn't that lovely! Whenever you see a beautiful thing, you see the face of Jesus. That was great. And then he showed me young mothers-to-be, all lying there ready to have their babies. In Uganda you do things tidily: there they were, all in a row, and they were all covered in little brown blankets, and I looked carefully at these brown blankets and I saw written across them 'Laker Airways'. Now, that's a good administrator: he happened to spot that Laker Airways had gone broke and he'd rushed off and bought all these blankets and put them all over these young mums! And I think it's worth saying that administrators, Christian administrators, can be really keen Christians and also really administratively sound, and not all of us are both. It's good when they are. But we, as Christians, are to live clean lives. As Christians, too we are to care compassionately for the sick, and we are to lead those who are seeking, and those who are suffering, and those who are in need, to Jesus. Our badge of the Order of Christian Unity, showing the Cross, with the hands meeting at the foot of the Cross, always reminds me of the great Sister Gemmell of the Church Army who said she ran the only 'Christian night-club in the West End' for her girls who were prostitutes, or who were on drugs. Sister Gemmell was such a marvellous person. She used to go up to Holloway Prison when her girls were coming out of prison, and she said to me, 'I used to stand there on the gravel early in the morning at 8, so I could get them before the men who made money out of them got them, and collect them, and care for them, but', she said, 'nonetheless, as they came out of Holloway Prison, I couldn't pick up so much as a handful of gravel to throw at them, because the ground is *level* at the Cross'. We are all sinners at the foot of the Cross, and the first person who was home to Heaven was the one who had been a murderer, a thief, a robber and a rebel and had said, 'Lord, remember me when you come in your kingly power', and Jesus said, 'Today you will be with me in the gardens of Paradise' and welcomed him home. So there is nothing wrong about facing, all of us, whether we are workers or sufferers, with our common sinnerhood, as long as we do it with gentleness, with compassion and with love, and earn the right so to do, because the Cross is the one great symbol of hope for time and for eternity. Therefore a Christian perspective for AIDS must ever have the Cross before us. And one very severely practical note at the end is this: that, if we are living holy lives and chaste lives, perhaps we are the one great group that needs to be deeply involved now in the Blood Transfusion Service. Because your blood is safe, because you are living a holy life, you can therefore offer help in the Blood Transfusion Service with no pride, with no special drawing attention to yourself. I believe it is one of the very simple and compassionate Christian challenges today that, if in fact we're living like that, then we know that we can offer our blood to help people.

AIDS produces in the most acute form the Christian dilemma: to condemn sinful actions, and to care for sinners in desperate need. The Church must unfalteringly proclaim that promiscuous sexual behaviour both homosexual as well as heterosexual, is sinful, and comes under the general judgment of all sin, by a holy God. The Church must also reach out with the compassion of Jesus Christ, to succour and care, even if it cannot heal, those who by the breaking of the natural law are already suffering the consequences of AIDS.

All judgment is ultimately in God the Father's hands, yet the hands of his risen and glorified Son still bear the marks of his suffering and sin-bearing on the Cross. Our hands, in gratitude for his salvation and in compassion for all who are sick, must reach out in care and contact and self-sacrifice to all in need. As involved Christians, we must walk forward, with our feet firmly planted on God's earth, but we must march to the drumbeats of heaven.

Review

On Moral Medicine. Theological Perspectives in Medical Ethics.
Edited by Stephen E. Lammers and Allen Verhey,
William B. Eerdmans, Grand Rapids, 1987, x + 657pp.,
£20.45, paperback (distributed in the UK by Paternoster).

On Moral Medicine is a substantial anthology of ethical and theological comment on the wide range of issues now covered by the phrase 'medical ethics'. It provides the student (medical, theological or otherwise) and his teacher – together with the informed general reader – with quite the best conspectus of the range of subjects and the ethical options currently available. The keen-sighted reader will even discover a brief reference to an early issue of *Ethics & Medicine*.

The range of subjects covered is considerable – there are nineteen main chapters. They range from discussions of preliminary considerations ('Religion and Medicine', 'Theology and Medical Ethics') through particular and fundamental issues of principle ('Life and its Sanctity', 'Death and its (In)dignity') to some of the frontier questions which the new medical technology has thrown up: 'Genetic Control', 'Technological Reproduction'). Under each chapter heading there is a brief introduction with a list of works for further reading, followed by a series of selections – generally between four and six – that may be taken to represent the spectrum of contemporary theological-ethical opinion on the matter being discussed.

Plainly, this is a north American book, and the British writers who find a way in (notably C. S. Lewis) no doubt do so despite their origins and not in order to reflect them. Moreover, there is something slightly eccentric about the inclusion of one or two selections from earlier writers (including one much earlier, from the Apocrypha) alongside essentially contemporary debate. Space given to Lewis and, for example, Barth, throws contemporary discussion into perspective, but also tends to upset the balance of current debate otherwise represented. Barth and Lewis, in their different ways, were addressing another world's debates about medical ethics, as their essays themselves reveal. Post-1967 and 1973, and more recently post-Warnock, we are all living in a brave new world in which an innocence we never knew we had a generation ago is found to have been lost.

A further comment relates to the failure of the editors to provide indexes. The present reviewer has some practical experience of the problems which this would have involved for them, and respects their (presumably conscious) decision to draw stumps when they did. But it does significantly hamper the usefulness of the volume for purposes of reference, and that cannot be good. If it goes to a second edition (and with the burgeoning medical ethics industry still in rapid expansion, there is every reason why it should) perhaps this will lie on the conscience of the publisher.

How long will my paperback copy survive? It is doubtful whether volumes of this size should ever appear in this flimsy form. But *On Moral Medicine* is more than worth its money, for what must be around three-quarters of a million words. Its appearance is greatly to be welcomed, and its editors are to be congratulated for their diligence.

Nigel M. de S. Cameron

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beforehand. Such counselling consists largely of giving them reasons why they should not have the test. If the test turns out to be positive their GP or dentist may be unwilling to treat them. They will not be able to get life insurance and they may have difficulty getting mortgages. There is an important reason in favour of knowing, however. This is that, if infected, they could transmit the infection to others. Knowing that one can and should personally take preventative action is a powerful motive for having the antibody test. The potential of causing infection in another takes precedence over personal social and economic disadvantage.

I know medical professionals who do not acknowledge this as a reason for having an antibody test. I know patients who do think that this is a reason. People who belong to one of the risk groups should be encouraged to have the test. This country needs an HIV self-notification campaign. People can find out for themselves if they are infected. A recent survey of male homosexuals found 95% of them willing to have the test. Haemophiliacs have already been tested. Why no official encouragement? It is because this involves public acknowledgement of personal responsibility.

The antibody test could be a powerful weapon to prevent spread of HIV. For example, antibody screening of two sex and social clubs in Minneapolis, Minnesota identified a woman in each who was infected. Many members of the clubs did not appreciate their AIDS risks. Both clubs were subsequently disbanded. The current position in the U.K. is that such initiatives are not encouraged. I know of no health authority which has attempted to contact and to test risk groups.

The Education Act of 1986 states in regard to sex education, that teaching must seek to encourage pupils to have due regard to moral considerations and the value of family life. Do the government's education programmes on AIDS pay due regard to moral considerations and the value of family life? I have yet to read any leaflet or pamphlet on AIDS produced by one of the statutory services which mentions marriage. AIDS, I have been told, must not be an excuse for reasserting Victorian values. Imagine thinking that marriage is Victorian!

There is nothing mysterious about the AIDS virus. There is nothing mysterious about how the virus spreads. AIDS is totally preventable and you can have sex, too. What can control AIDS? Marriage can control AIDS. That's the way the world is made.

AIDS: Is it God's Judgement? AIDS: Are there Biblical Perspectives?

The four papers carried in this issue of *Ethics and Medicine* were each delivered at Rutherford House Conferences on AIDS in April 1987. Those by Dr Larson, Bishop Wood and Mrs Riches were given at the Westminster Central Hall, London, and that by Mr MacLullich at Edinburgh University.

Two further papers delivered at these conferences, entitled *AIDS: Is it God's Judgement?* by Dr R. T. Kendall, and *AIDS: Are there Biblical Perspectives?*, by Professor Donald Macleod, are published in the Spring issue of *Evangel*, also published by Rutherford House. (Single issue £2, annual subscription £6.90. New subscribers pay only £3.45 for the first year.)