Religion, family planning, and abortion

SIR—Verkuyl (Aug 21, p 473) issues a challenge to Islam (and to the Roman Catholic Church) on attitudes to contraception. The official Islamic line is not opposed to contraception. Long before the family-planning movement of modern times, Muslims were allowed by Shari'ah law to space their children and choose the family size they wanted. After a comprehensive review of 1400 years of Islamic jurisprudence,[1] I concluded that family planning is acceptable to the great majority of theologians in almost all the legal schools (Madhahib), provided that the wife's permission is secured. The companions of Prophet Muhammad practised coitus interruptus (the only method then known) and neither the Qur'an (Koran) nor the Prophet prohibited that—indeed the Qur'an endorses breastfeeding for two years and the Prophet warned against a lactating woman getting pregnant lest the child's health should suffer.

There is, furthermore, much prophetic tradition (Sunnah) that clearly allows pregnancy prevention. Acceptable justifications for contraception in Islamic jurisprudence are thus:
(1) To space pregnancies for the protection of the mother's health.
(2) To prevent the transmission of hereditary or infectious disease to progeny.
(3) To protect a weak or ill mother from any aggravating impact of pregnancy and labour until she regains her fitness.
(4) To avoid economic embarrassment to the family from too many children, as advocated by Al-Ghazali, the 11th century theologian.
(5) To "safeguard the wife's beauty and to keep her fit and in good form", a justification also advocated by Al-Ghazali.
(6) To protect a breastfeeding child from the impact of a new pregnancy on the quality of the mother's milk.

Permissibility is not limited to coitus interruptus. It applies equally well to modern methods, on the jurisprudence principle of analogous reasoning (Quiyas). The permission is, however, subject to certain qualifications:
(1) Permission of spouse is required or preferred.
(2) Contraception is voluntary and should not be enforced by law, nor should a certain quota of children be specified.
(3) It is blameworthy to practise contraception to avoid having a female child, or for the woman to avoid assuming a maternal role.
(4) Contraception becomes mandatory for the prevention of health hazards.
(5) Abortion is not allowed as a family planning procedure, but can be performed during the first four months for a compelling health reason.

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1 Omran ARA. Family planning in the legacy of Islam. London: Routledge, 1992.

SIR—Several incidents in the USA highlight issues raised by Verkuyl and your editorial. The day the Pope visited Denver, Warren M Hern wrote in the *New York Times*, "this week, I began wearing a bulletproof vest to work. I am not a policeman setting out to raid crack houses. I am a doctor who does abortions". One week later Dr George R Tiller was shot as he left his abortion clinic. Tiller also often wears a flak jacket; he did not have it on Aug 19 in Wichita, Kansas, when Rachelle Shannon shot him several times with a hand gun. In March this year, Dr David Gunn was killed leaving his clinic in Pensacola, Florida, but fortunately Tiller was only hit in the arm and survived. Shannon was arrested returning a rented car to the airport.

The climate of extremism over abortion is getting worse. Operation Rescue, a group that takes physical action against clinics, prayed outside Hern's clinic for his death and Tiller's assailant seems to have been what Hern described as "the lone fanatic who steps out of the shadows to deliver the ultimate message of hatred for what I do to help women".

Recently, an Alabama Catholic priest wanted to run a newspaper advertisement calling the killing of an abortion doctor "justifiable homicide". His superiors have told him to recant or resign. Pope John Paul II was once almost killed by a lone fanatic: will he add his authority to this condemnation of religious fanaticism?

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SIR—Apart from the fact that Verkuyl's article is offensive bigotry, and therefore does not have a place in a scientific journal, it is highly unscientific. To claim that free condoms, widespread availability of chemical birth control and, between the lines one reads, legal abortions will solve third-world problems is the same as saying that killing the poor will solve developing world problems: "No children for the poor please, they have enough misery"! Verkuyl's wish will possibly be granted, but to the detriment of his country and the rest of the developing world.

For the sake of scientific and intellectual honesty, it would be also necessary to hear from doctors, patients, and religious leaders about the physical and psychological consequences of contraception (for example, the Norplant and Depo-Provera issues), of abortions (not only backstreet), and of failures of condoms to prevent both AIDS and pregnancy. Let the truth be heard.

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SIR—Verkuyl and your editorial attack the Catholic Church and Islam for lack of population control. You correctly admit that the Church currently and historically is the single greatest provider of health care throughout the world, in terms of its financial commitment, and in so many of its dedicated personnel. As a clinician who has worked in the developing world for over 25 years it is my experience that creating a satisfactory standard of living, including education for all, will lead people to adopt an acceptable (to them) family planning method. Reducing crippling international debt is also essential. Denying children medical care such as oral rehydration fluid as suggested by King[1] is abhorrent to all providers of health care in the developing world.

There is no evidence that population growth, in the absence of exploitation, causes poverty. Food production has kept ahead of population growth so that there is now more food available per head in the world than at any other time. Even the World Bank has done an about-turn on population. In the 1960s and 1970s Robert Macnamara, the executive director of World Bank stated that "population growth is the greatest obstacle to economic advancement". The president of the World Bank in 1989, however, said, "the evidence is clear that economic growth and excess population growth rates, can be achieved and maintained by both developed and developing countries".

Contraception does not reduce the need for abortion. In the UK during the past 20 years, contraception has been freely available irrespective of age, marital status, or parental consent, yet the abortion rate continues to rise, especially in the young. This rise was predicted by Malcolm Potts of the International Planned Parenthood Federation (whom you cite twice) in 1973, and by Judith Bury of the Brook Advisory Centre in 1981

when she stated, "there is overwhelming evidence that, contrary to what you might expect, the availability of contraception leads to an increase in the abortion rate".

Verkuyl also attacks natural family planning (NFP). In a poor rural area of Ethiopia between 1982 and 1990, the crude birth rate fell from 38 to 16·6 per thousand population and the fertility rate from 159 to 77 per thousand fertile women.[2] These decreases are attributable to an immunisation programme, to more children surviving, and to the use of natural family planning—truly preventive medicine.

Surely such an approach, which involved good primary health care, respect for the individual as a person, and acceptability to the local population, is better than forcing control from outside. NFP has no harmful physical side-effects—like Verkuyl I have seen patients with anaemia and gross pelvic infection in which the culprit was inappropriate use of family planning.

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1 King M. Health is a sustainable state. *Lancet* 1990; **336:** 664–67.
2 Webster F. Evaluation of the public health and development programme. Attat Hospital, 1982 to 1990. Ethiopia: Attat Hospital, 1990.

Runaway drug prices in Pakistan

SIR—The Ministry of Health of Pakistan has taken a novel step—removal of drug price control. The repercussions of this action are far reachng, which has caused an uproar in the public and profession alike.

Routinely, drug prices rise with the announcement of the annual budget. At present 20 multinational and national companies account for 50% of drugs on the market. These companies had threatened to close down if price revision was not done. It is also noteworthy that drugs banned or withdrawn for retesting in the USA and Europe remain widely available in third-world markets. The Ministry has justified this policy by stating that out of 13 000 drugs the prices of only 816 have been raised, and by a mere 5%. These 816 are front-line drugs, which will start a trend with respect to price rises for innumerable preparations. The Ministry also claims that only vitamins and cough syrups will be affected, which is not the true picture. New drugs yet to enter the market will be devoid of any control whatsoever.

This move is unjustified because companies make a 700% profit at the manufacturing stage alone. When this policy was announced, an immediate 100% increase in drug prices was noted. The price of drugs such as Ascorbon jumped by 300%. With respect to "registered" drugs, WHO has provided a list of 243 drugs that covers all common ailments, but in Pakistan the number has risen to 13 000. As long as corrupt officials occupy key positions, registration should not be a problem. Once registered, drugs, even if similar in formulation, are entitled to be treated under the umbrella of the now non-existent drug price control policy.

People are already having a tough time covering medical expenses. The government has covered health care with state-run hospitals but with few drugs. Even if admitted, the patient has to foot the bill for drugs and clinical investigations (only basic investigations can be done). Problems such as overcrowding, unhygienic conditions, lack of proper sewage disposal, and contaminated water have already caused infections to top the diseases list, causing a high level of mortality and morbidity. The situation has been compounded by blanket prescriptions of antimicrobials without adequate culture and sensitivity testing, which has created resistant strains of micro-organisms, which respond only to the newer antimicrobials. If the multinationals reduced their expenditure on introductory and promotional publicity campaigns then the need to increase prices would not be the only way to maintain profits.

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Is the study worth doing?

SIR—In a comprehensive review of criteria for deciding whether a study is worth doing, Carpenter (July 24 p 221) emphasises the idea that, other than in exceptional circumstances, a study is only worth doing if it is sufficiently large to achieve a prespecified level of statistical power to detect a prespecified size of effect. However, the development of meta-analysis in the past 10 years has put the question of the required size of individual studies in a quite different light. If one takes the view that there is now a comprehensive, developed, and reliable technology for combining the results from small studies, does this criterion still apply? Certainly, if several small studies have already been published which, taken together, are still not sufficient to determine whether a critical advantage is present or not, then another small study, of itself too small to detect such an effect with any power, may be adequate to settle the issue. Indeed, even if the study is pioneering, the position often taken by statisticians that it is both unethical to subject patients to alternative treatments in a trial which is not large enough to resolve the question[1] and that small trials are "essentially futile"[2] is clearly no longer valid. Small well-designed studies yielding high quality data may, in the long run, be more useful than large and relatively poorly conducted multicentre studies, for example. It might now be time when we are refereeing research proposals to pay more attention to the probable quality of data and coherence with other research and less attention to quantity and power.

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1 Altman DG, Gore SM. How large a sample? In: Statistics in practice. London: British Medical Association, 1982.
2 Pocock SJ. Clinical trials: a practical approach. Chichester: Wiley, 1984.

Gun laws

SIR—How amusing it is to see recreated in *The Lancet* (May 29, p 1375; July 10, p 111) the vituperative debate on guns which is common in American society. In response to any attention given to deaths from gunshot wounds, the usual cast of characters makes its appearances. Blackman is the National Rifle Association (NRA) staff member whose job it is to write responses to articles such as your editorial. Individuals such as Waite like to misquote the Second Amendment to the US Constitution and paint unsubstantiated pictures of what life in America would be like if guns were outlawed. And then there are individuals such as Sutter and his organisation, who firmly believe and loudly proclaim that any scientific research showing that gun availability is linked to violent death is obviously incompetent or, worse, represents scientific misconduct. They regard prestigious journals such as the *New England Journal of Medicine* as "biased, myopic and politicized", and disregard the process of rigorous peer review of published articles. Such can hardly be said of the publications that they cite to support their positions.