Easter 2008

for today's Christian doctor

triple helix

Act justly

HFE Bill, ethics teaching, SSMs, communication, gambling, medical retirement, parish nursing, reviews, news from abroad

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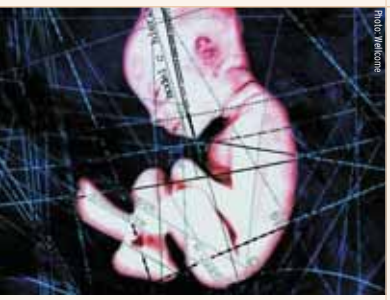
contents

Reducing the upper abortion limit

Time for change



The Human Fertilisation and Embryology Bill, currently before Parliament, opens the 1967 Abortion Act up for amendment. The upper limit for so-called 'social abortion' was initially 28 weeks but was lowered to 24 weeks by the 1990 Human Fertilisation and Embryology Act. This change reflected improvements in neonatal care. More premature babies were surviving at lower gestations and under the Infant Life Preservation Act, which is still in force, it remains a crime to abort a baby 'capable of being born alive'.

In written evidence submitted to the House of Commons Science and Technology Committee it was noted that 63% of MPs, nearly two thirds of the public and more than three-quarters of women support a reduction in the 24-week upper age limit. 76% of the public think that aborting a baby at six months is cruel.[1] A recent poll by Marie Stopes International[2] found that two thirds of GPs wanted a reduction from 24 weeks. It is therefore somewhat ironic that the BMA remains opposed to a reduction and suggests that the BMA is overly influenced by pro-choice activists and out of touch with grass-roots opinion.

It is not hard to understand why public opinion has changed. Professor Stuart Campbell's highly publicised 4D ultrasound images have shown babies in amazing detail 'walking in the womb' from 12 weeks and stories of babies born alive after failed abortions are increasingly common.[3] A March 2007 paper[4] presented data on termination of pregnancy for fetal anomaly from a large population-based cohort of births occurring within a 10-year period from 1995 to 2004 in the West Midlands region of the UK. The authors found that out of a total of 3,189 cases of termination for fetal anomaly, 102 (3.2%) babies were born alive. These live births occurred in 18 out of the 20 maternity units in the West Midlands, and the proportions at different gestations were 14.7% between 16 and 20 weeks, 65.7% between 20 and 24 weeks and 19.6% at or after 24 weeks. Accounts such as these understandably shock the public.

Adding to the growing perception of the humanity of the fetus is the evidence that increasing numbers of babies in the very best neonatal units are surviving below 24 weeks. Individual high profile cases like Manchester's Millie McDonagh,[5] born after a 22-week pregnancy and the world's most premature baby, and Amillia Taylor, who was born a week younger in the US on 24 October 2006,[6] are well known.

The EPICure study,[7] which is used by institutions like the RCOG and BMA to justify not lowering the abortion limit, has been criticised for averaging out survival rates across a variety of UK centres to create the false impression that survival rates of premature babies have not improved. But in the best centres, such as in Minneapolis, Minnesota, 66% of babies born at 23 weeks will survive.[8] A recent study from University College London,[9] which made headline news,[10] confirmed these data in a UK context and showed that the level of disability in premature babies is much less than is commonly believed.

And then there is the question of whether fetuses feel pain. The general public intuitively conclude that they do when they hear that from 16 weeks babies will recoil from a noxious stimulus in the womb and that premature babies born earlier than 24 weeks, if stabbed in the heel with a needle, will withdraw and cry. Some experts claim that it is just a complex reflex we are observing, that babies of this age do not have the proper neurological connections between thalamus and cortex to sense pain. But others, like Professor KJ Anand from the University of Arkansas, who recently addressed MPs in Parliament,[11] say that this view is based on an outdated understanding of physiology, and that fetuses do have the apparatus to feel pain down to 18 weeks.[12]

Of course, hormone changes, neurological connections and reflexes do not prove that fetuses feel pain but it seems reasonable to give them the benefit of the doubt. Can any of us imagine telling the mother in a first pregnancy who feels kicks at 19 weeks, or at 17 weeks in a later pregnancy, that her baby is not a sentient being worthy of the utmost respect? And we know that babies are 'alive and kicking' much younger than this when their limbs are too small to be felt.

Although we would argue that the value to God of an unborn baby's life is not determined by its capacity for sentience, movement, physiological response or survival outside the womb, but rather by the fact that God knows it,[13] nonetheless, these considerations are increasingly important to many in the general public and are fuelling a demand for a decrease in the 24 week upper time limit. The country may not yet be ready for major restrictions to abortion, however much we might want to see them. However, the tide of public opinion is turning and a lowering of the upper limit, even to 20 weeks, will save over 3,000 human lives a year.

***Peter Saunders** is CMF General Secretary*

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news reviews

Stem Cell Delusions

The government juggernaut rolls on

Review by **Peter Saunders**
CMF General Secretary

In order for a belief to be considered delusional, argued the psychiatrist and philosopher Karl Jaspers, it must be held with absolute conviction and not be changed by compelling counterargument to the contrary. The determination with which the British government has pursued embryonic stem cell research, despite its failure to deliver new therapies, fulfils this definition.

CMF has long opposed embryonic stem cell research as *unethical* on the basis that, by destroying human blastocysts in order to extract stem cells, it uses embryonic humans as a means to an end. But the evidence is growing that embryonic stem cell research is also *unnecessary*, as ethical alternatives to embryonic stem cells yield more treatments each month.[1]

The government, on the basis of the (long outdated) 1999 Donaldson Report, has consistently argued that embryonic stem cells were more versatile than adult or umbilical cord blood stem cells and could potentially be used therefore to treat a greater range of diseases. In order to overcome the problems with immune rejection of donor cells, it further recommended that embryonic stem cells be harvested from embryos produced by cell nuclear replacement ('therapeutic cloning'), the same technique used to produce Dolly the Sheep. The patient's own somatic cell nuclei were to be placed into enucleated eggs.

The main problem with this technique was the low success rate (it took 277 attempts to produce Dolly). Difficulties in obtaining the large number of eggs and the highly publicised risks to donors of ovarian hyperstimulation syndrome (OHSS) have now led to a change in strategy; the use of animal-human hybrids produced by the same cloning technique.

The Human Fertilisation and Embryology Bill, currently before Parliament, seeks to legalise this practice, although in a flagrant abuse of the democratic process, the HFEA recently granted two licences for producing animal human hybrids even before the bill had passed.[2] Ironically, on the very day the House of Lords was debating the issue, researchers in both Japan (Yamanaka) and the United States (Thomson) announced that, by inserting four genes, they had successfully reprogrammed human skin cells into cells with all the properties of human embryonic cells,[3] leading Dolly's creator Ian Wilmut publicly to say he was abandoning cloning technology.[4]

To date, not a single embryonic stem cell line has been produced from cloned human embryos, whilst there are over 70 diseases that are currently being treated successfully using adult or umbilical cord blood stem cells.[5] David Burrowes MP, in introducing a recent bill to improve the harvesting and use of cord blood stem cells has further highlighted the fact that the government has its eggs in the wrong basket.[6]

As the truth continues to emerge, there will no doubt be many suffering from degenerative diseases who will be asking why they have not been told the truth and why the government, backed by self-interested biotechnology companies, continues, against the evidence, to drive down a scientific blind alley.

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Open all hours?

The BMA clash with the government over plans for extended open hours

Review by **Rachael Pickering**
Triple Helix Associate Editor

The New Year kicked off with an announcement of yet another NHS shake-up. In a speech pegged around the forthcoming 60th anniversary of the NHS, Gordon Brown revealed that the nation's rarely-seen-in-the-NHS, *healthy* citizens are to be encouraged to see the doctor anyway, in order to prevent them turning into sick, expensive patients.[1] The Prime Minister committed the NHS to a screening programme to rival the private sector: 'the health service has really got to change...from being the curative service... to being also a preventative service'. And it's going to be less *www.nhs.uk* and more *www.my-nhs.uk* : 'So you get to see the doctor you want at the time you want and the hospital you want'.[2]

The Prime Minister also hinted that he would make getting to see the doctor a whole lot easier. And sure enough, following up on Labour's pre-election-that-never-was promise,[3] a plan to get GPs to work evenings and Saturdays for no extra pay was unveiled in early February. The BMA declared it a lose-lose situation for GPs – accept Plan A or have Plan B (an even worse financial deal) imposed on you – but Health Secretary Alan Johnson went over their heads and appealed direct to every GP partner in the land.[4]

How then should we assess this situation? We could look at things financially. This proposal could make a huge dent in many CMF members' wallets. Should that matter though? After all, Christians are not meant to be motivated by money.[5] On the other hand, a 'worker deserves his wages'[6] and accepting what is actually a back door pay cut will make giving cheerfully to the Lord somewhat harder![7]

The deeper approach is to ask why the government feels the need to drive through these screening and opening hours measures. Gordon Brown's speech provides our answer: he is doing all this to 'meet the rising expectations of the British people'. *Consumerism* – the desire to 'have it perfect' with a perfect service and perfect health – is the driving force behind this and all other recent NHS initiatives.

What then should we do? We should pray for a lasting solution for the NHS. Pray for the healing of our nation from the sickness of consumerism.[8]

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Abortion

Misinformation in high places

Review by **Peter Saunders**
CMF General Secretary

The Human Fertilisation and Embryology Bill, currently before Parliament, does not specifically deal with abortion but does nonetheless open up the whole of the Abortion Act 1967 for amendment. This is because its predecessor, the 1990 HFE Act, lowered the upper limit for so-called 'social abortion' from 28 to 24 weeks and raised the limit on disability from 28 weeks to birth.

Since 1967 there have been almost 7 million abortions, now 200,000 a year, with one in four pregnancies ending in abortion. Despite this there is a concerted move amongst pro-choice activists, abortion providers, some MPs, and institutions like the RCOG and BMA further to liberalise the law.[1] To support this agenda there has been misinformation in very high places.

The House of Commons Science and Technology Committee, chaired by Liberal Democrat MP Phil Willis, reported on 31 October 2007 after an enquiry into scientific developments relating to the Abortion Act. It recommended no lowering of the 24 week upper limit for 'social abortion', scrapping the need for two doctors' signatures, nurses doing abortions, and medical abortions in GP surgeries with completion at home. The committee report is important because it has since been accepted by the government and is already being used to inform Peers and MPs debating amendments to the 1967 Act.

However, serious questions have been asked about vested interests, transparency and competence. The pro-choice composition of the committee had been very clear from the beginning and although the written evidence received was relatively evenly balanced, 13 of the 18 witnesses chosen to give oral evidence were coming from a pro-liberalisation perspective.

A minority report issued by MPs and committee members Nadine Dorries and Bob Spink claimed that the committee selected evidence and experts on key issues such as neonatal survival, foetal pain and the relationship between abortion and preterm birth, mental health problems and breast cancer to support a pro-choice agenda. It later emerged in media reports that the committee's report was largely rewritten by Liberal Democrat MP Evan Harris. Harris, who is Secretary to the All Party Prochoice and Sexual Health Group of MPs and whose partner works for the BPAS, one of the country's largest abortion providers, allegedly put down 126 amendments to the Chairman's first draft, some running to more than a page.[2] He has campaigned vigorously for more liberal abortion laws for many years, and has also used his position on the BMA Ethics Committee to influence that organisation's policy on abortion. Harris later set out to discredit in the national press witnesses, including some CMF members, whose evidence he didn't like.[3]

We would recommend that MPs make an effort to read Dorries and Spinks' minority report and make some attempt to review the reams of written and oral evidence received by the committee that have been sidelined and ignored. All the evidence submitted to the committee, including the final committee report, the minority report and relevant press coverage, is accessible via the CMF website.[4]

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Opt-out or opt-in?

Organ donation policy

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

In 2007 about a thousand people died in the UK while on the organ transplant list or having recently been removed from it because they were too ill. It is claimed that a system of 'presumed consent' – where unless you have specifically opted out it will be presumed you are thereby opting in – would have made many more organs available and would have saved lives.[1] An anonymous account by an NHS doctor of her husband's untimely death[2] can only add to the pressure to do something about the gap, but is opting out the right way to go?

In a 2007 CMF submission[3] to a House of Lords Select Committee we expressed strong support for the principle of organ transplantation and saw no major ethical problems *per se*. Regarding opt-out we noted that CMF had not yet been able to hold a full debate, were aware that British Medical Association policy was to support an opting-out principle, and were aware of statistics in several EU countries reporting increased retrieval rates after introducing opt-out policies.

However, we placed much emphasis on the theological basis for our support for donation – namely that of altruistic free gift in a context of fully informed consent. A national opting-out policy would mean that at death the body effectively became the property of the state, and for many Christians this would conflict with the respect owed in biblical and church tradition to the dead body. We had commented extensively on this in a 2002 submission to the Department of Health.[4] Pragmatically, there remains much concern in the UK about the retention of tissue and organs following the Alder Hey scandal, and this may have motivated Parliament when in 2004 it rejected opt-out.

We recognise though the low rates of organ transplantation in the UK. We understand why an opting-out system seems attractive and if the UK is to continue opposing it, we must all do more to increase rates of donation. The Christian church should teach and support the principles of organ donation and transplantation. To the extent that Christian teaching influences public choices we hope this would increase donation rates, though people dislike planning for death because they do not like intimations of mortality. Some celebrities have lent their support to blood donation and bone marrow donation. Prominent Christian figures should join such role models in encouraging organ donation.

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Helen Barratt advocates action to achieve the Millennium Development Goals

Photo: PA Photos

ACT JUSTLY

key points

In 2000 the eight Millennium Development Goals aimed to meet the needs of the world's poorest by 2015, but just over half-way, most governments are not keeping their promises.

Three Goals concern health, and there is a long way to go. We should concentrate on 'the causes of the causes' and tackle the social determinants of health.

The 'Micah Challenge' encourages Christians to 'act justly and to love mercy and to walk humbly with your God'. Specifically, we should hold leaders accountable in securing a more just and merciful world.

In sub-Saharan Africa in 2005, the mortality rate in children under five averaged 169 deaths per 1,000 live births – 28 times the industrialised country average of six deaths per 1,000.[1] More than 500,000 women die each year in childbirth, most of them in developing countries.[2] Worldwide, 39.5 million adults and children are currently living with HIV/AIDS and almost 4.3 million new infections occurred in 2006.[3]

Back in 2000 at the United Nations Millennium Summit, leaders from 189 countries, including the UK, adopted the UN Millennium Declaration. From this an eight-goal action plan, the 'Millennium Development Goals' (MDGs), was promoted, to meet the needs of the world's poorest by 2015. Summarised in the box, the goals range from providing primary education to environmental sustainability.

The Millennium Development Goals (MDGs)

1: Eradicate extreme poverty and hunger
2: Achieve universal primary education
3: Promote gender equality and empower women
4: Reduce child mortality
5: Improve maternal health
6: Combat HIV/AIDS, malaria, and other diseases
7: Ensure environmental sustainability
8: Develop a global partnership for development

Healthy targets?

Supported by both rich and poor nations, the MDGs address key development challenges. However, no clear implementation plan was put in place, and the initiative was poorly resourced. In 2008, we stand just over halfway to the target date of 2015, yet – despite all the good intentions – most governments are not keeping their promises, and the UN itself has admitted 'there is a long way to go to keep our promises to current and future generations'.[4]

Health is at the centre of the MDGs (Goals 4 to 6), and the Summit pledged to:

- Reduce by two-thirds, between 1990 and 2015, the number of children five years old or younger who die from preventable illnesses
- Reduce by three-quarters, between 1990 and 2015, the number of women who die giving birth
- Have halted by 2015 and begun to reverse the spread of HIV/AIDS
- Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Although some progress has been made, there is a long way to go. Unless efforts are increased, particularly in sub-Saharan Africa and Asia, there is little hope of eliminating avoidable child deaths. More children are surviving their first years of life but, if current trends continue, the MDG will not be achieved until 2045 – 30 years too late.[5] Ratios of maternal mortality also seem to have changed little in regions where most deaths occur (sub-Saharan Africa and Southern Asia). Inequality between urban and rural care at the time of delivery still exists within many countries, particularly in sub-Saharan Africa. Several countries report success in reducing HIV infection rates, largely through interventions that promote behaviour change. However, rates of infection overall are still growing, and deaths continue to increase. The epidemic remains centred in sub-Saharan Africa, believed to be home to 64 per cent of HIV-positive people and to 90 per cent of children under the age

of one living with the virus. Twelve million children in this region have also been orphaned by the virus. Additionally, new tuberculosis cases are on the rise, at a rate of one per cent per year, with the fastest increases again in sub-Saharan Africa.[6]

Achieving health equity

Health is a universal aspiration and a basic need, yet massive inequities – unjust inequalities – exist worldwide. Those in low-income countries suffer from higher rates of illness, particularly infectious diseases. Scarcity of food, poor sanitation, and lack of medical care all contribute. Traditionally, Western response has been to throw money at these problems to increase local financial resources, but is there more to it than this?

The World Health Organisation (WHO) Commission on Social Determinants of Health helps countries and global health partners address the social factors leading to ill health and inequities. Going beyond the contemporary concentration on the immediate causes of disease, the Commission seeks to focus on 'the causes of the causes', to tackle the social determinants of health, including unemployment, unsafe workplaces, urban slums, globalisation and lack of access to health systems.[7]

Commission chair Professor Sir Michael Marmot argues that 'although the Commission recognises the contribution that economic growth can make to the availability of resources for reducing health inequities, growth *per se* is not a sufficient prescription for equitable improvements in population health… rather action within and between countries to mitigate and remove structural, destructive inequality is the necessary counterpart to worldwide growth'.[8]

WHO hopes the Commission will launch a global movement that perceives equitable health as a societal good by emphasising 'the social determinants of health that are known to be among the worst causes of poor health and inequalities between and within countries'.[9]

The outcry against health inequity has been growing around the world for many years, and the 'Make Poverty History' campaign, established in 2005 when the UK hosted the G8 summit, did much to raise public awareness about the financial problems faced by developing countries, such as unjust trade systems and crippling debt burdens. However, halfway to the MDG target date of 2015, further action is needed – and governments must be held to account – if the goals are to be achieved.

'What does the Lord require of you?'

I'd not really thought about all this before moving from clinical medicine into public health, but the more I learn, the more I realise that much of the work I do is profoundly Christian. Proverbs 31:8 could be the mission statement of many global public health initiatives: 'speak up for those who cannot speak for themselves'. Indeed there are over 2,000 biblical references to poverty and injustice, from the Old Testament prophets who spoke out against personal behaviour that exploited the poor, to the parable of the Good Samaritan[10] and numerous examples of Jesus speaking up and acting for the poor.

God clearly has the poor in his heart. He calls us to act with mercy[11] and to love our neighbour,[12] and will call us to account for our action or lack of it.[13] Our social involvement also ultimately bears witness to the transforming grace of Jesus Christ. With him as our example, being involved in social justice encourages us to examine our attitudes not only to the poor, but also to our possessions and economic power. Jesus warns those who store up treasures on earth: 'woe to you who are rich, for you have already received your comfort. Woe to you who are well fed now, for you will go hungry.'[14] We constantly need to be seeking God's guidance about using our material blessings.

Although the MDGs may not be met by 2015, progress has been made, and many Christian agencies have contributed. Those whom God has not called to work overseas should support this vital work financially, but we need more than generous individuals. We need governments to respond with generosity and justice to the needs of the poor, to address more than merely the immediate causes of disease.

The Micah Challenge

Micah Challenge UK is a coalition of Christian organisations and churches, of which CMF is a core member, united to fight global poverty and hold our government to account for its MDG promises. It is part of a global initiative seeking to unite Christians in speaking out against injustices.[15]

The 'challenge' is Micah 6:8. 'And what does the Lord require of you? To act justly and to love mercy and to walk humbly with your God.' By highlighting such biblical truths, Micah Challenge seeks to sensitise and engage Christians into greater political and practical involvement in poverty issues. It inspires Christians to pray, take action, speak out, and engage with these issues, in the UK and overseas. Building on the momentum of 'Make Poverty History', the coalition will run 'Micah Challenges' to keep the spotlight on Government about delivering the MDGs by 2015.

Focusing on five key areas – AIDS treatment, water and sanitation, climate chaos, trade justice and primary education – the 'Blow the Whistle' campaign in 2007 examined the 'half-time scores' so that extreme poverty and hunger might really be halved by 2015. In 2008, the 'Take Five' campaign[16] focuses on a different MDG each month, providing information, practical ways to take action, specific prayer points, and guidance about lobbying.

Micah Challenge seeks to encourage believers to work together to pursue justice, to call decision-makers to act on their MDG promises, and to work with others in holding leaders accountable in securing a more just and merciful world. Will you take the Challenge?

Helen Barratt *is a Specialty Registrar in public health in London and an Academic Clinical Fellow at University College London*

Photo: PA Photos

what can I do?

- Visit *www.micahchallenge.org.uk* and sign The Micah Call
- 'Take Five' this month – learn more, pray and do a Micah action
- Encourage your local church to take up the Challenge too
- Pray for those negotiating around the MDGs

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Wendy Hiscox looks at who's teaching what...

Photo: PA Photos

Teaching ETHICS

key points

Recent research into medical ethics teaching in UK medical schools concluded that although ethics is now an accepted component of the curriculum, 'more can be done to ensure that the recommended content is taught and assessed optimally'.

The author argues that 'bedside ethics' teaching alone is insufficient and a solid grounding in fundamental theory helps cultivate a professional disposition and approach that lessens the prospect of ethical problems arising in the first place.

Ethics is never morally neutral, and the views and behaviour of teachers and the culture within each medical school are highly significant influences. We should be alert to the 'hidden curriculum'.

Setting the scene

The place of ethics in the undergraduate curriculum continues to be a hot topic in UK medical schools. For many years now, few have disputed that medical students should be introduced in the classroom to the wide array of ethical issues in medicine. This early exposure provides necessary ethical foundations upon which to build during subsequent training. In an effort to provide some guidance and uniformity across the UK, a 1998 consensus statement outlined the core undergraduate curriculum for ethics and law.[1] In the intervening decade though, much has transpired – Harold Shipman, the Bristol Royal Infirmary and Alder Hey scandals, not to mention the many remarkable technological advances in medicine. Fresh, up-to-date guidance is desperately needed.

Research

Recently, two researchers from the Peninsula Medical School investigated the current situation, looking at the learning, teaching and assessment of ethics in UK medical schools, and also the training and expertise of the teachers.[2,3] Mattick and Bligh analysed completed postal questionnaires from 22 of the 28 UK medical schools, looking at answers relating to each school's approach to ethics teaching, staffing matters, and assessment.[4] Participants also described the particular strengths and weaknesses of their ethics teaching, and identified their future concerns.

Mattick and Bligh's conclusion was that, although ethics is now an accepted component of the medical curriculum, 'more can be done to ensure that the recommended content is taught and assessed optimally'.[5] Whilst agreeing with this, my own investigations lead me to conclude that several areas require further exploration.

Bedside ethics

Medical ethics teaching is designed to produce sensitive doctors who are well-equipped to recognise and resolve the ethical dilemmas they face in medical practice.[6] One lingering area of debate, however, concerns the importance of a thorough appreciation of the theoretical or philosophical base that underpins medical ethics discourse. Only half of Mattick and Bligh's respondents specified providing a conceptual or theoretical understanding of ethics as an objective of ethics teaching.[7] This is in keeping with my initial research: all too often, very little theory is covered and the level of philosophical sophistication among medical students is not consistently high. Integrating theory into clinical

scenarios was found to be more popular with students, whereas formal or systematic emphasis on ethical theory and principles was generally considered to be uninspiring.[8] This raises concerns about downplaying the importance of theory. Ethical principles are giving way to 'bedside ethics'.

A basic understanding of medical theory is necessary for students to become good and capable doctors. Likewise with ethics: might not students fail to recognise ethically sensitive issues if they are placed in a clinical setting prior to being introduced to general ethical theories and principles in the classroom?[9] Moreover, a solid grounding in fundamental theory arguably helps to cultivate a professional disposition and approach that lessens the prospect of ethical problems arising in the first place.[10]

Whilst it is plainly *not* advantageous to have ethics teaching wholly divorced from clinical reality, some issues do require a familiarity and understanding of basic ethical principles. Can one fully appreciate the importance of obtaining informed consent from patients without rigorous exploration of the principles of autonomy and paternalism? A detailed understanding of fundamental theory therefore lies at the core of ethics education and, assuming it is given some clinical relevance by the individual teacher, any scepticism about its value seems misplaced.

Who's teaching what?

Although it may be accepted that contemporary medical ethics education should not impose a particular ethical perspective, ethics by its very nature is not a morally neutral discipline. Nor is ethics taught in a vacuum: beliefs invariably are defended and encouraged depending on one's ethical standpoint. This central issue needs careful unpacking if we are to gain an accurate understanding of medical ethics teaching in this country.

My research into the ethical standpoint of individual teachers revealed that medical ethics is being taught from a variety of different perspectives. Ethics teachers are a decidedly diverse group.[11] A wide range of attitudes and beliefs exists – utilitarian, virtue ethics, religious or otherwise. The content and approach taken to medical ethics teaching cannot fail to be influenced, however subtly, by the particular teacher's philosophical leanings. For example, the utilitarian approach embraced by Professor Julian Savulescu at the University of Oxford and Professor Jonathan Glover at King's College London lies in sharp contrast to the Aristotelian perspective of Dr June Jones at Birmingham University and the Christian approach of Dr John Lennox at Green College Oxford.

Hidden curriculum

Another area that could be investigated is the ethos or 'hidden curriculum' of each particular institution.[12] It can be argued that it is the *medical school's* culture and the subtle values and behaviour of its *teachers* that ultimately determine a student's own values and behaviour.[13] This reinforces the need to consider the ethical perspectives of individual ethics teachers,[14] and also means that any ethics curriculum must take into account the broader cultural milieu within which it exists.[15] Those who teach ethics must focus on the formation of their students' characters and the cultivation of desirable attitudes not only by teaching about virtue, but by serving as positive role models. Negative role modelling by those who lack ethical sensitivity and exhibit inappropriate behaviour is destructive and can single-handedly undermine the formal ethics training of medical students.[16] The hidden curriculum is something, therefore, that we cannot afford to ignore.

Further scope

An exploration of links with other programmes and faculties (law and philosophy for example) or of other institutions where medical ethics is being taught would have been useful, and arguably would further have enhanced the Peninsula study.[17] The University of Manchester, for example, offers a BSc in Health Care Ethics and Law, which is open to medical students who take a year out of their medical degree. Similar options are available at Imperial, Birmingham, Leeds, and Bristol to name but a few.

Non-medical institutions also offer ethics-related degrees. My own faculty, St Mary's University College, offers an MA in Bioethics, which several CMF members (including medical students) have undertaken. Middlesex University also runs an MA programme in Ethics and Law in Healthcare Practice. The Centre for Professional Ethics offers an MA and Postgraduate Diploma in Bioethics and Medical Law. These are all important pieces of the UK's ethics jigsaw puzzle, and offer scope for additional research into ethics teaching to be undertaken.

Conclusion

Mattick and Bligh's conclusion that ethics 'now has an established place within the undergraduate core curriculum'[18] may be somewhat premature. Whilst ethics undoubtedly is firmly established at the majority of medical schools – with Leeds, Birmingham and Oxford being notable models – several institutions continue to tack it on as a mere 'addendum' to the curriculum, viewing it as 'form' rather than 'substance'. The Peninsula study goes some way to isolating many of the manifold challenges facing ethics educators today. Nonetheless, much more work needs to be done before we can see the complete picture that is UK medical school ethics teaching.

Wendy Hiscox *is a lecturer at St Mary's University College, Twickenham*

Photo: PA Photos

The hidden curriculum is something we cannot afford to ignore

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Sarah Gwynne enthuses about a new opportunity

Special study modules in Christian medical ethics

Imagine if *Christian* students were allowed to study *Christian* medical ethics at *medical school*! Five medical schools around the UK are doing just that, running special study modules (SSMs) in medical ethics from a Christian perspective.

To date there are courses running for between two and eight weeks in Birmingham, Cardiff, Leicester, Newcastle and Oxford. In Cardiff we ran our first SSM in 2007 and we want to encourage others to consider doing the same.

What are SSMs?

SSMs, also known as student selected components (SSCs), are increasingly a part of the UK medical curriculum. They give students opportunity to study areas of medicine that are of personal interest to them. Some CMF members have grasped this opportunity to teach medical ethics from a Christian perspective in an SSM.

How did I get involved?

After hearing about SSMs in other medical schools I wondered if we could do the same in Cardiff. Local CMF students were overwhelmingly positive about the idea.

SSMs can be started either by a tutor submitting a proposal (as I did) or by students making their own requests.

What did we cover?

We looked at the theoretical basis of ethics from secular and biblical perspectives. We then covered specific topics such as abortion, euthanasia, brainstem death, conscientious objection and the Mental Capacity Act.

Students had two or three tutorials a week with the rest of the time spent researching a chosen topic. These included end of life issues, abortion, circumcision, and the human papilloma virus vaccine. Topics were written up for assessment and at the end of the eight weeks each student made a presentation to the group. They were also encouraged to arrange a clinical placement in a relevant area, such as a genito-urinary medicine clinic, pregnancy advice centre or hospice.

Who did the teaching?

In Cardiff we shared out the teaching between CMF staff and local doctors. On the whole people were very happy to be involved; some teaching for the first time. Becky McGee, a Cardiff GP, shares her experience...

Initially I was a bit apprehensive at the prospect of leading a student seminar on abortion – especially when I was sandwiched between Peter Saunders and a consultant paediatrician – but the experience was positive.

The preparation made me revisit the biblical principles and helped ensure I was up to date with the current law and practice of abortion in the UK.

The students were receptive and eager to learn. Discussing situations from my own practice helped to ground this in real life, not just theory.

I would encourage anyone to participate in an SSM. You will be encouraged by students' enthusiasm and idealism and the opportunity for them to study Christian ethics as part of their curriculum is one that we should all support.

It is not clear how long we will be free to teach Christian medical ethics in our medical schools. Let's take the opportunity while it's available.

Who can help?

Setting up this kind of SSM is a lot of work but there are many others who have experience. Alex Bunn in the CMF student department (*alex.bunn@cmf.org.uk*) can put you in touch with others who have run similar SSMs, and CMF can send you a resource CD with sample proposals, timetables and talks.

Books such as *Matters of Life and Death*[1] are really helpful as student texts and for preparing talks. The CMF website (*www.cmf.org.uk*) also has lots of great information on it. Local doctors can bring a wealth of knowledge and experience and CMF staff are often happy to speak on a specific topic if you need them.

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Is it worth it?

I'll let Hannah, one of our students, answer that one.

What did you enjoy most about the SSM?

I loved all aspects of it! In particular the overt opportunity to intertwine my Christian values and beliefs with my degree. It was fascinating and intriguing to discuss issues I had never even considered before.

What topic did you choose to study in more detail?

I chose physician-assisted suicide (PAS) and spent a day in a local hospice; it was an amazing experience. I was inspired by the positive effects of good palliative care and by the potential to show Christ-like love and compassion to patients at this precious time of life. Spurred on by this and the recent Joffe Bill, which attempted to introduce PAS into England and Wales, I explored the existing situation in Oregon where PAS is legal, the potentially detrimental effects of its legalisation here, and the ethical arguments surrounding PAS.

How has the SSM prepared you for the future?

It has encouraged me to seek God first in all my decisions; as a student now and in the future as a doctor, to put being a Christian first. Debating ethical dilemmas with other Christians helped me formulate my own stance before entering emotive real-life situations. It has further motivated me to become a good doctor, and a good ambassador for Christ to patients and colleagues.

Would you recommend this to others?

The teaching was excellent, thought-provoking and rousing. I would thoroughly recommend this SSM.

***Sarah Gwynne** is a former CMF staffworker and now a specialist registrar in oncology in Wales*

Rachael Pickering and **Anna Hunter** try to communicate...

Let's communicate

Juniors' Forum has decided to spend a few issues exploring the gentle art of good communication. 'Oh no!' I hear you cry. 'How boring!' Certainly that's how I felt as a houseman (pre-registration doctor), but then my one and only undergraduate experience of 'learning communication skills' had been highly ironic – a solid hour's lecture on the theory of good communication, delivered in a monotone voice by a tweed-suited academic who failed to introduce himself and never once looked up from his densely worded acetates!

Like many GP registrars, I endured rather than enjoyed videoing my consultations; you have to watch them with your tutor, critique your communication skills and read all about different consultation models. Woe betide the candidate who attempts the MRCGP viva before digesting Roger Neighbour's book![1] Amongst all the theory though, I did glean some very sensible tips that have made my subsequent clinical life an awful lot easier. Optimising your communication skills can help you...

Forestall complaints

'You've had a complaint...' One of the most stressful phrases a doctor ever hears. Instinctively you ask yourself, 'What have I done?!' Actually though, the complaint is more likely to be about what you've *said*, or not said, than what you've done! A high percentage of formal complaints are rooted in poor communication rather than medical error.[2] Only on *House* does diagnostic brilliance prompt patients to tear up half-written complaints about their physician's appalling lack of social skills! In the real world, patients often rank our ability to communicate as more important than our diagnostic accuracy! Most of the thank-you notes we receive express gratitude for kindness and empathy rather than diagnostic skill.

It's often possible to pick up on people's discontent. At this early stage, it's often relatively easy to defuse the situation.

- *Adopt unthreatening body posture – unfold your arms and express concern on your face.*
- *Acknowledge distress – 'I see that you are upset. I would like to help...'*
- *What are their ideas, concerns and expectations?*
- *Offer to explain any obvious misunderstandings.*
- *Summarise their grievance – 'So, and please correct me if I've misunderstood, you feel that...'*
- *Use the S word – 'I'm sorry that you've been upset'.*

Pass exams

Optimising your communication skills can help you pass exams! Most of the Royal Colleges now include some assessment of candidates' communication skills in their membership exams. Medical schools too are becoming increasingly concerned about good communication. Today's medical students receive a mixture of theoretical seminars and practical workshops in the art of communication. Students get to practise talking on medical actors to start with, rather than embarrassing themselves in front of real patients. And come exam time, the student who's worked to develop their communication skills is easy to spot.

Share faith

Just about every hospital has its resident 'grump' – the surgical registrar everyone dreads having to bleep. But, just like you, the majority of juniors are happy and genial enough. What else then could mark you out as a Christian? What about your way of communicating with patients? Anna recalls...

I disliked my new job. The Obs & Gynae department seemed cold and unfriendly, nothing like the comradely atmosphere I'd enjoyed in A&E. I was a supernumerary SHO, headed for GP Land, whereas all the other juniors were career gynaecologists, set on getting to theatre as often as possible. As I was a spare pair of hands, they were forever asking: 'Could you just pop down to EPU [Early Pregnancy Unit]? It's my turn but I want to stay in theatre!' Soon I was making almost daily trips down to EPU.

Every miscarriage is a personal tragedy. I counted it a privilege to gently break the news to each woman and then provide good medical care for her. I enjoyed working with the unit's lovely nurse and hoped for a suitable opportunity to share my faith with her. Yet I was very surprised when she herself provided me with my opportunity: 'I've been thinking about you. You talk to the women, explain things, and deal with them so kindly. Why are you like that?' I was more than happy to answer her question! Moreover, I was thrilled to realise that I'd been communicating my faith all along.

I share my faith with everyone I meet and occasionally I use words. (St Francis of Assisi)

***Rachael Pickering** is a Portfolio GP in London and **Anna Hunter** is a GP trainee in London*

Most of the thank-you notes we receive express gratitude for kindness and empathy rather than diagnostic skill

Next isssue

In the next issue, CMF juniors will be sharing how they discuss conscientious objection with patients, managers, GP trainers and other colleagues. Do email your contribution to rachael.pickering@cmf.org.uk

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David Pitches considers medical and Christian concerns

A harmless FLUTTER?

key points

UK plans for megacasinos are on hold, but have highlighted problem gambling: 'persistent and recurrent maladaptive gambling behaviour that disrupts personal, family or vocational pursuits'.

Gambling affects individuals and the whole of society. It has a differential impact on the poor and the rich, with associated health consequences.

Although the Bible appears not to prohibit gambling, traditional Christian concerns are more about the underlying principles behind the acquisition and use of resources.

The UK Gambling Act, introduced in 2005, anticipated the development of many new casinos across the country, including several 'megacasinos', which would have over a thousand slot machines capable of delivering jackpots of up to £1,000,000.[1] Advocates claimed megacasinos would create thousands of jobs and regenerate poverty stricken areas. However, critics argued that the plans would increase the number of people addicted to gambling, lead to tawdry new developments, and precipitate crime, both that committed by problem gamblers to satisfy their debts, and organised crime. Ultimately the plans stalled as, in the face of hostility towards megacasinos, the government restricted the number to eight nationwide, then just one. Finally, in one of his first announcements as premier, Gordon Brown ordered a review of gambling, ending any imminent prospect of a megacasino.[2]

Risks of gambling

Although the megacasino is on hold, a recent survey for the Gambling Commission showed that just over two thirds of UK adults had gambled in some way in the past year. At its simplest, gambling refers to any game of chance with a financial risk. For many people, their only form of gambling is buying a National Lottery ticket, but there are other forms, from the traditional tombola or bingo, to casinos, financial spread-betting and internet games. The Gambling Prevalence Study questioned 9,003 people between September 2006 and March 2007 about 17 types of gambling – from scratch cards to casinos.[3]

The survey also suggested there are around 250,000 'problem gamblers' in the UK, although numbers have remained steady since the last survey in 1999, despite the rise of online opportunities. Problem gambling is defined by the American Psychiatric Association as 'persistent and recurrent maladaptive gambling behaviour that disrupts personal, family or vocational pursuits'.[4] It is characterised by preoccupation with, and loss of control over, gambling and inability to desist despite harmful consequences.

With the exception of bingo, men are more likely to gamble than women anyway (71 compared to 65 per cent), but problem gamblers are most likely to be single males, in poor health, and to have a parent with a gambling problem. There is also an association with being black or Asian, separated or divorced, having fewer educational qualifications, and being under 55. Problem gamblers tend to play newer forms such as online games, and the Royal College of Psychiatrists has expressed concern about the difficulty of regulating these to protect people from harm and exploitation.[5]

The strategies gamblers use to secure a continuing income stream can be equally harmful, potentially leading to depression, crime, family breakdown, unemployment and even suicide. Young people who

gamble are more likely to engage in other harmful and delinquent behaviours, such as consuming excessive alcohol, using illicit drugs or smoking.[6]

Perhaps an equally pernicious effect of gambling is its differential impact on the poor and the rich, with associated health consequences. Less affluent people are more likely to play the National Lottery – some doubtless lured by the misconception that happiness can be gained through riches – yet the profits from Lottery sales tend to favour the pleasures of the rich. In economic parlance, it is a regressive form of taxation. Although studies have shown that the middle classes contribute the most in monetary terms, the poorest in society actually contribute a higher proportion of their overall income to the Lottery.[7]

One of the central arguments proposed by advocates of megacasinos was that they would catalyse urban regeneration. This claim has perhaps been insufficiently scrutinised: whilst Las Vegas is known the world over for its casinos, the other major American venue, Atlantic City, has not had such good fortune. Elsewhere casinos have also been criticised for drawing money out of the local economy that could otherwise be spent on more beneficial pursuits.[8]

Christian reflections

Although the government's review is still awaited, the megacasino proposals have reignited debates about gambling and society. Over the past few years, churches have been some of the most vociferous critics of government gambling proposals. Indeed, most churches would accept that gambling can be harmful, although there is a broad range of views about the extent to which it is morally wrong, or merely something that should not be encouraged.[9]

There are plenty of references to gambling and chance in the Bible, but apparently no specific prohibitions, except perhaps for one reference to forsaking the Lord and spreading a table to 'Fortune', a Semitic god.[10] Casting lots in order to determine the division of the Kingdom of Israel was a divine command given to Moses,[11] and the eleven disciples cast lots to determine who should replace Judas Iscariot.[12] Some churches still follow this tradition when appointing elders[13] on the grounds that casting lots solves disputes[14] and the results are determined not by chance but by the will of God.[15]

Traditional Christian arguments against gambling have been more about the underlying principles behind the acquisition and use of resources.[16] Firstly, gambling appeals to covetousness and greed, falling short of the first, second, eighth, and tenth Commandments.[17] Secondly, one's reward is contingent upon someone else's misfortune – by definition, gambling means doing to others what we would not have them do to us.[18] Thirdly, gambling denies the biblical work ethic that associates honest labour with deserved reward.[19] Gambling is not a wise use of the resources we have been entrusted with[20] and like other addictions can lead to loss of self-control.[21] It also moves us away from dependence upon God for our daily needs.[22] At a wider society level, we read elsewhere about the anger God feels when the poor are exploited.[23]

A Christian response

How concerned should Christians be about gambling? Some individual Christians will be directly affected, either because they or a close friend or family member are experiencing problem gambling, or because they work in some capacity for the industry. Should Christians work for a casino? If not, does performing as a musician at a concert in a casino count? Does the tombola or raffle have a valid place in church fêtes, and if not, should we allow games that guess the weight of cakes on the grounds that these may be perceived as games of skill rather than chance?

Many churches have had to grapple with the ethics of applying for National Lottery funding. Economically speaking, there is an opportunity cost: grants given to churches cannot be spent on other projects, perhaps less wholesome. To offer money to a historic building with insufficient funds to tend to its roof, or to build a community centre, is very appealing; perhaps indeed a divine gift. On the other hand, does accepting such a gift imply a lack of trust in God to provide through less tainted channels? Might conditions be attached to a Lottery grant that would compromise the mission or witness of a church? How would local beneficiaries feel about Lottery funding?

From a societal perspective, some have argued that forms of gambling, such as the National Lottery, widen inequalities of income with potentially important implications for health. This is demonstrated by the expanding literature about the association between inequalities of income and lower life expectancy, and is something as Christians we should be seeking to tackle.[24] On a more personal level, problem gambling is an addiction and can have medical consequences in the same way as other addictive behaviours. Doctors are encouraged to ask about smoking and alcohol habits, but rarely address gambling in routine consultations. There are several organisations and charities seeking to help those affected by gambling, but surprisingly few Christian resources are available, despite the recent efforts of the church in the UK to address the Gambling Act.

Alongside the medical considerations, what should be our response as Christians to current gambling policies? At a national level, there has been impressive unity amongst churches protesting against gambling deregulation. At a local level you might consider whether you could influence your local council's decision about gambling: Sandwell in the West Midlands was the first council openly to refuse to allow new casinos to be built, citing the negative impact on health in an already impoverished area for the decision.[25] Finally, you could consider giving to charities and support groups for people affected by problem gambling.

David Pitches *is an Honorary Consultant in Public Health for Sandwell Primary Care Trust, and currently works for Medair in the Democratic Republic of Congo*

resources

- There is wider consideration of the UK Gambling Act at: *www.christian.org.uk/pdfpublications/gwof_feb05.pdf*
- Support for people affected by gambling:
- GamCare - *www.gamcare.org.uk*
- Gamblers Anonymous - *www.gamblersanonymous.org.uk*

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Jean Maxwell on coping with early medical retirement

I miss the SOUND OF THE WIND

As a child, our large garden had many trees, and I remember lying in bed listening to the wind, and feeling secure. My parents were Christians, but as a teenager I had no belief in God – religion made no sense to my scientific way of thinking. Fortunately, I now know God believed in me.

I was one of the last to undertake 1st MB and entered St Thomas' in 1969. Studying was hard, and looking back some years later I realised I had a dyslexic 'trait' which meant I stumbled from one exam to another. Gradually I began to attend the Christian Union and a local church, where I was later confirmed. As my faith in God became a reality so I became a much happier and more confident person, and reading and studying immediately became easier.

After qualifying I trained as a GP but later changed to palliative medicine. Somewhere in all this I found time to train as an Anglican Reader. My faith and my spirituality have been moulded by working in palliative care, by the difficult questions, and by the pain of loss. For my own support I attended conferences organised by St Columba's Fellowship, where palliative care and spirituality could be explored together. Eventually I became a trustee of that organisation, which is now known as 'hospice23'.

My final few years of work were as Medical Director at Farleigh Hospice in Chelmsford. I was drawn there by exciting plans for the development of a brand new hospice, but sadly had to leave just one year before it opened.

Hearing loss

I had developed a high frequency hearing loss which gradually progressed. Eventually I could no longer hear conversation in noisy surroundings, and meetings were becoming increasingly difficult. Finally even one-to-one conversations could be a struggle. Over the years I found my own solutions: gadgets for the phone, a personal loop system, a fancy stethoscope, and ways of asking questions until I was sure of the content of discussions.

From time to time I went back to the hearing aid consultant to have the settings adjusted. Then one day I went hoping for another tweak, but one look at the audiogram told me I had lost some speech frequencies completely. This time there was no room for denial, and I was hit by the implications for work, knowing I was already missing more and more.

I remember that day. I also thank God now for his timing. Being given such devastating news coincided with a conference at Lee Abbey. Safe amongst friends I had grown to trust, but away from home and work, I had time to think things through.

So began a six month process. No one ever did decide if I was safe with a stethoscope, but from then on I always got someone to check. That however led to a feeling of inadequacy, and loss of confidence. Occupational Health and my managers were brilliant, and after a risk assessment allowed me time to work through the implications as I made decisions for my future.

Medical retirement

I needed time to grieve, and could only cope with a few knowing I had applied to retire. Waiting for the official verdict was terrible, and a strain on those who did know, as they couldn't plan. Then, while at a similar conference six months later, the news came through that retirement had been granted. What timing! The right people again there for me, in the right surroundings, with time away from work. So I left the place I loved just one year before the new hospice was up and running.

> I thank God now for his timing

'What are you going to do?' 'I am going to learn to be, not do', I replied. I still believe the difference is so important. Life didn't stop and new opportunities appeared. Farleigh moved, and I was able to be a tour guide! Church has moved on and we are looking at 'fresh expressions'. I still lead a home group, although struggle. They are very patient with me.

But as I look back, I can also see how God began years ago to provide the openings for the future. I now co-ordinate *hospice23*, mostly by email, and value supporting an organisation aiming to sustain a Christian presence at the heart of palliative care.

The sound of the wind

I am scared of the future. Hearing has vanished from my left ear, which used to be my good one. Surroundings are not silent but sound is distorted, and a room of people can be too noisy. It can be very lonely in company. I miss conversation, especially in groups, and prefer one-to-one. I can understand very little speech unless I can see the speaker, and depend on lip reading and subtitles. I miss the sound of the wind.

I am on the waiting list for a hearing dog, for company in a crowd as well as alerting me to alarms and bells. Perhaps this dog will signal my moving on another stage in my own journey, from denial to acceptance. And when I finally reach heaven, and healing will have taken place, I look forward to hearing the sound of the wind in the trees.

Jean Maxwell *can be contacted at info@hospice23.org.*
Website www.hospice23.org

Jill Eveleigh outlines a new Christian concept in healthcare

Photo: Jill Eveleigh (doctored on left)

Parish nursing

What is parish nursing?

It was founded in the USA in 1985 by Rev Dr Granger Westberg, who proposed a new concept of 'nursing guided by the Holy Spirit which is provided to both the congregation and the wider community, alongside existing pastoral care'.[1]

It is 'the most exciting and fulfilling of the nursing specialties… a dynamic process of working with parishioners and families in the community toward wholeness of body, mind, and spirit'.[2] Parish nurses are 'not purveyors of injections and dressings. They are nurse practitioners with experience in preventive medicine and some theological training. They are staff members of the church's ministry team, working together with the congregation to promote the holistic message of the Gospel in the local community… They are integrators of faith and health, health educator, personal health counsellor, referral agent, trainer of volunteers, developer of support groups and health advocate.'[3] 'After completion of training and portfolio (usually about a year) the Parish Nurse has access to the International Parish Nurse Resource Centre (IPNRC).'[4]

'There are now approximately 10,000 in churches throughout America with another 6,000 in Canada, Korea, Australia, New Zealand, Swaziland, South Africa, Zimbabwe, and around 40 in the UK; with interest shown in Brazil, Madagascar, Japan, China, Mozambique, Jamaica, Sudan, Malaysia and Singapore; connected by the World Forum of Parish Nurses.'[5]

How did I get into it?

After completing State Registration at UCH London in 1981, I moved to The Royal Marsden Hospital to specialise in oncology nursing. There then followed an enjoyable 21 years before I made the move to Croydon as a Macmillan Clinical Nurse Specialist.

Many years earlier I had been given the verse Jeremiah 29:11 coupled with Isaiah 61:1-3 and these words had been in the background of my spiritual walk and vocation as a nurse (it was never just a job). It meant that although I had been progressing through the ranks of my profession, I still felt deep down there was more. I felt God wanted me to work in the church in some capacity and realised that parish nursing could perhaps provide this, so I investigated further. After much discussion my husband and I felt God was leading me to work unpaid for the church, mainly because we both felt this role should not be dependent on funding from other trusts or organisations and could be totally accountable to the church. I was commissioned on Sunday, 7 January 2007.

What do I do?

I work around 30 hours a week and since starting have obtained 54 clients, all with health needs of some kind – spiritual, physical, psychological or social. I can and do respond quickly to an official referral or just an informal request. These have come from the Citizens Advice Bureau, GPs, other health professionals, police Community Support Officers, and church members. Out of my 54 clients 25 attend church, 29 do not.

I give ongoing support to a mother with adopted children who has no parental skills; support a bereaved widow and encourage confidence in going out; attend hospital appointments with clients and interpret medical information; act as an advocate between client and officials; support clients and their relatives with mental health issues; act as a co-ordinator between multidisciplinary healthcare teams; visit hospital and home on behalf of the church; pray with the dying and their relatives; help a family find a Christian home for their relative and assess the outcome; raise the profile of the elderly in the church; and generally have a presence, praying and giving advice as and when needed. I look at my client as a whole person and try to give a more rounded 'holistic' approach, listening constantly to what God might be saying. He knows more than I do what a person needs and if anything I rely on him as much if not more than on my nursing experience.

How am I accountable?

Professionally – I have RCN Indemnity Insurance and a clinical supervisor, employed by the Primary Care Trust (PCT) but who is also a member of the congregation. Annual compulsory training for RNs is provided by the PCT and regular study helps me comply with registration criteria. Parish Nursing UK helps, through the London regional and national co-ordinators, and I am also accountable to the local PCT.

Church – As I am unpaid a 'Voluntary Contract' gives cover under church insurance. My support group meets monthly. Members include my clinical supervisor, prayer intercessors, and people with finance, administration and health management expertise.

Spiritually – I work within a staff team under the authority of the pastors and elders of the church on a low supervision, high accountability basis. My spiritual supervisor is a counsellor and Catholic priest, and of course, I am accountable to God, who has made me who I am and asked me to do this for him. I can only do it with his help and am amazed at what he is doing in people's lives.

Further information

Contact Helen Wordsworth on helen.w@parishnursing.co.uk, or see www.parishnursing.co.uk for more information.

Jill Eveleigh *is Parish Nurse at Morden Baptist Church, South London. jill@faithinmorden.com*

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3. *www.parishnursing.co.uk*
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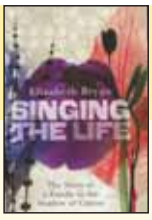


Singing the life

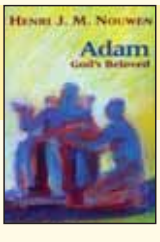
The story of a family in the shadow of cancer
Elizabeth Bryan

- Vermilion 2007
- £12.99 Hb 306pp
- ISBN 0 09191 7158

Elizabeth Bryan was a much loved paediatrician, acclaimed internationally for establishing the Multiple Births Foundation, and a personal friend. This book tells the story of how the dominant cancer gene BRCA1 has been variably expressed across her extended family, finally and fatally affecting her own pancreas. She advises genetic screening for patients who report 'cancer in the family' – affected relatives need sensitive counselling about surveillance, prophylactic surgery and the controversial issue of pre-implantation genetic diagnosis.

Without self-pity, Elizabeth describes her family's turmoil as one sister died and another endured bilateral breast cancer. Yet, despite the clouds, her story breathes not gloom but hope. Elizabeth courageously reiterates – and illustrates – her dying sister's conclusion: 'This is all happening so that love may grow'. By echoing Thomas Merton's prayer, we are shown how faith too can grow: 'I will trust you always; though I may seem to be lost and in the shadow of death I will not fear, for you are ever with me, and you will never leave me to face my perils alone'. This is the keynote of *Singing the life*.

***Janet Goodall** is Emeritus Consultant Paediatrician in Stoke*



Adam – God's Beloved

Henri J M Nouwen

- Darton, Longman & Todd Ltd 1997
- £7.95 Pb 128pp
- ISBN 0 23252 2464

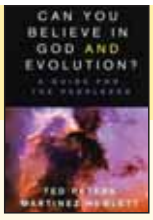
'While at first it seemed quite obvious who was handicapped and who was not, living together day in and day out made the boundaries less clear.' So writes Henri Nouwen, a Dutch Roman Catholic priest who left academia to live at L'Arche Daybreak, a community centred on core members with disabilities.

This short book reflects on the life of Adam, a young man who needed help with all his day-to-day activities and could not talk. Nouwen became Adam's carer, reluctantly at first because he saw him as someone *'very* different' from himself. Over time, however, the relationship transformed Henri. Adam became his friend and guide, helping him to see more clearly the face of God and to understand his own limitations.

We are used to a Christian viewpoint that encourages us to speak out on behalf of the vulnerable and to care for the weak. We are less familiar with Nouwen's message that God may be speaking to us through these people, if we are willing to receive the gifts they offer us.

Nouwen intended to write a book about the Apostle's Creed. But Adam died, so prompting him to write this moving account instead. I am glad he did.

***Emma Hayward** is a GP in Leicester*



Can you believe in God and Evolution?

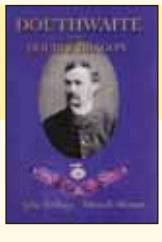
A Guide for the Perplexed
Ted Peters and Martinez Hewlett

- Abingdon Press 2006
- £6.99 Pb 98pp
- ISBN 0 68733 5515

Darwin's *Origin of Species* caused a sensation on its publication in 1859. The idea that living things gradually evolve through natural selection shocked Victorian society. It called into question the previously unshakeable belief in a Creator. Theologian Ted Peters and molecular biologist Martinez Hewlett write from a genuine concern about the confusion surrounding evolution and religion and from a fear that young Christians might be put off scientific careers.

The book outlines the spectrum of views – scientific creationism, theistic evolution in the centre ground, and atheistic materialism. The authors believe God built into the Big Bang the possibility of evolution from inanimate matter to life and eventually to conscious life. Unfortunately, there are exaggerations (eg. 'transitional fossils are discovered almost daily') as well as a tendency to attribute all medical successes to the neo-Darwinian paradigm. None of the outstanding biomedical discoveries of the past century depended on guidance from neo-Darwinian evolution. Nevertheless, this book provides a useful synopsis of the various views in the 'Evolution Wars'.

***Norman Nevin** is retired Professor of Medical Genetics in Belfast*



Douthwaite of the Double Dragon

John Owen and Diana Morgan

- Braiswick 2007
- £9.95 Pb 176pp
- ISBN 1 89803 0138

Written by descendants with access to extensive letters, this is an account of the life of one of the China Inland Mission's most distinguished doctors.

Such records provide valuable accounts for those interested in the history of Chinese medical missions. Anyone thinking of going to China should read it to set their own service in a wider context. The life of any successful man or woman has much to teach us all, especially if that life is committed to Christ and the gospel. The courage of Arthur Douthwaite and his two wives (he died aged 50 before he could marry his third bride-to-be) is a challenge to the complacency that often passes for Christian discipleship today. Arthur's constant grappling with conflicting demands – his heavy clinical load versus his strong sense of calling to preach the gospel – has a contemporary ring. His published research in the *China Medical Missionary Journal* reminds us of the huge contribution medical missionaries have made to the progress of medical science. The Double Dragon? Well, you'll have to read the book to find out. Do so, and be reminded of the shortness of life and the sweetness of heaven.

***Peter and Audrey Pattisson** are retired medical missionaries now living in Brockenhurst*

The Busy Christian's Guide to Busyness

Tim Chester

- IVP 2006
- £7.99 Pb 160pp
- ISBN 1 84474 1249

There can't be many Christian doctors who don't struggle with busyness. But what can we do about it? Tim Chester's book could easily be subtitled, 'tough on busyness, tough on the causes of busyness'. Sure, there is some good advice on how to pack more into our busy days by being more organised, but the main focus is not on *doing more*, but on making clear decisions about *what* we're spending time on, and *why*. Chester urges us to move away from focusing merely on our 'to do' lists – 'Instead of measuring our lives in terms of tasks done and left undone, we should evaluate them in terms of time well spent or not well spent'. The second half looks at specific ways that busyness can reflect spiritual pathology – needing to prove ourselves, fear of people's expectations, needing to be in control, preferring pressure, funding extravagant lifestyles and being enslaved by 'living life to the max'. None of these topics made me shout out 'That's totally me!' However, I certainly recognised several tendencies in my life, and each of these chapters has helpful advice and biblical reflection. This short, helpful book really could help you sort out your life.

***Mark Pickering** is CMF Head of Student Ministries and a GP in London*

The Traveller's Good Health Guide

Dr Ted Lankester

- Sheldon Press 2006
- £10.99 Pb 320pp
- ISBN 0 85969 9914

This is no ordinary travel health guide. It's a personal one with medical advice for sending organisations, support for stress and burnout on the field, and a short textbook of tropical diseases thrown in for good measure. Simple enough for non-health professionals without patronising professionals, this excellent book caters for the longer-term vocational concerns of a missionary audience while not overlooking the different values and risks of travellers with different worldviews. For example, although the importance of sexual abstention or mutual monogamy is emphasised, condom use is also promoted vigorously. A further one-tenth of the book is devoted to malaria, the primary tropical health problem for British travellers. Increasingly, travellers are not the fit, healthy young sorts without pre-existing medical conditions. Obtaining appropriate advice for travellers with health issues – such as asthma, diabetes and pregnancy – can be bewildering. This book dispenses much wisdom on these conditions. Equally valuable are the chapters on managing stress and reverse culture shock. Perhaps the chapter on security is a little too brief, but otherwise it is hard to fault such a comprehensive book.

***David Pitches** is a consultant in public health in the Congo*

Approaching the End

A theological exploration of death and dying

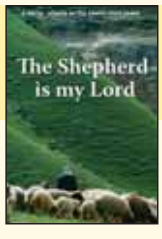
David Albert Jones

- Oxford University Press 2007
- £55.00 Hb 242pp
- ISBN 0 19928 7155

This scholarly work by a professor of bioethics looks at two questions: 'How can we live well in the face of death?' and 'When is it ethically permissible to deliberately end human life?' It examines the writings of Ambrose, Augustine, Thomas Aquinas and the twentieth century theologian Karl Rahner. It covers New Testament and some Old Testament teaching along the way, as the scriptural index shows. It also touches on such unlikely subjects as virginity, marriage and angels!

The teaching of Ambrose is summarised as seeing physical death as a good thing. Augustine saw physical death as 'good for the good, bad for the bad' (in contrast to the 'second death' which is not good for anyone). Aquinas considers death to be natural in one way (because we are animals) but unnatural in another, as we have a soul 'which is of itself immortal…so that immortality is more natural to human beings than to other animals'. Rahner views death as both something suffered and to be achieved. Though primarily a theologian's book, *Approaching the End* will interest CMF members for its discussion of practical issues such as suicide, assisted suicide, euthanasia, withholding and withdrawing treatment and sustaining unconscious patients.

***Trevor Stammers** is a GP and lecturer at St Mary's College in Twickenham*



The Shepherd is my Lord

A doctor reflects on the twenty-third psalm

Janet Goodall

- CMF 2007
- £8.00 + p&p Pb 140pp
- ISBN 978 0906 747377

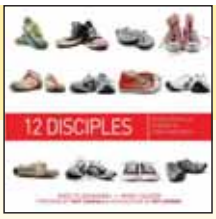
Janet and I met 50 years ago, at medical school in Sheffield, and I have always admired her Christian walk. Her book on Psalm 23 certainly exalts the Shepherd in refreshing and challenging ways.

She approaches this subject as a gifted paediatrician but also as a person with a profound knowledge of sheep and shepherds. I like her reference to a favourite saying of shepherds – a sheep's worst enemy is another sheep!

Love of her Shepherd has been Janet's life-long inspiration. This is demonstrated in her love and esteem for children and her dedication in research and work for these 'whole persons'. In this book, she looks afresh at her favourite psalm and, along the way, shares stories about Christian friends and colleagues. Time and again, she focuses on their humility, which reflects the character of the Shepherd. She also draws rich personal applications from her personal walk with the Shepherd.

While this devotional and reflective work will be of natural interest to medics, *The Shepherd is my Lord* has broader appeal. It really is worth reading just one more book on Psalm 23!

***John Davies** is a retired GP living in London*



12 Disciples

Young People's Stories of Crisis and Faith
Andy Flannagan and Ann Calver

- Monarch Publications 2007
- £7.99 Pb 256pp
- ISBN 1 85424 8014

Have you ever thought, 'If only God would *do* something?' Here is a book about young people – often in a mess – and the God who really does act.

Andy Flannagan, CMF member and one-time editor of *Nucleus*, and Anne Calver have pulled together twelve amazing life stories from their myriad experiences, including those at Youth For Christ – tales of teenage pregnancy, self-doubt, Caesarean section, drugs, and even death.

Also, the two authors have woven in another astonishing story, that of the stumbling disciple Peter being guided skilfully by Jesus. I frequently found myself, getting up from a read, being prompted to *do something*. As an example: Peter did get wet when he tried to walk on water...but at least he *did* it, before getting back into the boat. Let's remember that and give a kind word to that gutsy person who tried hard but had that sinking feeling. I have turned to *12 Disciples* for inspiration and encouragement and for guidance from the Lord. On one occasion, God spoke through it to me on *three* levels – about me, my family and my youth work – all at once! Forget the dull cover. Read and be inspired!

***Mark Houghton** is a GP in Sheffield*

Suffering and Healing in America

An American doctor's view from outside
Raymond Downing

- Radcliffe Publishing 2006
- £24.95 Pb 144pp
- ISBN 1 84619 1300

This elegant collection of 16 essays is much more than a critique of the failings of healthcare in the USA. It suggests solutions and its strength is that it is written by an experienced primary care physician. The 'view from outside' comes from his years of working in Africa and in particularly poverty stricken parts of the USA. He uses fascinating metaphors from Greek mythology and frequent quotes and stories for illustration. Later in the book he uses the Bible explicitly, and his perspective is always implicitly Christian, but people of different faiths and none could read this book cover to cover with great profit and no offence. There are both evidence based and anecdotal assessments of 'medicalisation' in the US and the message is summed up by Professor Pust in the Foreword: 'America's societal willingness to invest in these medical treatments ultimately reflects the American culture. America has money and science; but we may have abandoned the spiritual and social context of our lives, and deaths.' As the UK moves towards the inappropriate US approach, we here need the message of this excellent book, which is packed with that increasingly rare commodity: common sense.

***Andrew Fergusson** is CMF Head of Communications*

Caring for Dying People of Different Faiths

Linda Emmanuel and Julia Neuberger

- Radcliffe Publishing Ltd (third edition) 2004
- £19.95 Pb 104pp
- ISBN 1 85775 9451

This useful volume is written in a straightforward style intended for healthcare professionals. It aims to address the paradox quoted: 'dying well means living well – that also says that we are all different and yet all the same'.

As people come close to death, many will need to focus on significant aspects of life. Julia Neuberger recognises that all who prepare for this final event share a position of vulnerability, but not necessarily the same concerns. The preferred mode of dying and care of the body after death depend on a host of religious and cultural factors. At this difficult time the ignorance of healthcare professionals may be most marked, and can inadvertently cause offence when dealing with unfamiliar beliefs.

This overview conveys a 'sense of the rightness of dying well' and avoids simplistic generalisations, by focusing on the journey of the individual. Practical advice is offered for those dealing with representatives of all major religions and none. Considering the subject matter, this is not gloomy, but provides a surprisingly light and uplifting read. Perhaps it is time to rediscover a theology of death and dying, so that we can understand what John Wesley meant when he said 'my people die well'.

***Paul Dakin** is a GP Trainer in north London*

Infertility: The silent and unseen issue

Rosemary and Barry Jubraj

- Roper Penberthy Publishing Ltd 2007
- £6.99 Pb 64pp
- ISBN 978 1903905 31 9

Infertility is often a hidden issue. Unfortunately, many couples suffer in silence, blaming themselves, each other, even God. Rosemary and Barry Jubraj open up this painful and heartbreaking subject with wisdom and sincerity. Their personal experiences of infertility provide a valuable first-hand account. This book presents the issues from both male and female perspectives, giving insight into how Rosemary and Barry dealt with their infertility, together as a couple but also as individuals.

They do not claim to have all the answers. Indeed, their openness and honesty, apparent from the first page, includes discussion of where they feel they went wrong, how they learned from their mistakes, and how they are still striving to learn more. They encourage couples to think and talk openly and honestly with each other and also with God. Importantly, this book seeks to place infertility within the context of a biblical worldview. It also looks at infertility's potential to affect a Christian's relationship with the Lord. This book could be an invaluable aid for infertile couples, their friends and church leaders.

***Aarthi Campbell** is a specialist registrar in obstetrics and gynaecology in London*

eutychus

The rubber has finally hit the road

A *BMJ* Head to Head 'Are condoms the answer to rising rates of non-HIV sexually transmitted infection?' revealed astonishing concordance between camps. For 'Yes', Steiner and Cates were positive about abstinence even though it is 'difficult to achieve', warned about 'risk compensation' (feeling safer so taking more risks), and said the 'ABC' strategy was a 'reinforcing epidemiologic truism'. Genuis, for 'No', described the limits to protection and commented 'the relentless rise of sexually transmitted infection in the face of unprecedented education about and promotion of condoms is testament to the lack of success of this approach'. (*BMJ* 2008; 336:184-5)

Screening requires wisdom

Gordon Brown's announcement that GPs would screen much more for diabetes, aneurysms, and kidney disease met a cool reception, not just because of the lack of prior consultation with the profession and the perhaps ill-advised diversion of funds, but because it failed to appreciate the principles of screening. Glasgow GP Des Spence: 'The inverse care effect will, as ever, see the predictable, miserable lines of low risk, worried well clogging up NHS services. The high risk, unworried sick will continue happily to ignore our screening initiatives.' (*BMJ* 2008; 336:160)

Cannabis and lung damage

One area where government could usefully intervene for health would be to reclassify cannabis as a Class B drug, having downgraded it to Class C in 2004. Two recent studies highlighted by the BBC suggest that compared to tobacco smokers, heavy cannabis users are at greater risk of chronic lung disease and cancer. Bullous emphysema occurs 20 years earlier in cannabis smokers, and smoking one joint a day gave a higher risk of lung cancer than smoking 20 cigarettes a day over the same period. (*http://news.bbc.co.uk/1/hi/health/7217601.stm*)

Hospice humour

Sheffield SpR Becky Hirst says 'palliative medicine is fun' and mentions 'the rather dark hospice humour'. She describes a hospice volunteer who 'sheepishly recalled collecting dirty crockery. Entering a room where the family was gathered, the end being near, he indicated to the used cups and said: "Are these dead?"' Later she adds: 'The West would do well to learn from Buddhism, which embraces death and dying as integral parts of life's journey that have to be done as well as possible.' (*BMA News* 2008; 19 January: 7)

A bridge to peace

On a clinical attachment in Israel, SpR in respiratory paediatrics Patrick Stafler saw medicine as 'a bridge to peace' and believes doctors can convey harmony. His article begins with a quote from Isaiah 2:4: 'Nation will not lift sword against nation and they will no longer study warfare'. Perhaps somewhat out of context, but Eutychus is always glad to see scriptural quotes in the journals. (*BMJ Careers* 2007; 8 December: GP219)

A real choice?

Leeds GP James Gerrard considers the concept of choice in relation to abortion and the effect on decision making. Quoting a previous article that 'framing a decision as a choice can enhance the perceived value of a particular option' he suggests 'perhaps the default state for a society in dealing with crisis pregnancy shifts towards abortion and more women may opt for it'. And perhaps that's why BPAS in their regular advert in the same journal headline 'choice, value and expertise' and conclude 'pregnant women know that they have a choice. A real choice.' (*BJGP* 2007; December: 996, 978)

Frankenfurters

The US Food and Drug Administration has authorised the sale of meat and milk from cloned cattle, pigs and goats and from the offspring of such clones. The FDA does not expect clones themselves to enter the food supply as they are expensive and rare, and most of the 600 or so US cloned animals will be used for breeding. Their offspring, bred normally, will be used for food. No special labelling of meat or milk products is required, and the US public seems unconcerned. If the same happened here, we might expect 'Frankenfood' headlines. (*BMJ* 2008; 336:176)

Doctor as 'surrogate priest'

A substantial article about roles suggests that the 21st century GP will have to be physician and priest. To illuminate this claim the authors draw on the paradoxes of censuses. While 'the most recent national government census in 2001 still highlighted Christianity as the religion of 72% of the population', at the same time 'there has been a well-documented decline in church going in the UK. The reasons for this are numerous and are for theologians and clerics to address, but... the 2005 English Church Census... revealed that 94% of the population do not go to church'. (*BJGP* 2007; October: 840-2)

Saying sorry

Ophthalmologist member Will Sellar had a helpful piece in *BMJ Careers* about apologising, which used Scripture to confirm the important principle of 'not letting the sun set while still angry' (Ephesians 4:26) and suggesting the reconciling spirit of Matthew 5:23-6 to prevent bitterness. Unfortunately, while the references were listed at the end, an editorial oversight meant they were not indicated within the text. (*BMJ* Careers 2007; 15 September: GP103-4)

Real beauty

A review of a Dutch TV documentary investigating cosmetic surgery stated 'by the time every girl reaches 17 she is likely to have seen an estimated 250,000 beauty related images. Every year in the Netherlands 1,000 young women seek cosmetic vaginal surgery – but why?' Peter tells us in 1 Peter 3:3-4 that 'your beauty should not come from outward adornment... it should be that of your inner self, the unfading beauty of a gentle and quiet spirit'. (*BMJ* 2007; 335:541)

news from abroad

What's changed?

I recently had the privilege of being part of a small team of obstetricians and midwives, teaching a basic skills course in obstetrics in Malawi. This was a joint venture of the Liverpool School of Tropical Medicine and the Royal College of Obstetricians, linked into an ongoing project-in-country seeking to diminish maternal mortality in line with the WHO Millennium Goals.

Interestingly, we arrived in Lilongwe 40 years to the day from my arrival there in 1967 to work as a General Medical Officer in the government general hospital. Prior to my trip, I had looked out the detailed records I had kept of the maternity statistics for the same hospital in 1968-70 and a couple of papers I had published in the early 1970s about the causes of maternal mortality in Malawi and Tanzania. It was a salutary experience to compare those figures with the statistics for 2006 being kept by the in-country organisers of the course we were about to hold. While there was plenty of evidence all around of the way the infrastructure of the country as a whole had 'improved' (more tarmac roads and posh hotels), the statistics I was given were no better, and in some cases worse, than they had been 40 years ago. The main causes (and numbers) of maternal deaths were virtually identical.

The poor will always be with us

Writing recently about her time in DR Congo, one of our members commented:

We saw many health development projects being run on almost no resources. The faith and perseverance of the people running these was impressive. Examples included running a school for the deaf with no clear ongoing funding, a Bible College with no textbooks and no income, a health post set up by the community because their women were dying before they reached the nearest maternity unit.

In her acceptance speech for the 2007 Nobel Prize for Literature, Doris Lessing spoke of schools in Zimbabwe where there is

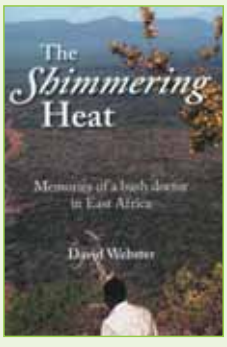
no atlas or globe, no textbooks, no exercise books or biros. In the library there are no books. The teachers are not paid and the pupils have to walk many miles to school. They can't do their homework because there is no electricity and it is dark by the time they get home. The girls have to walk miles to fetch water before they set off for school and on the way back.

What hope Africa? What hope in such situations? We found, even while teaching the basics of obstetric care to midwives and clinical officers working in a District Hospital and rural health centres in Malawi, that they didn't have an Ambu bag or access to magnesium sulphate (to treat eclampsia) and the only vacuum extractor in the hospital was 'broken' though not irreparable.

The reasons for these situations are many, complex, and often interwoven with a number of historical, cultural and economic problems; but the need for us as Christian doctors to reach out and share our skills and wealth with the poor remains and seems to increase with the passing years. The opportunities are there. The need to build capacity into these situations and provide resources is endless. The need for someone to go, and stay, and provide service needs in rural areas where many nationals are not willing to work (often for very good reasons) will always be there for those willing to go longer term. But who will go and who will stay?

I came away challenged, encouraged and sad. The welcome, appreciation and generosity of those we met were overwhelming, and the satisfaction of feeling we had contributed just a very little bit in an ongoing process of seeking to help in the midst of such poverty and need made it all very worthwhile.

The Shimmering Heat



Subtitled *Memories of a bush doctor in East Africa*, this very readable and extensively illustrated book by CMF member David Webster tells of his service in Uganda and Kenya in the 1960s and 1970s. 'Running a one-doctor hospital in the bush was a challenge...But one thing was always possible – to make a difference.'

Copies available from: Dr David Webster, The Grange, Hill End, Upton-upon-Severn, Worcester WR8 0RN for £9.99 + £1.50 p&p. Proceeds from sales via this notice will be shared between CMF and Crosslinks' work at Marsabit.

Challenged and want to read more about working abroad?

Visit our website at *www.healthserve.org/pubs* and read the new edition of *Working Abroad* or get in touch with me at *peter.armon@cmf.org.uk*

Current opportunities

see *www.healthserve.org/overseas_opportunites*

- General medical officers (GPs) in Nepal and South Africa
- Obstetricians - urgently required in Pakistan and Bangladesh
- Paediatric anaesthetist - to work with Cure International in Ethiopia
- Paediatric orthopaedic surgeon - to work with Cure in The Dominican Republic
- Plastic surgeon - to work with Cure in Kenya
- General surgeon to help short term as a locum in Bangladesh
- Doctors experienced in HIV/AIDS to help run workshops with Mildmay International

Peter Armon *is CMF Head of Overseas Ministries, and will be retiring this summer*

Mike Keighley finds fulfilment in early retirement

Photo © PA Photos

Indian summer

We met by chance in 2002 and agreed an evening of opera together. Afterwards we talked about the Christian Medical College in Vellore, south India and Andrew, an old school friend and fellow surgeon who helps with postgraduate UK training for CMC surgeons, promised to put me on the programme.

First contact

Thus in January 2003 I had my tourist, seven day overview of CMC. What an amazing place! The vibrant but small medical school has only 60 students in each year, 30 women and 30 men. Forty eight are sponsored from Christian churches within India and a few neighbouring countries (Nepal, Sri Lanka, Malaysia, Bangladesh among others) and 12 places are filled from the highest ranking school leavers in India.

The hospital was founded 107 years ago and has 2,100 beds. The pathology amongst the 1,500 new outpatients seen each day is mind boggling. No 'worried well' here! Of the surgical patients, 65% travel over 1,000 miles for treatment, and in some disciplines research and specialisation are well advanced. There is a college of nursing, a rehabilitation unit, and essential support services. The funding mechanism is complex and has to make a profit for CMC to survive. Outside aid is only used for new developments and to provide free medical care for the poor.

Chapel *Compline* services are sensitively led by students, and the hospital worship with midweek ward prayer and Bible study meetings gives CMC an inescapable spirit of Christian love and service. Uniquely, over 80% of graduates stay in India and 55% practise in rural communities.

On my last day I was asked to consider running the Department of Surgery for five years: 'We can sort out the visa situation'! Their second line of approach was to ask me to run colorectal surgery since they were committed to forming six sub-specialties.

Return visit

My wife Margaret had travelled with me and we were able dispassionately to discuss retirement opportunities in India. I was approaching 60 and we had both bought 'added years'. I was being encouraged to retire – too outspoken about NHS reforms, increasing bureaucracy, lack of patient care and staff support, and university disinterest in undergraduate education and mentoring.

I decided I could make no decisions without a longer visit to see what life was really like when not a 'visitor'. I thus saved up as much holiday and sabbatical as possible and returned for nine weeks the following January. During the intervening year, when beset by frustrations in an NHS and university which seemed to have lost the plot, I found hugely positive the prospect of doing something different overseas on a specialist colorectal unit, struggling to establish itself but with enormous research and training opportunities.

This Gideon's fleece period had moments of enormous fulfilment: helping with a difficult pouch operation, planning potential research projects, climbing some local mountains, praying with Christian friends, and introducing to students the concept of a 'risk benefit' analysis for patients a long way from home and with limited financial resources. On the other hand, there were moments of great loneliness; I missed my wife, our rapidly growing grandchildren and our springer spaniel.

> probably the best thing I have ever done

I had a new edition of a surgical textbook to produce, which would have been well nigh impossible at home. I also identified some viable research projects and filled hours writing protocols and ethics committee submissions. Weekends needed some planning; for clinicians at CMC they did not usually begin until 4 pm on Saturday. From then until 6 am Monday there seemed a long siesta punctuated only by three or more worship opportunities for the very committed Christians! I hired a bicycle, unearthed a walking group, discovered the magic of the Indian train as the best way to explore distant locations, and found a driver as definitely the best option for local excursions.

Even after nine weeks on the treadmill CMC remained for me an amazing place. The glove seemed to fit perfectly. My 'call' was clearly meant, but when should I start and how long would it last?

Retirement

I returned home and in March 2004 handed in my notice since future four to six week visits three times a year were not possible while employed. In August 2004 I stopped fighting the NHS and university and over time was able to forgive. CMC has been a real healing experience.

Visitors are confined to a six month tourist visa and returning home periodically not only provides time for family but helps networking. I need to stay on the GMC Register and continue in private practice whilst at home. I keep up to date by speaking or presenting research at postgraduate meetings. My 2006 appraisal was with Benji, the head of the colorectal unit at CMC! I supervise research, have written a student text book with an ex-student, and co-ordinate student elective projects. To pay air fares I act as an expert witness.

I have been visiting CMC regularly now for five years and get withdrawal symptoms if I stay away too long! CMC is probably the best thing I have ever done; it has certainly changed my life and provided real fulfilment in early retirement.

Mike Keighley *is a colorectal surgeon who was Barling professor of surgery at the University of Birmingham until August 2004. He is an honorary faculty member at CMC, linked with India Interserve.*

letters

Abortion

***David Hawker**, a retired consultant anaesthetist in Cornwall, shares some personal experiences of the Abortion Act.*

I want to thank Peter Saunders for his forthright article on abortion (*Triple Helix* 2007; Autumn: 3). With the throwing out of the Christian ethic, which according to Sir Jonathan Sacks began in 1961, as a profession and nation we have no guidelines. It is therefore right that we speak up and out on ethical topics. So, thank you.

I was a final year medic when the Abortion Act became law, and I had some sympathy. The way pregnant single girls were treated, at least in Edinburgh, was appalling, and the way they were not even allowed to see their babies after birth, having them whipped away for adoption and never held, was perhaps more wicked than abortion, so it wasn't a clear issue to me. It was a struggle as a junior doctor, and as an anaesthetist, to sort these things out clearly. I was able to take a stand as time went on, and never was able to sign 'the form'.

Part of the pressure to do abortions was the issue that if it isn't done on my shift, someone else will have to do my dirty work, because it will be done. I was much helped by an ODA who refused to be in theatre during abortions, resulting in the opportunity for me to refuse, and subsequently no more abortions were done on that gynae list.

Spiritual care

*Following the article on practice chaplaincy by Ross Bryson and Anne Hughes (Triple Helix 2007; Autumn: 16-17) **Peter Hill**, a retired Birmingham GP, describes a Christian response to spiritual needs.*

So what should we do? The patient's need is spiritual and we know there is an answer. We could address it ourselves or even put the patient in touch with someone else who has more time. But is it right? Even if right, would it be seen as acceptable by colleagues or the authorities?

Times have changed. Some developments within the service which cause concern (including hypnotherapy, acupuncture, aromatherapy, transcendental meditation and greater use of homoeopathy) have created opportunities for Christians.

One medical practice in the Home Counties runs a substance misuse clinic which is overtly Christian, with offers of prayer, Christian counsel and access to Christian literature. Results are good and patients are happy, but the authorities wondered if the faith based approach was appropriate. Dialogue followed, and in time, agreement that satisfied the Primary Care Trust and the Christian team was reached. Patients are being blessed as they are treated – now with PCT permission.

In our primary care practice in Birmingham we felt we should be more radical in helping patients who had a spiritual component to their problem. We publicised our willingness to offer Christian Spiritual Medicine alongside our normal service. This consisted of having a Christian counsellor as part of the team, running Christian groups, offering literature, and praying for patients. To do things right we wrote to the PCT for permission to practise in this way.

The response was wonderful. It's there in black and white on PCT headed paper. The topic is Christian Spiritual Medicine and the permission is clear: 'It is acceptable to offer this service to patients'.

> We are free, within the confines of good medical practice, to help patients be touched by God's love

This is liberating good news. We are free, within the confines of good medical practice, to help patients be touched by God's love. One barrier, namely fear of the authorities, is gone or at least reduced. Let's make use of this opportunity to bless patients and bring glory to our wonderful God.

If any would like to know how we got this permission please write to *hillhome1234@blueyonder.co.uk*

Retirement

*The **Editor** comments:*

Triple Helix welcomes letters and like most periodicals receives very few, so there is a good chance of being published.

Both these comments on articles in the last edition have been written by members who have recently retired, and there are two articles in this edition that feature the opportunities and challenges of retirement. Mike Keighley (p21) chose to retire early and is finding fulfilment in regular surgical visits to India, while Jean Maxwell (p14) had medical retirement forced on her, but has discovered new avenues for service.

In autumn 2007 CMF held its first conference for those who had recently retired, or were approaching retirement. It was over-subscribed and was a great success. Another is planned for this autumn. *Triple Helix* welcomes from all members contributions which have both Christian and medical content, but maybe some who have retired have particularly useful experiences to share?

Jason Roach reminds us why ethics are not optional

Jack Bauer MEDICINE?

The television series *24* is set in the fictional US government Counter Terrorist Unit (CTU) and each season depicts a 24 hour period in the life of Special Agent Jack Bauer. Although the series has been hugely successful, *24* has repeatedly aroused media attention for its dubious take on ethics.

Writing in the online journal *In these times*, Slavoj Zizek points out that CTU agents are frequently seen taking the law into their own hands to obtain vital bits of information, in a race against time to stop terrorist activity. As you watch, it's easy to believe that acting outside normal ethical frameworks might sometimes be genuinely necessary. Limited time and the complexity of the situations apparently don't allow for the luxury of reflection, resulting in a separate 'ethics of urgency'.[1]

The truth is of course somewhat different, and applies in the time-poor world of medical practice as much as anywhere else. Urgency does not give Christian doctors *carte blanche* to act as they see fit and shelve ethical reflection for a later date. Jesus' observation that those who love him obey his commands was not situation dependent.[2] Time may well be limited, but it is rarely non-existent.

Three practical factors often prevent us from thinking through the challenges of medical ethics. Firstly, juniors frequently rotate jobs and consequently often face unfamiliar scenarios; secondly, the more senior among us can increasingly operate in auto-pilot; and thirdly, there is the basic reality of sin in our lives. Too often we resolve to think about an ethical issue, but months later still haven't taken action to address our uncertainty.

Proverbs 14:8 reminds us 'the wisdom of the prudent is to give thought to their ways'. Reflecting on complex cases is encouraged in medical training, but thinking through problems *biblically* seems a rarer exercise. We are also meant to encourage each other to live gospel centred lives.[3] Therefore, whatever else we do, when we meet together we could try to thrash out biblical answers to these kinds of issues.

The option of pretending it doesn't matter isn't available to us: ignoring the Bible's teaching dishonours God, and there is a danger that failing to act ethically corrupts us.[4] The words of Jeremiah 2:5 are striking: 'They followed worthless idols and became worthless themselves'. If we allow our values to be driven by the world, we become like the world.

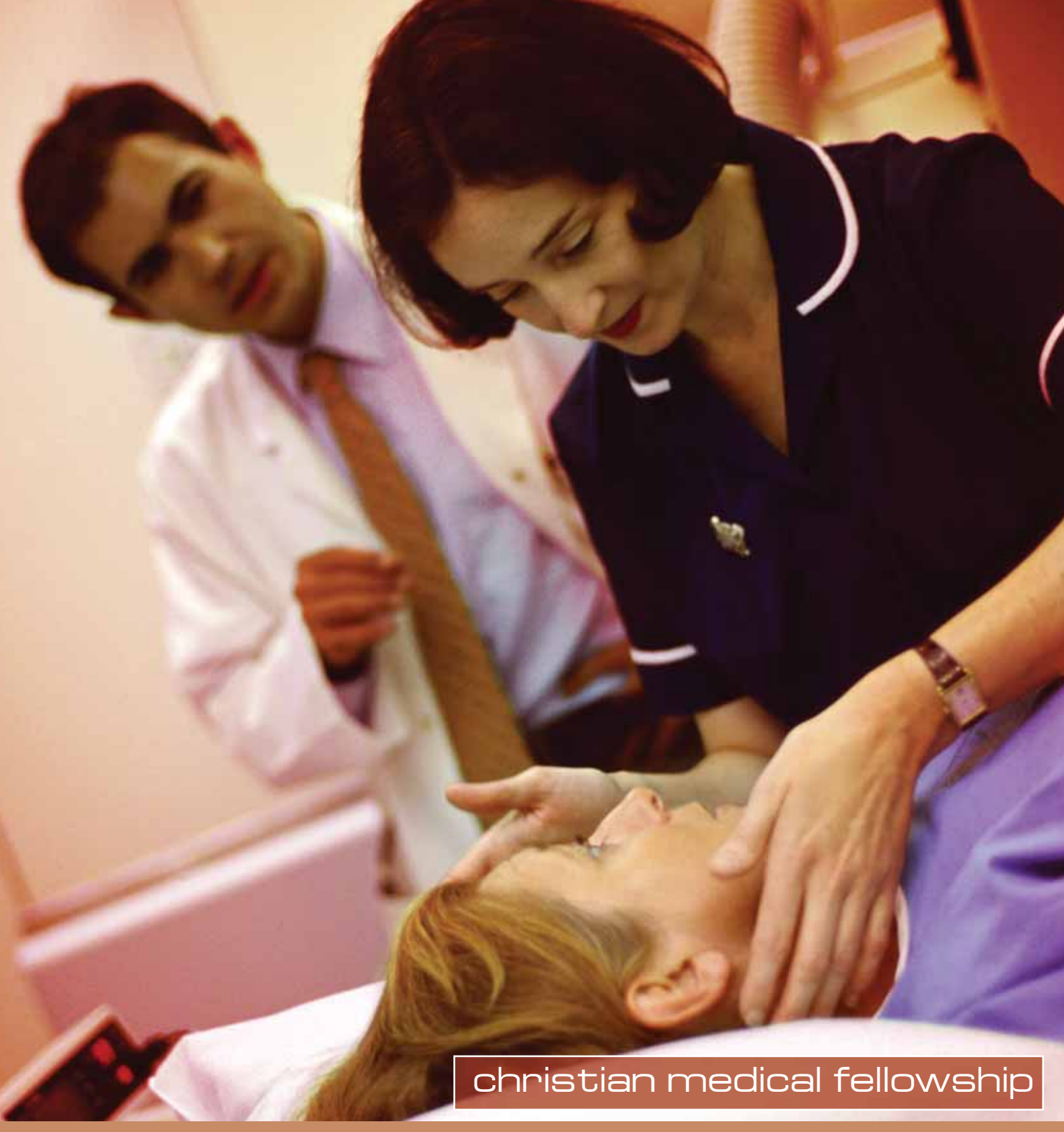
Above all though, staying soaked in Scripture will make us wise in the many and varied situations we face in life. Of course there will often be no simple proof text, not to mention times when Christians disagree, but these are not reasons to abandon the endeavour.

For the record, I am a big fan of *24*. In fact, I wouldn't mind being equipped with many of Jack Bauer's traits. But when it comes to the ethics, I think I'll pass.

***Dr Jason Roach** is training for the Anglican ministry in Oxford*

references

1. *www.inthesetimes.com/article/2481*
2. John 14:15, 21
3. Hebrews 3:13
4. 2 Timothy 2:16, 1 Timothy 6:9, Romans 6:16



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