

in emergencies. In more controlled circumstances, however, efforts should be made to confirm the presence of hypoxia by pulse oximetry before giving oxygen. In this way normoxic patients, who do not require treatment with oxygen, will avoid the risks associated with hyperoxia.

Pulse oximeters should be available in all clinical areas where acutely ill patients are managed and oxygen is given, allowing oxygen saturation to be monitored on a continuous basis. At the very least, oxyhaemoglobin saturation should be documented before and intermittently during oxygen therapy. Supplemental oxygen can then be given on a rational basis focusing on the attainment of target oxygen saturations, which may differ between patient groups, rather than on using fixed flow rates. However, patients requiring high inspired oxygen concentrations to maintain adequate oxygen saturations must always be cared for in areas where intensive monitoring is available. In addition, arterial blood gas analysis can be done if necessary to confirm that appropriate oxygen and carbon dioxide tensions, and pH, have been achieved. In this way patients can get oxygen therapy that is tailored to their need and the unfavourable cardiopulmonary effects of hyperoxia can be minimised. The use of oxygen prescription charts similar to those advocated by Dodd and colleagues may, in non-specialist areas, help achieve these aims.¹

Oxygen therapy remains a cornerstone of modern medical practice. To further quantify the risks associated with hyperoxia more trials are needed. The results of well conducted trials may lead to refinements in the use of oxygen. Unfortunately, due to its accepted role in therapeutic practice and virtually non-existent potential for commercial development, oxygen therapy has attracted little research funding in recent years. At present doctors should strive to ensure that oxygen is prescribed, administered, and monitored

with care. This will enable us to achieve optimal tissue oxygenation for more of our patients.

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Adoption by lesbian couples

Is it in the best interests of the child?

The report of the American Academy of Pediatrics in February¹ supporting the introduction of legislation to allow the adoption by co-parents of children born to lesbian couples sparked enormous controversy not only within the medical profession but among the public as well. Almost without exception, only the mother who gives birth to or adopts the child may currently be the legal parent, even in cases where a couple plan a family together and raise their child in a stable family unit. The academy has taken the view that children in this situation deserve the security of two legally recognised parents in order to promote psychological wellbeing and to enable the child's relationship with the co-mother to continue should the other mother die, become incapacitated, or the couple separate. This position is based on evidence derived from the research literature on this issue.² The *Washington Times* described the

stance of the academy as “an unfortunate surrender to political expediency” and accused the academy's Committee on Psychosociological Aspects of Child and Family Health of sacrificing scientific integrity in order to advance an activist agenda.³ Is it the case that children born to lesbian couples “can have the same advantages and the same expectations for health, adjustment, and development as can parents who are heterosexual,” as stated by the academy? Alternatively, is the academy simply pandering to a politically correct agenda?

Two main concerns have been expressed in relation to lesbian mother families: firstly, that the children would be bullied and ostracised by peers and would consequently develop psychological problems, and, secondly, that they would show atypical gender development such that boys would be less masculine in their identity and behaviour, and girls less feminine,

than boys and girls from heterosexual families. Lack of knowledge about these children and their parents in the light of a growing number of child custody cases involving a lesbian mother prompted the first wave of studies in the 1970s. This early body of research focused on families where the child had been born into a heterosexual family and then moved with the mother into a lesbian family after the parents' separation or divorce. Regardless of the geographical or demographic characteristics of the families studied, the findings of these early investigations were strikingly consistent. Children from lesbian mother families did not show a higher rate of psychological disorder or difficulties in peer relationships than their counterparts from heterosexual homes. With respect to gender development, there was no evidence of confusion about gender identity among these children, and no difference in sex role behaviour between children in lesbian and heterosexual families for either boys or girls.^{4 5}

A limitation of the early investigations was that only school age children were studied. It was argued that sleeper effects may exist such that children raised in lesbian mother families may experience difficulties in emotional wellbeing and in intimate relationships when they grow up. Further, they may be more likely than other children to themselves adopt a lesbian or gay sexual orientation in adulthood, an outcome that has been considered undesirable by courts of law. To address this question, a group of children raised in lesbian mother families in the United Kingdom was followed up to adulthood.^{6 7} These young adults did not differ from their counterparts from heterosexual families in terms of quality of family relationships, psychological adjustment, or quality of peer relationships. With respect to their sexual orientation, the large majority of children from lesbian families identified as heterosexual in adulthood.

In recent years, attention has moved from the issue of child custody to whether lesbian women should have access to assisted reproduction procedures, particularly donor insemination, to enable them to have children without the involvement of a male partner. The findings from studies of these families, where the children grow up without a father right from the start, indicate that the children do not differ from their peers in two parent, heterosexual families in terms of

either emotional wellbeing or gender development.⁸⁻¹¹ The only clear difference to emerge is that co-mothers in two parent lesbian families are more involved in parenting than are fathers from two parent homes.

A limitation of the existing body of research is that only small volunteer or convenience samples have been studied, and thus mothers whose children are experiencing difficulties may be under-represented. Nevertheless, a substantial body of evidence indicates that children raised by lesbian mothers do not differ from other children in key aspects of psychological development. On the basis of this evidence it seems that the American Academy of Pediatrics acted not out of political correctness but with the intention of protecting children who are likely to benefit from the legal recognition of their second parent. At present in the United Kingdom, lesbian women are individually eligible to adopt children, whether living with a partner or not. However, members of parliament have recently voted to allow unmarried couples, whatever their sexual orientation, to adopt children jointly.

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Forensic pathology services

Quality must be guaranteed

Forensic pathology services are an essential part of systems of investigating deaths worldwide. In England and Wales these forensic services, the entire death investigation system, and the coroner service are currently under review. Forensic pathology in Britain has had chronic problems as an orphan specialty excluded from the NHS at its inception and now largely ejected from the universities. Today the 35 or so pathologists accredited by the Home Office are con-

tracted to police forces to support the investigation of suspicious deaths and homicides. About half are in full time private practice. They also provide autopsy services to local coroners, but most of the 120 000 coroner's autopsies performed annually are carried out by NHS pathologists as an approved form of private practice.¹

The chronic problems of the forensic pathology service have now precipitated a review by the home

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