

TRIPLE HELIX

Autumn 2000

For today's
Christian doctor

HUMAN GENOME PROJECT

Are we expecting too much?

JODIE AND MARY

The limits of technology

ARE
TRANSSEXUALS
BORN
THAT WAY?

THE NEW NHS PLAN

OVERSEAS
OPPORTUNITIES

POSTMODERN NHS

The societal shifts
underlying the changes

HALLMARKS OF HEALTHCARE

The Good Samaritan
as an example

EUTYCHUS

SUSTAINABLE DEVELOPMENT

A flawed approach?

CYBERDOC

Websites on cloning

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Front cover photo:
Wellcome Trust Photo Library
DNA Analysis, Gel electrophoresis





Jodie and Mary

The birth of Siamese twins has always been a topic of popular fascination. In a previous age such births were usually interpreted as a supernatural event. They were variously seen as signs of blessing or warning, a portent for the future, or a judgment of past wrongs. In our enlightened times, the human interest is seen in the headline news, the feature articles, and in the unusual sight of Appeal Court judges agonising in public. The media coverage illustrates a strange combination of fascination, revulsion and sympathy for the family trapped in this extraordinary drama.

So, does biblical Christianity have anything distinctive to say about this case? Firstly, a Christian response must emphasise the human tragedy of the twins and their parents. These are not freak show exhibits, nor are they merely the raw materials, for complex, legal, philosophical and theological disputes. No, they are human beings, made out of the same flesh and blood as the rest of us, beings to whom we owe a duty of love, respect and protection, flawed masterpieces whose flaws are simply more dramatic than usual. Above all they are tragic lives – destined, almost inevitably, to die within weeks or months. So as Christians we must firstly be concerned to protect the dignity, privacy and grief of the family.

Secondly, the Christian perspective encompasses a strange ambiguity towards medical technology. On the one hand we embrace and celebrate the life-sustaining potential that complex reconstructive surgery can offer. At the same time we recognise that this kind of surgery can be harmful and even abhorrent in its destructive capacity. In Christianity death is not the ultimate tragedy. To decapitate and dismember a living child in the name of medicine may be a worse outcome than ensuring that both children have appropriate palliative and symptomatic care. For the Appeal Court to force this surgical disaster on the twins against their parents' wishes seems unconscionable. In Christian thought death, although always a tragedy, may in certain circumstances be a severe mercy and even a strange kind of healing. Paradoxically, it is our very respect for human life which may lead us to say no to the possibility of technology medicine.

John Wyatt

Professor of Neonatal Paediatrics at University College and Chairman CMF Medical Study Group

Therapeutic Cloning

This autumn the British Government is expected to become the first in the world to endorse therapeutic cloning. MPs and peers will vote on extending the 1990 Human Fertilisation and Embryology Act to adopt the proposals of the Donaldson Committee report; allowing scientists to clone stem cells from human embryos.

The technique potentially could lead to the generation of tissue for burns victims, transplant patients and those suffering from degenerative diseases such as Parkinson's and Alzheimer's. Public reaction has been predictably enthusiastic, but how should we be responding as Christians?

Ethical scientific research is part of good stewardship; but the end does not justify the means. Therapeutic cloning involves the production of human embryos purely as sources of cells for the benefit of other human beings – and it is likely, given the difficulties so far encountered in cloning research, that many more embryos will be sacrificed in the refining of techniques. It is therefore ironical that the government is moving to embrace therapeutic cloning at a time when research into other far more ethical sources of tissue (such as adult stem cells) is continuing apace and showing great promise.

Sadly, the prospect of revolutionary new treatments will undoubtedly entice investors to move funds away from other less glamorous, but potentially more promising avenues of research. Furthermore, once therapeutic cloning is allowed, all that will be required for the cloning of whole human beings is a progression of small steps. The technology will be impossible to police.

An uninformed public wooed by prophecies of miracles cures, and unaware of details of techniques, likely success rates, costs involved and alternatives available will understandably vote that the perceived benefits to research outweigh any ethical considerations. But the warm welcome given to the recommendations of the Donaldson report at the height of the summer 'silly season' (when spin doctors are often most active) seems to have been based more on political expediency than wise reflection.

Peter Saunders

CMF General Secretary and Managing Editor of Triple Helix

The NHS plan

It is probably true that a nation gets the healthcare it deserves, but does Britain deserve new Labour's NHS plan? 'A plan for investment, a plan for reform' is the subtitle for the proposals that are envisaged to restore the NHS to the healthcare system the world most envies. The plan contains many targets, particularly for responding to patients' demands, and is backed by monetary investment that aims to compensate for the years of lower expenditure in the UK compared with other countries. Details of the how and when of achieving these targets is sparse and some sections of the medical profession have reacted strongly against a few of the proposals.

So what is the biblical model for healthcare? This sounds a bit like the question the lawyer put to Jesus (Parable of the Good Samaritan - Luke 10: 25-37). Healthcare should involve identifying the needs of the patient and then ensuring the healthcare provider provides for those needs by becoming the patient's servant, expending professional skill, time and effort to heal the sick and comfort those he cannot heal.

As Christians we can support the founding principles of the NHS and much of this plan is based upon them, but the plan also endorses some things that we must resist in order to prevent further damage to our healthcare system. One example is the private finance initiative introduced in 1992 for hospital building projects. This is now the main way of financing hospital building but was discredited as bad stewardship of taxpayer's money by a well researched series of *BMJ* articles published before the NHS plan was devised. A new King's Fund report criticises the Department of Health for sanctioning £1.4 billion of investment in private finance initiative schemes without any strategic view for the future roles of the hospitals and before the national bed inquiry had reported.

Despite the plan's shortcomings there is still much to support and CMF members must continue to strive to serve our patients with compassion and not financial considerations as our motivation.

Anthony Bell

CMF Treasurer and Professor of Neurosurgery, Atkinson Morley

No information is unaffected by bias

The Family Planning Association has issued a new six-page booklet, *Abortion - just so you know*, that aims to help readers understand more about abortion. But does it? The text is clear enough. It is sometimes entertaining, supported by semi-humorous sketches. It gives statistical information, like the number of terminations in the UK (180,000 pa). It tells how to diagnose and confirm a pregnancy, explains the options for contraception, and describes the various methods of termination. Feelings after abortion are discussed; it even says that the best way to avoid pregnancy is not to have sex.

It does many things well but there are limitations. First, readers might assume from this booklet that their GPs will not be helpful. How useful is that? Then, the cartoon presentations of people who disagree with abortion (pages 2 and 3) are unpleasant. Why was it necessary to lampoon those with whom the publishers disagree? Parents are presented being upset at the news and this is the normal teenager's expectation. In reality, however, they often respond more positively.

More seriously the booklet makes only passing mention of alternatives such as continuing with the pregnancy. Women's views on abortion can change when they become pregnant (page 6). It should also be pointed out that those who have strong views against

abortion and then have one may well have difficulties coming to terms with it later on. The booklet is weak on the question of where to seek advice after abortion. Some sources of help are listed but these are heavily biased towards the provision of abortion.

The FPA wants doctors to declare their hand (p16) which is fair enough (and many practice brochures do) but it only implicitly states its own bias by its membership of 'Voice for Choice'. The FPA surely owes it to readers to explain this clearly. Better still would be an honest admission that no source of information is unaffected by bias. Both pro-choice and pro-life orientated sources of help should be listed with a clear indication of the camp in which they belong.

Everyone has a view to impose on the poor pregnant girl. Who's on her side?

Paul Vincent

GP and trainer Co. Durham

Revalidation for Missionary Doctors

Mission doctors do not need to fear revalidation and may find the process helps them in applying for or maintaining registration in their host country. Dr Andrew Fergusson (previous CMF General Secretary) and I recently had the opportunity to discuss the consultation document about revalidation *Ensuring standards, securing the future* at the General Medical Council. We were informally reassured: 'It is essential that revalidation does not obstruct vital work by UK - registered doctors in mission and volunteer situations.'

The GMC hopes that 'a large proportion of doctors working overseas will be able to participate in revalidation if they so wish.' Some may face a period of supervised work or even some form of objective assessment. Some UK-based doctors working overseas may choose to go on the non-revalidating list, their qualifications nevertheless remaining valid. The GMC will clarify with national medical councils 'whether they would foresee difficulties with certificates of good standing that relate to doctors on the non-revalidating list or part of the Register'.

Meanwhile we are encouraging overseas doctors to start keeping folders that record what they do. Hospital annual reports, research evidence, visits by doctors from home, and refresher courses 'offer potential for the collection and frequent and regular review of information about doctors' fitness to practice'.

Assessment is planned on a five-year cycle. 'Revalidation groups based in the UK would be able to consider doctors' folders. These groups would need to be able to demonstrate understanding of the circumstances facing doctors working overseas for voluntary or missionary organisations.'

Non-revalidating doctors will be able to re-enter the list in the same way as those who have taken career breaks. The consultation document says 'many doctors should be encouraged to return to practice safely after a career break'. Another doctor in their host country should carry out an annual appraisal. One not on the UK Register (eg. visitor from USA) might be the appropriate person.

Guidelines will need to be produced, but those who begin to keep folders now may benefit and may even influence how the system develops. The folders will also provide them with an opportunity to give feedback on their work.

David Clegg

CMF Overseas Support Secretary and General Secretary of MMA Healthserve

Gene Genies?

Let's be careful not to overstate the facts

A new era of cancer treatments, vaccines, personalised pills, extended lifespan and treatments for genetic diseases? The June announcement by the Human Genome Project and Celera Genomics that they had deciphered the 3.1 billion letters of the human genome has been hailed as altering the whole basis of medicine.

Perhaps, but we need to be careful not to overstate the facts. Last summer's 'milestone' was simply the production of a 'working draft'. 97% of the human genome has been mapped and 85% sequenced so far; containing 38,000 genes and 115,000 possible genes. A high-resolution map may take another three years – and even then we will only be beginning the task of identifying the function of the individual DNA sequences. Finding new treatments based on them must follow that.

There is no doubt that the human genome project offers great potential for good; but as Christians we also need to be wary of the potential for misuse of the new technology for commercial, political and eugenic ends.

The project will need financial investment to produce results; but with biotechnology stocks already in high demand, there is the danger that human greed rather than human need will shape research priorities. And treatments developed may be out of the price range of poorer families, and indeed poor (or even rich) countries. This raises the issue of gene patents. Investors are keen to get a return – but should genes, which are discoveries and not inventions, be subject to this kind of commercial exploitation? If they are, this will surely encourage hoarding of intellectual property by those out to make a profit and research will inevitably suffer.

The use of genetic fingerprinting to identify criminals must be welcome if it makes it more likely that the guilty are brought to justice and the innocent are exonerated. But confidential genetic information could also be used by corrupt governments to exploit vulnerable groups. Likewise employers and insurance companies could use it to discriminate against those with special needs. Safeguards are urgently needed.

New treatments may still be some way off. The relationship between genes and disease is often not simple; and patterns of inheritance and the likelihood of a particular gene being expressed are not easily predictable. Despite the hype, gene therapy results are so far disappointing. In the last ten years, over 30 major gene companies have been launched and several thousand people treated but as yet only very small numbers of people with rare conditions (like severe combined immune

deficiency) have been helped.

In practice it is far easier to cull genetically impaired individuals in utero or in vitro, than it is to fix damaged DNA and 'genetic selection' is already taking place in the UK. Prenatal screening and abortion mean that 90% of children detected in utero with Down's syndrome never see the light of day; and pre-implantation diagnosis and embryo disposal for cystic fibrosis, Tay-Sachs disease and muscular dystrophy is now well established.

There are strong moves to deploy this technology more widely, to identify and eliminate individuals before birth with a much broader range of genetic disorders, on the pretext of 'cost-effectiveness'. (It costs £80,000 to detect and abort one Down's baby and £120,000 to cover a lifetime's cost of care). The tragedy is that this ante-natal 'search and destroy' is taking place at a time when there are many breakthroughs for previously untreatable genetic conditions. (The life expectancy for cystic fibrosis has doubled in recent years, along with a vast improvement in quality of life).

This eugenic approach devalues handicapped people, many of whom lead fulfilling lives, and all of whom are precious in the sight of God. Furthermore, it channels funds away from finding new therapies. We must not underplay the considerable physical, financial and psychological cost of raising children with special needs, but the way we treat the most vulnerable members of our community speaks volumes about the sort of people that we are. Christian ethics is not about survival of the fittest; it's about bearing one another's burdens and making sacrifices for weak and vulnerable.

We are much more than our genes; human beings are a complex product of nature, nurture and personal choice. More importantly, the wonder of the genetic code reminds us that we carry the master-designer's fingerprints – each one of us individually crafted in his image – yet each different. As US President Bill Clinton has commented, the human genome project is helping us understand 'the language in which God created life'. This same God calls us to be stewards of his creation – and the scientific exploration of life, including its genetic foundation, is right and good – but we must ensure we use this new information in ways that glorify him. Not against people but for them. Not to exploit, but to serve. And let's keep it all in eternal perspective. It's the resurrection, not the genetic revolution that will ultimately bring perfect health and extended lifespan.

Peter Saunders is CMF General Secretary and Managing Editor of Triple Helix

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Neil Whitehead takes issue with the claim that transsexuality is biologically determined

Are trans

Only about 5% of cross-dressers, or transvestites, have any desire to be the opposite sex, but those who do are often convinced they are trapped in the wrong body.¹ One in thirty thousand of the population is transsexual, with more men than women being affected. To meet their demands, ten thousand sex-change operations have been done to date,² creating people physically of one sex but chromosomally of the other. Despite this high absolute figure, only a small proportion of transsexuals actually undergo surgery. A significant number withdraw for reasons of unsuitability of appearance, psychological instability or expense, although some resort to prostitution for financing. Many refuse essential preparation such as living successfully two years as the opposite sex, and fail to keep follow-up appointments, thus disqualifying themselves from surgery.

Many transsexuals are therefore frustrated; they do not undergo surgery yet continue to live as the opposite sex. Loneliness is a significant problem² and comes on top of a surprisingly high rate of psychiatric disturbance.^{3,4} A significant minority regret even a successful operation.

The question arises as to whether these people should have special rights. The Civil Rights movement in the USA produced case law that said one criterion for new rights was the unalterable nature of a given condition (eg. black skin). Groups such as transsexuals and homosexuals⁵ therefore argue that their biology determines their sexual orientation. This strikes a chord with many, particularly sympathetic Christians. This is a modern argument as fifty years ago, 90% of homosexuals believed they

Oswald Chambers

Intellectual darkness comes through ignorance: spiritual darkness comes because of something I do not intend to obey.

sexu als born that way?

AS MORE STUDIES ARE PRODUCED AND MISREPORTED EACH YEAR, SO THE GAP BETWEEN SCIENTIFIC THOUGHT AND POPULAR BELIEF WIDENS.



Photo: PA photos

were not born that way while today, most transsexuals think that their longing for sex-change is innate, biology-derived and unchangeable – a standpoint known as ‘determinism’.

Biologists discarded behavioural determinism decades ago yet politicians and activists still cling to this theory. Even sociobiologists such as E.O Wilson deny determinism: ‘Scientists never speak of genes causing behaviour except as a kind of laboratory shorthand and they never mean it literally’. Downright maverick is the opinion of Richard Dawkins: ‘We are survival machines - robot vehicles blindly programmed to preserve the selfish molecules known as genes’.

Identical twin studies have been carried out to determine the degree of influence of genes on transsexual behaviour. Identical twins (virtually always) have identical genes so if genes directly cause sexual orientation, both twins should demonstrate the same orientation. Few twin studies on transsexual behaviour have been conducted, so studies on homosexual behaviour are examined. It has been shown that homosexual behaviour in co-twins is 50% or less. One small study⁶ on four monozygotic male twin pairs, one of whom was transsexual, showed only one pair to be concordant in transsexual behaviour. Genes do not, therefore, exclusively determine homosexual or transsexual behaviour, so we are not compelled to believe in determinism.

Transsexuals (and homosexuals) argue that studies have shown that their brain microstructure is more feminine.^{7,8} While it is difficult to determine whether brain structure in a particular person is produced by or influences their behaviour, the most unequivocal evidence is that structures are

produced by long-continued behaviour. It is known that the brain changes physically in response to our behaviour – London taxi drivers, for example, have an enlarged part of the brain dealing with navigation! Transsexual brain differences are therefore more likely to be the result of transsexual behaviour, rather than its cause.

Studies on enzymic and hormonal abnormalities, physical dexterity, auditory phenomena and psychological profiles of transsexuals have also been carried out.^{9,10} There is little consistency between the studies, they are poorly replicable and only demonstrate minor links between sexual behaviour and the variables studied. Physiological differences cannot therefore be claimed to determine or even influence sexual orientation.

Many transsexuals (and homosexuals) showed childhood gender non-conformity with boys displaying girlish behaviour and girls acting as tomboys.¹¹ Only a small minority of these children become homosexual or lesbian, and a much smaller proportion become transsexual. Early sexual experience or distant fathers may be a factor in the development of sexual orientation in some boys, but only a minority progress to adult homosexuality, let alone transsexuality.

Unfortunately, the language used by the media to describe homosexuality and transsexuality often appears to support determinism. A scientific study which suggests a correlation or link between transsexual or homosexual behaviour and brain structure or hormones, for example, is reported as showing that these behaviours have a ‘biological basis’ or are ‘genetic’ or ‘due to hormones’. The actual strength of the correlation is rarely mentioned. As more of these studies are produced and misreported each year, so the gap between

KEY POINTS

Most transsexuals believe that their longing for sex-change is biologically determined. However there is no real evidence for a biological basis for transsexuality in terms of measurable differences in genes, brain microstructure or physiology. Like homosexuality, transsexuality appears to be the result of a complex interaction between biology, social environment and personal choice. Relationships between the sexes are intended to mirror that between Christ and his bride, the church. Transsexuality is therefore wrong; but the Christian response should not be judgement, but rather love and compassion, providing the means and support for a change in behaviour.

Albert Einstein

Science without religion is lame. Religion without science is blind.

Transsexual Rights

Men and women who have undergone sex-change operations may be allowed to marry and adopt children under new proposals drawn up by Home Office Ministers. It is currently illegal for Britain's 5,000 transsexuals to have their original sex altered on their birth certificate. However last year they won the right under the Sex Discrimination Act to have their new gender recorded on passports and driving licenses; and also to have sex change operations on the NHS. Civil liberties groups claim that Britain is out of step with the rest of Europe where, with the exception of Andorra, Albania and Ireland, transsexuals are not prevented from marrying. The Evangelical Alliance is opposed to any change in the law. The issue hit the headlines in June this year when the Bishop of Bristol, Barry Rogerson, gave his blessing to a vicar having a sex change operation. (*Daily Telegraph* 2000; 22 July)

scientific thought and popular belief widens.

There is thus no evidence for the political case that transsexualism is an unalterable condition and therefore there is no basis for special civil rights to be granted to transsexuals. Behaviour genetics, for all its faults, has established that all behaviours are a mixture of genes, family environment, unique circumstances, and individual choice. No one forces us into a given behaviour. The influence of each factor may be alterable; for example the contribution of genes may be minimised by more intervention from the environment. It may become clear with time to an individual that his will can be used to support genetic tendencies or fight against them. Sexual orientation may be established in adolescence and people may make such lifestyle and belief changes that they come to believe that they were born that way. It is these individuals in particular who come to the attention of clinicians, yet this sample is highly biased and gives the false impression that all transsexual behaviour is equally entrenched and difficult to alter.

What should the Christian response to this difficult area be? I suggest that the ideal for a Christian in the medical profession is that any behaviour or practice should be done 'on earth as it is in heaven'.¹² Relationships between the sexes are supposed to mirror the relationship between Christ and his perfected bride. It must therefore be asked whether a particular sexual activity mirrors the final glorious and pure relationship found at the marriage supper of the Lamb. Divorce is inappropriate for a Christian because Jesus will never divorce his bride. Homosexuality (however loving it may be) is wrong because it does not reflect the relationship. Transsexuality is wrong because it tries to alter the pattern.

As Christians, however, we must be careful not to condemn a particular wrong in others. We are all wrong-doers very much in need of God's daily grace, help and forgiveness in our lives to enable us to become more like Christ. Jesus condemned the Pharisees, 'They tie up heavy loads and put them on men's shoulders, but they themselves are not willing to lift a finger to move them'.¹³ We as Christians should show love and compassion towards transsexuals and provide the means and support for a change in behaviour.

For a Christian transsexual, at least, this ideal must be slowly and gently presented, preferably with personal testimony from those who have reached it. Skilled psychotherapeutic help is often needed. In the USA I know of one such specialist transsexual Christian counselling ministry. For the non-Christian transsexual, however, change in behaviour is still possible, although it may not be deemed necessary and may even be discouraged in today's Western culture.

So is it possible to change? Definitely. I have personally met some who have slowly lost their lonely longing. It is possible to come to believe that God has made us physically, and intends that we are fulfilled as he made us. It is possible to lose desire to become a member of the opposite sex, and then to marry. It is possible to find fulfilment, particularly in Jesus, and to believe that problems here on Earth are negligible compared with the future glory. It is possible with God's help to become the people God wants us to be.

Following an interdisciplinary PhD (which included biochemistry) Neil Whitehead (whiteh@iconz.co.nz) worked for the NZ Government and United Nations for 27 years. He is presently a scientific consultant with an interest in the psychological sciences.

References

- 1 Docter R F, Prince V. Transvestism: a survey of 1032 cross-dressers. *Archives of Sexual Behavior* 1997; 26: 589-605
- 2 Israel G, Tarver D E. *Transgender Care*. Philadelphia: Temple University Press, 1997
- 3 Rekers G A. *Gender Identity Disorder*. Rekers G A, Oakes J S, Gay J. (Eds.) *The Journal of Human Sexuality*. Carrollton, Texas: Lewis and Stanley 1996; 11-20
- 4 Cole C M, O'Boyle M, Emory L E, Meyer W J. Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior* 1997; 26:13-26
- 5 Whitehead N E, Whitehead B K. *My Genes Made Me Do It!* Lafayette, Louisiana: Huntington House 1999. For reviews and other information see mygenes.co.nz
- 6 Buhrich N, Bailey J M, Martin N G. Sexual orientation, sexual identity, and sex-dimorphic behaviors in male twins. *Behavior Genetics* 1991; 21: 75-96
- 7 Gorman C. Trapped in the body of a man? *Time* 1995; 66-67
- 8 Zhou J N, Hofman M A, Gooren L J G, Swaab D F. A sex difference in the human brain and its relation to transsexuality. *Nature* 1995; 378: 68-70
- 9 Dörner G, Poppe I, Stahl F, Kölzi J, & Übelhack R. Gene- and environment-dependent neuroendocrine etiology of homosexuality and transsexualism. *Experimental and Clinical Endocrinology*, 1991; 98:141-150
- 10 Bosinski H A, Peter M, Bonatz G, Arndt R, Heidenreich M, Siffell N G, Wille R. A higher rate of hyperandrogenic disorders in female to male transsexuals. *Psychoneuroendocrinology* 1997; 22:361-380
- 11 Zucker K J, Bradley S J. *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents*. New York: Guilford Press, 1995
- 12 Matthew 6:10b
- 13 Matthew 23:4

Brave new postmodern NHS

Huw Morgan suggests that recent upheavals reflect wider cultural changes

IT IS ALWAYS EASIER FOR GOVERNMENTS TO DO COSMETIC, VOTE-CATCHING THINGS THAN TO TACKLE THE WIDER ISSUES THAT ARE THE REAL PROBLEM.

Image: Wellcome Trust Photo Library, PH.L.S HQ Building

I can claim little more than an amateur's interest in the contemporary shifts in culture that surround us as we enter the twenty first century. Having spent twenty years in Inner-City General Practice and sixteen of those involved in education and training, however, I do feel able to comment on the profound upheavals that the NHS has undergone in that time, and to seek to relate them to the wider cultural changes that have engulfed our society in the last quarter of a century.

Post-modernism is the collective term used to describe the end of the modern era and the death of the Enlightenment project that began back in the seventeenth century. The Enlightenment ushered in a way of thinking that dominated the development of the industrial nations with its belief in the supremacy of reason, the inevitability of progress, and the rise of the nation-state.¹ All of these things have now been consigned to history. The dominating themes of the post-modern era include the loss of grand meta-narrative (a unifying world-view held by the majority of people in any society – in our case the Judao-Christian one). With it came the deconstruction of hitherto sacrosanct institutions and language, the cult of individualism, and the emphasis on process issues (such as management science) rather than content.^{2,3}

It can be argued that the Judaeo-Christian value system that under girded the major institutions of our society (Medicine, Law, Education, the Media and

indeed Government itself) lost its grip. It began back in the sixties when a whole series of laws were changed that reflected the rise of liberal humanism as a dominant world-view. Not all of this was bad, of course, as the rigidity and intolerance of some of the laws that had supposedly controlled moral behaviour since Victorian times were replaced with more flexible, tolerant ones that mirrored changing times and opinions. The liberal humanists have had little time to rejoice, as their perspective has in a few brief years become just one of many possible interpretations of reality in a society that no longer believes in the possibility of unifying truth or total explanations of the way things are. Whereas in the seventies and eighties Christian doctors and other health professionals who were opposed to abortion, for example, were considered reactionary and narrow-minded, now such an opinion is simply one of many possible views, supported increasingly by empirical evidence from ever more detailed and early technological methods of examining the developing fetus. I shall consider each of the features of post-modernism listed above, and relate them to the NHS today.

Loss of grand meta-narrative

For the best part of two generations, Christians had a fairly comfortable time in the NHS. Its foundational principles of free at the point of access health care for all, based on sound scientific medical research,

Oswald Chambers

There is continual testing in the life of faith, and the last great test is death.

funded and regulated by government from general taxation, were in harmony with Christian concern for equity, justice and truth. More than this, the caring ethos of the health service was strongly Christian in tone, and thousands of individual Christians contributed enormously to the climate of compassion, high standards, and going the extra mile that made the service in its earlier days the much-vaunted 'envy of the world'. (The council of reference of the Christian Medical Fellowship lists many such individuals). In General Practice, the contract negotiated in the late sixties that resulted in the renaissance of the discipline, also placed the doctor-patient relationship (which might extend over thirty or more years) at the centre of the major access point to health care for the entire population. This gave enormous potential for Christian doctors to be there for their patients through many ups and downs of life, as well as their births and deaths, as trusted and known medical advisors, quietly demonstrating the love of Jesus in compassionate, skilled medical attention and care over many years.

Although thousands of Christians continue to work in the NHS, today's climate is very different. One of the major reasons for this is that the world-view and the values that surrounded its formation are simply not there any more. This has radically changed the way that the public view the professions. There is no longer the assumption that a professional person has high integrity and is motivated by a desire to do the best for their patient or client. (With good reason, perhaps a cynic would add, mindful of recent media revelations about incompetent doctors.) Indeed, many, if not most young doctors today see medicine as a job rather than a vocation and the NHS as a largely outdated and not very good, but at least secure, employer. The sense of commitment to high standard, compassionate care by the professionals, and the respect that this engendered in patients and public, can no longer be assumed in today's NHS. The memory and heritage of Christian values that gave rise to these things has gone, making it a less comfortable and more challenging environment for Christians to work in.

Deconstruction

For many years the NHS existed as a venerable institution that was used as a vote catcher at election time by successive governments, and was held in affectionate and respectful regard (tinged with impatience at its waiting lists) by the public. Those working for it could safely assume that like Mount Everest it was there, and would remain so for the duration of their professional lives. All that changed in 1990 when Margaret Thatcher's clever advisors prompted the introduction of the internal market. This was a brilliant political manoeuvre that had the key players (in terms of managers and lead clinicians) scrambling for cash for their hospital (trust) or practice. They were, however, failing totally to

challenge adequately the chronic under-funding and laissez-faire public sector management that had caused the problems in the first place. Since then change has continued at a frightening pace, instituted by successive political administrations that have studiously ignored the morale-lowering effect that this has on the overburdened professionals struggling to keep the service going.

Not only is the service itself being deconstructed (Labours' recent NHS Plan being the latest scattering of the jigsaw pieces), but the language used in documents detailing the next round of management changes has itself lost any objective meaning, in true post-modern fashion. On many occasions in the last few years I have read a circular several times, showed it to colleagues and managers, and we have all eventually agreed that we don't have a clue what it actually says. It is particularly difficult for Christians to cope with this, as not only do we assume that words have meaning and importance, (we believe for instance that the Scriptures communicate God's Word to us) but also we find that our values that helped sustain the NHS as it was prior to 1990 seem increasingly to be irrelevant to the fragmenting, government-driven protocol systems that today's NHS is becoming.

Individualism

Demographic changes over the last fifteen years show an increasing number of people living on their own through choice, as well as increasing numbers of single parents and isolated elderly people. The great god consumerism has become a rampant force, affecting all areas of life and leading to a virtually twenty-four hour society where the shops never close, and lifting a telephone can get you almost anything you want at any hour of the day or night. The loss of family and social networks of support has resulted in the loss of coping skills for illness, which coupled with consumerist expectations has led to an inexorable rise in patient demand for health care on a twenty-four hour basis. The advent of co-operatives and deputising services have been how General Practice has sought to deal with this, and NHS Direct and Walk in Centres are the present government's attempt to meet the individual consumerist agenda.

The one big problem with all this is that health is not a consumer product. It is inextricably linked to lifestyle and choices for which individuals may be personally responsible, as well as being determined significantly by wider issues such as poverty, housing and employment or lack of it. As Christians we need to be critical of government when it fails to address these issues and tries to make the Health Service respond to the individualist, consumer-driven demand in the false assumption that this will improve people's health.

It is always easier for governments to do cosmetic, vote-catching things than to tackle the wider issues that are the real problem. All the spending on efforts to persuade people to stop smoking, for example, (which is now an explicit responsibility of health care

The Trivial Round

Does it seem too much of a platitude that for us it is still and always important to do the trivial things well. No matter how boring they seem to us, they matter to those who are seeking our help, and they are worth doing. It is all part of our 'reasonable service' (Romans 12:1 AV) and our 'spiritual worship' (RSV).

**The trivial round, the common task,
Will furnish all we ought to ask;
Room to deny ourselves; a road
To bring us daily nearer God
(John Keble)**

Extracted from a contribution by Ronald Winton in The Doctor's Life Support published by ICMDA/CMF

POVERTY, HOUSING, EDUCATION, EMPLOYMENT AND PERSONAL RESPONSIBILITY ARE ... MUCH MORE SIGNIFICANT FACTORS IN DETERMINING HEALTH OR LACK OF IT THAN ... SERVICES PROVIDED BY PROFESSIONALS

professionals under the National Service Framework for Coronary Artery Disease) panders to the individualist perspective. Putting the price of cigarettes up significantly would be far more effective, but might reduce the tobacco revenue that raises lots of money for the Treasury. The truth is that poverty, housing, education, employment and personal responsibility are and always will be much more significant factors in determining health or lack of it than any individual services provided by professionals. This has been known for years, yet still the gap between rich and poor continues to grow and NHS staff are made to do things of no proven benefit simply because they reflect the drift of post-modern society.

Process Issues

It is no coincidence that things like Clinical Governance, NICE, CHIMP, PCG's, PCT's and Revalidation are all coming into being now. These are all management systems that reflect the final feature of post-modernism that we're considering. The emphasis has shifted from what we are doing to how we are doing it, and how we can show that we've met the various pre-determined targets along the way. In a system that has no values to guide and drive the professionals who run it (such as the NHS today), it is inevitable that the increasingly powerful managers will impose control protocols and log frames that demonstrate whether or not their agenda is being met. Not all of this is necessarily a bad thing, and medical conditions (such as diabetes) where clear evidence exists about what constitutes effective practice in terms of reduced morbidity and mortality clearly benefit from well-organised and structured care. Patients stand to benefit from a well-organised diabetic clinic with evidence-based protocols more than from a disorganised one without such protocols and Christians have no problems complying with that.

However, there are problems in imagining that something as complex and variable as medical practice can be controlled and regulated so tightly that every last decision and action of the professionals within the service can be determined. It's the patient as a person made in the image of God, with their unique problems and situation, to whom the doctor is responsible. If they don't happen to fit the latest protocol or guideline, the doctor as an independent, compassionate and skilled physician will take such action as he or she believes to be in the best interest of the patient, whatever the protocol says. This I believe is an important freedom

for doctors working in any health care system, and there is some risk that present trends in the post-modern NHS will threaten it. As Christians we must remain responsive to the true needs of individual patients and act like the highly educated professionals we are, not as servants of the state management systems that government seems to want us to be.

There are however positive aspects to all this change that I shall consider in closing. The loss of a unifying world-view and the values derived from it has led to a resurgence of individual spiritual searching, exemplified by (for example) the New Age movement, meditation, Eastern religions, numerous alternative therapies and various forms of counselling and psychotherapy. Rather than seeing these as a threat and ranting against them from the pulpit (as has sometimes happened), I believe Christians need to recognise the opportunities they may give. It is much more acceptable now to talk about personal spirituality than it was just ten years ago. The dominance of materialistic humanism has declined and the aching void that it gave rise to is driving many to search more deeply for personal meaning and truth. Thus it is possible to talk about God and prayer without automatically getting a cynical response.

Perhaps more than ever, the need for truly-patient centred doctors who listen empathetically to their patients' concerns and respond with compassion and skill, is paramount in the post-modern NHS. This will never diminish, whatever changes in the means of delivery of health care occur. It is here that a Christian doctor can continue to demonstrate the love of Jesus and remain the patient's advocate and friend, speaking up for those who are confused and marginalised by the sweeping cultural changes that society and the NHS is undergoing.

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References

- 1 Ashley D. Habermas and the Project of Modernity. In *Theories of Modernity and Postmodernity*. Bryan Turner (ed). London: SAGE, 1990
- 2 Appignanesi R and Garratt C. *Introducing Postmodernism*. New York: Totem Books, 1995
- 3 Tester K. *The Life and Times of Postmodernity*. London: Routledge, 1993

KEY POINTS

The NHS has undergone huge upheavals in recent years. These are a reflection of wider cultural changes in society; collectively described as postmodernism. The dominating themes of the post-modern era include the loss of grand meta-narrative (a unifying world-view held by the majority of people in any society – in our case the Judao-Christian one), the deconstruction of hitherto sacrosanct institutions and language, the cult of individualism, and the emphasis on process issues (such as management science) rather than content. Each of these has had its effect in shaping the NHS. Christian doctors need to respond with the love of Christ to those confused and marginalised by the changes.

Peter Saunders
challenges the
HFEA on the moral
status of the
human embryo

The Status of the Embryo

From a Christian perspective, the moral status of the embryo is one of the key pressure-points in ethical debates about post-coital contraception, therapeutic cloning, preimplantation diagnosis, and artificial reproduction. The issue, which has profound implications for our practice as doctors, has divided Christians for centuries and remains controversial within CMF.^{1,2,3,4,5} As a contribution to the ongoing debate we publish an abridged version⁶ of Peter Saunders' verbal submission to the HFEA (Human Fertilisation and Embryology Authority) pro-life consultation on 29 June 2000. Responses and further debate are welcome.

It is a fundamental principle both of Christian teaching and of natural justice that human beings deserve utmost respect.

Christians believe that human beings have been individually created by God and derive their integrity and worth from the fact that they are made in the image of God - regardless of genotype, age, size, location or degree of dependence and disability. The presence of a disability, either inherited or acquired, does not detract from a person's intrinsic worth. All human beings are thereby worthy of the utmost respect. They must never be treated as means to an end. At the heart of the Christian ethic is self-giving love, whereby the strong make sacrifices for, and if necessary lay down their lives for, the weak.

Historical medical ethical codes, recognising the power and strength of doctors, enshrine a view similar to the Christian one:

The Declaration of Geneva (1948) stipulates that doctors should 'maintain the utmost respect for human life from the time of conception'. In like manner, the International Code of Medical Ethics (1949) says that a doctor 'must always bear in mind the obligation of preserving human life from the time of conception until death'.

The Declaration of Helsinki (1975) says that in biomedical research 'the interest of science and society should never take precedence over considerations related to the well-being of the subject'. 'In any research upon human beings, each potential subject should be adequately informed of the aims, methods, anticipated benefits and potential hazards for the study...' and 'the subjects should be volunteers'. 'It is the duty of the doctor to remain the protector of the life and

health of that person on whom biomedical research is being carried out.'

By contrast the emerging view amongst contemporary ethicists (such as Peter Singer⁷) is that human beings are nothing but the product of matter, chance and time; merely highly specialised animals. The value of individual human beings is determined by their level of rationality or self-consciousness, physical attributes or capacity for relationship. Human life that has fewer of these qualities is of less value and can be disposed of. This 'Darwinian ethic' with its aim of 'survival of the fittest' places the demented, mentally handicapped, brain-injured and unborn (particularly the human embryo) in great danger.

The Human Fertilisation and Embryology Act

We are all familiar with the story of the Irishman who when asked for directions said, 'I wouldn't start from here'. I submit that the HFE Act is fundamentally flawed because it starts with a presupposition that has never been properly established - that the human embryo is not a human being with rights, and can therefore be treated as a means to an end. In keeping with this foundation the Act sanctions embryo freezing, research and destruction along with abortifacient contraception and the disposal of abnormal embryos after genetic testing - practices that we would not countenance for human beings at any other stage of development. With the HFE Act the devil is not in the detail but in the very foundation - and it is the foundation of the Act, not its detail that should be the proper subject of debate.

The Human Embryo

Any biology textbook tells us that human development is a continuous

process beginning with fertilisation; essentially the only differences between zygote and full term baby are nutrition and time. Biologically the human embryo is undoubtedly human; it has human chromosomes derived from human gametes. It is also alive, exhibiting movement, respiration, sensitivity, growth, reproduction, excretion and nutrition. It is therefore most accurate to speak of it as a human being with potential, a human being in an early stage of development or a potential adult; not as a potential human being.

Secular arguments

Philosophers, theologians, biologists and politicians, however, have advanced arguments to undermine the status of the human embryo and I want to address the major ones now. You already have my fuller paper on the issue to the HFEA/ACGT consultation on pre-implantation diagnosis:⁸

1. Human embryos are not human beings worthy of respect because they lack rationality or capacity for relationship.

This was the thinking behind the Warnock Committee's recommendation of no embryo research beyond 14 days, as the neural crests first form 10 days after fertilisation. Others have suggested that breathing movements (12 weeks), or 'quickening' (20 weeks), or even the first breath of air should be the end point. It has even been argued that newborn babies are not persons since they lack 'self-awareness'. But the development of the nervous system is a continuous process beginning at fertilisation and choosing an arbitrary point on this continuum discriminates on the basis of neural function. It is therefore 'neuralist'.

Neuralism varies from racism and sexism only on the basis of the non-morally significant quality selected as the basis for discrimination. It is simply another form of ageism. Our value as human beings does not consist in our capacities or attributes but in the fact that we are human. Arguing that the value of any human life depends on its place of residence (uterus, fallopian tube or petri dish) or degree of independence similarly discriminates on the basis of non-morally significant characteristics.

2. Human embryos are not human beings worthy of respect because they have a high mortality; about 40-70% don't reach maturity.

But the value of human beings is not contingent on their survival rates. We don't say that refugees in Chechnya, flood victims in Mozambique or AIDS sufferers are less important simply because they have a high mortality. Similarly, if survival rates at any stage of development are low this does not justify us actively ending life. The general strategy of medicine is rather to save and preserve life. The figure of 40-70% may well be an overestimate anyway. No one really knows how many early embryos die as there is no biochemical marker for fertilisation, as opposed to implantation.

3. Human embryos are not human beings worthy of respect because many embryos that do spontaneously abort have a high incidence of genetic (particularly chromosomal) abnormality.

But all of these abnormal embryos have formed from the union of two human gametes. Aren't they therefore just human lives with severe handicap, human lives with special needs? We would not argue in any other sphere that the value of any individual human life was contingent on its level of normality; far less that abnormality justified killing by 'disposal'.

4. Human embryos are not human beings worthy of respect for a religious reason - embryos don't have souls.

But the idea that human beings can be divided into body and soul is based on the ancient Greek idea of body and soul being separate entities; a notion which finds no

biblical support. Whilst it is true that all human beings survive death and face judgement (Heb 9:27), our destiny as redeemed human beings is to be clothed in a 'resurrection body' (Phil 3:21). The biblical word 'soul' (Gn 2:7) includes the body. We have bodies and are souls, rather than the other way round. The soul and the body begin life together. Given that the body has its origin at fertilisation, it follows logically that the soul must also.

Conclusions

I submit that the arguments used for devaluing the status of the human embryo are both unconvincing and discriminatory. I further submit that the human embryo should be given the benefit of any doubt regarding its status.

We have a choice: we either act to ensure the protection and survival of the most vulnerable members of our society by endorsing the Christian ethic of the strong making sacrifices for the weak; or we continue to ensure the non-survival of the weakest by politicising the 'Darwinian ethic'. The HFE Act has politicised Darwinism by enshrining in statute law discrimination against the weakest and most vulnerable members of the human race. It is one of the major instruments making non-survival of the weakest a public duty in this country. It is built on a fundamental presupposition that has never been established logically, philosophically ethically or morally and it has no place in a civilised society.

I submit that as HFEA members you are helping to administer an Act, endorsed by the parliament of this country, which violates fundamental principles of natural justice. As such, by definition, you share responsibility for perpetrating that injustice. Society has placed you in a position of enormous influence - and I appeal to you to review your position and to become advocates for vulnerable human life; rather than being complicit in its destruction. I believe that if you don't the judgement of history and of God himself will be that you will have failed to act to protect the most vulnerable members of our society when it was in your power to do so. Thank you for this opportunity to voice my concerns.

Peter Saunders is CMF General Secretary and Managing Editor of Triple Helix.

WITH THE HUMAN
FERTILISATION AND
EMBRYOLOGY ACT THE
DEVIL IS NOT IN THE
DETAIL BUT IN THE
VERY FOUNDATION.

KEY POINTS

The moral status of the human embryo is a central issue in ethical debates about contraception, genetics and artificial reproduction. Christian teaching and historical ethical codes both assert that human beings deserve the utmost respect and human embryos are the most vulnerable of human beings. Arguments which attempt to devalue the human embryo by pointing to its early stage of development, high mortality, genetic instability or lack of a soul are fundamentally flawed. At very least the embryo should be given the benefit of any doubt. On this basis the Human Fertilisation and Embryology Act is an instrument of discrimination and should be repealed.

References

- 1 Vere D. When is a Person? *JCMF* 1988; July:34(3):18-23
- 2 Browne S, Vere D. When is a person? - the debate continues. *JCMF* 1989; April 35(2):8-13
- 3 Berry C. *Beginnings: Christian Views of the Early Embryo*. CMF:1993
- 4 Burton E, Fergusson A. *CMF Members' Attitudes to Abortion: a survey of reported views and practice*. CMF:1996.
- 5 Saunders P. Deadly Questions on the Status of the Embryo. *Nucleus* 1998; July: 28-34
- 6 A fuller version of the submission is available on the CMF website at www.cmf.org.uk/ethics/subs/status.htm
- 7 Singer P. Sanctity of Life or Quality of Life? *Paediatrics* 1983; 72(1):128-9
- 8 www.cmf.org.uk/ethics/subs/pgd.htm

Andrew Fergusson draws out five 'service standards' from the parable of the good Samaritan

Hallmarks for Healthcare

The Parable

And behold, a lawyer stood up to put him to the test, saying, 'Teacher, what shall I do to inherit eternal life?' He said to him, 'What is written in the law? How do you read?' And he answered, 'You shall love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind; and your neighbour as yourself.' And he said to him, 'You have answered right; do this, and you will live.'

But he, desiring to justify himself, said to Jesus, 'And who is my neighbour?' Jesus replied, 'A man was going down from Jerusalem to Jericho, and he fell among robbers, who stripped him and beat him, and departed, leaving him half dead. Now by chance a priest was going down that road; and when he saw him he passed by on the other side. So likewise a Levite, when he came to the place and saw him, passed by on the other side. But a Samaritan, as he journeyed, came to where he was; and when he saw him, he had compassion, and went to him and bound up his wounds, pouring on oil and wine; then he set him on his own beast and brought him to an inn, and took care of him. And the next day he took out two denarii and gave them to the innkeeper, saying, "Take care of him; and whatever more you spend, I will repay you when I come back." Which of these three, do you think, proved neighbour to the man who fell among the robbers?' He said, 'The one who showed mercy on him.' And Jesus said to him, 'Go and do likewise.' (Luke 10: 25-37 RSV).

The parables of Jesus generally make a single point and we should beware of reading too much into the details. In the case of this parable, however, it is recorded in only one Gospel - that of Dr Luke. Luke's account would have been informed by his outlook as a professional. It is possible, therefore, to discern a secondary meaning - permanent principles that, according to Luke, are hallmarks for healthcare.

Jesus tells the parable to a lawyer who gets the answers to his first questions correct with the two 'Great Commandments': 'You have answered right'. But Jesus goes further: 'Do this, and you will live'.

The lawyer now feels threatened and has lost face too. There's no way he can qualify love for God ('with all your heart, and with all your soul, and with all your strength, and with all your mind' draws on Deuteronomy 6: 5) but maybe he can regain credibility by establishing limits on neighbourliness. It's in answer to his supplementary 'And who is my neighbour?' that Jesus tells the parable.

Comprehensive compassion

But a Samaritan, as he journeyed, came to where he was; and when he saw him, he had compassion...

A traveller has been mugged. We are told nothing of him beyond his sex. He is just 'a man' left 'half dead'. 'By chance' a priest comes along, perhaps having spent a week in the Temple serving God. Now is his big chance to serve his fellow man, but 'when he saw him he passed by on the other side'. We don't know why. It may have been fear of falling victim or of ritual defilement by a dead body.

'Likewise' we know no more about the Levite - although as a Temple servant, he may have had the same motivation. Jesus has really wound up the audience. Who's going to be the good guy?

Probably, most are expecting a Jewish layperson in a story with an anti-clerical point.

We would need to live among ethnic conflict, with hatred in a divided community, to appreciate what follows. When Jesus says 'But a Samaritan . . .' there would have been outrage. 'Who is my neighbour?' was common in theological debate. For Jews, neighbour was fellow Jew or full proselyte. Pharisees excluded tax collectors and sinners. But that the real neighbour should be a Samaritan . . . !

He was the one who 'had compassion' and it is with compassion that healthcare should begin. The English roots mean 'to suffer with'. It's strong feeling for our fellow man, pity or mercy for others, sorrow for the sufferings of another.

In healthcare, compassion has to be more than a subjective feeling. It has to be objective, with a practical outcome. Who do you show compassion to? You show it to your neighbour. And who is my neighbour? Well, that's where we came in. The whole point of the parable is to make us sensitive to the responsibility placed on us by the need of any other human being. The compassion foundational for healthcare is comprehensive. There should be no limits to love for neighbour, and this is healthcare's first hallmark.

Costly commitment

and went to him...

The Samaritan first had compassion, then 'went to him'. This involved risk. The figure might have been a decoy, intended to lure others, but his compassion moved him. Compassion in healthcare takes action. It requires commitment. But we need to recognise the cost. If truly committed to comprehensively compassionate healthcare, we will certainly as individuals face financial cost.

KEY POINTS

Jesus' parable of the good Samaritan only occurs in the Gospel of Luke the Physician. In it, as well as answering the lawyer's question, 'who is my neighbour?', the Lord gives us five hallmarks for healthcare which we will do well to apply as Christian doctors today: comprehensive compassion, costly commitment, conscientious competence, continuing care and Christ's commendation.



Salaries for many will be higher in other walks of life. Whole nations responding would face even greater health bills than those they are not coping with now! We will face pressures on family life, may face physical risks of infection, may even lose our lives.

Counting the cost is a biblical principle, and again it is Dr Luke who reports the words of Jesus: *'Suppose one of you wants to build a tower. Will he not first sit down and estimate the cost...?' (Luke 14: 28)*

Conscientious competence

and bound up his wounds, pouring on oil and wine...

The Samaritan did the right things. They may seem quaint now, but oil and wine then were state-of-the-art. He did the best he could given the knowledge of his day, and the resources available. This conscientious competence is still vital today. Conscientiousness is a hallmark of all Christian service:

Whatever you do, work at it with all your heart, as working for the Lord, not for men...It is the Lord Christ you are serving. (Colossians 3: 23-24)

So, even if limited by resources, we must serve as best we can – we must be conscientious. But we must also be competent. We must perform as well as any in our specialty. Western medicine has rightly become concerned with quality. In the UK we may resent yearly appraisal, governance, and re-accreditation, but we must endorse them.

Christ was a carpenter who made tables and chairs well. We are doctors – we must work as well as any similar colleague reasonably could. We must show conscientious competence.

Continuing care

then he set him on his own beast and brought him to an inn, and took care of him. And the next day he took out two denarii and gave them to the innkeeper, saying, 'Take care of him; and whatever more you spend, I will repay you when I come back.'

We should beware reading too much into parables. It would be a mistake, for instance, to base transport,

accommodation and fiscal policies for a health service on this quote. However, there is clearly a concept here of continuing care. More words are spent on the chronic care than the acute situation.

No health manager purchasing care anywhere today would write a blank cheque to the provider. Even the richest nations face real challenges from the costs of continuing care. Emergency and intensive care are dramatic, glamorous, exciting – easy for fundraising and big budgets. The Cinderella specialties are the opposite, but patients in these categories matter every bit as much.

Down the years Christians have pioneered and maintained service in unpopular specialties. A God who longs passionately for justice and mercy wants his people to be wherever needed for as long as they are needed there. And that care continues appropriately until life reaches its natural end. At that point, those who die in Christ live in the new reality of John's vision: *'... God himself will be with them and be their God. He will wipe every tear from their eyes. There will be no more death or mourning or crying or pain, for the old order of things has passed away.'* (Revelation 21: 3-4)

Christ's commendation

'Which of these three, do you think, proved neighbour to the man who fell among the robbers?' He said, 'The one who showed mercy on him.'

'It is the Lord Christ you are serving.' (Colossians 3: 24). Is our motivation in medicine Christ's commendation, that 'Well done, good and faithful servant!' of Matthew 25: 23? Or is it rather to receive prestige and status, fame and fortune, that long list of honorary degrees? Are we doing it for office in the College? For honours or a knighthood? These rewards are not wrong but the lure of them can be a snare.

So, how sterling will our service be? What hallmarks will it show?

Andrew Fergusson, formerly CMF General Secretary, now has a portfolio career which includes the Centre for Bioethics and Public Policy and the General Medical Council

My Shepherd

*The Lord is my Shepherd
I shall not want
(Psalm 23:1).*

Doctors are often impatient by nature. The pressures of over work and of life-threatening crises mingled with the subservience of our patients and high expectations of other team members, can lead to an arrogant and hasty approach to others, conducive neither to good patient care nor to a good team spirit. Tests of patience come in many guises: the intrusive 'phone call, the opportunist consultation ('while you're here, doctor'), the blocked drip or the over-booked clinic - we each have our own last straw. In time, we may learn to use each as an opportunity to run to the shepherd, choosing to stay close to him rather than running wildly out of control. Then we shall have daily exercises in seeing how he can, and does, lead us towards calmer waters. Then a more cohesive spirit will invade the team, patients will perceive a more restful attitude and we shall learn that when requests are made according to his will, he really does supply. I shall not want.

Extracted from a contribution by Janet Goodall in *The Doctor's Life Support* published by ICMDA/CMF



EUTYCHUS

Discriminatory diplomacy?

Doctors who have a conscientious objection to prescribing post-coital contraception or IUCDs that act after fertilisation will no longer be able to obtain the Diploma of the Faculty of Family Planning (DFFP) of the Royal College of Obstetricians and Gynaecologists. According to the College's October 1999 Guidelines, while 'doctors who hold moral or religious reservations about any contraceptive method are very welcome to undertake the training', they will not be eligible for a diploma if they 'restrict (their) repertoire of methods'. Whilst the absence of a diploma does not yet disqualify a doctor from giving contraceptive advice, it seems that job discrimination against Christian doctors who hold conservative ethical views is now inevitable.

Supernatural remedies?

'The Lord created medicines from the earth, and a sensible man will not despise them' (Sirach 38:4) Evidence is now emerging from systematic reviews and meta-analyses of randomised trials that some herbal medicines are efficacious. Recent examples include St John's wort for depression, ginkgo for dementia, palmetto for benign prostatic hyperplasia and horse chestnut seed for chronic venous insufficiency. Past examples, of course, include aspirin (willow bark), digitalis (foxglove) and morphine (poppies). Obviously the natural ingredient does need to be clearly identified and given in the right dose! (*British Medical Journal* 2000; 321:394-5, 12 August)

A fate worse than debt?

The United States has offered sub-Saharan Africa a \$1billion loan programme to buy anti-AIDS drugs. The offer has been condemned by Oxfam as 'a debt tomorrow's AIDS orphans will be forced to pay'. The US offer requires countries to buy drugs manufactured in the United States. Oxfam accused the US of setting up a deal to help drug companies fight off competition from generic drugs that can be manufactured locally at a fraction of the cost. 24.5 million people in sub-Saharan Africa are currently infected with HIV. (*British Medical Journal* 2000; 321:260, 29 July)

Killing the pain, not the patient

A *Lancet* study of 238 patients at St Christopher's Hospice has concluded that the use of opiates does not shorten the lives of terminally ill patients. Those who received markedly increased doses in the last week of life did not have shorter survival periods than those who received no increases. Researcher Nigel Sykes observed: 'This study dispels the myth that good pain control at the end of life means killing the patient. People should not fear that taking morphine for pain need shorten life... There is no connection between competent symptom control and euthanasia.' (reported in *SPUC News Digest* 2000; 3 August)

Telediagnosis for the developing world

In sub-Saharan Africa there are on average less than 10 doctors per 100,000 people - but now 53 out of 54 African countries have email access - and SatelLife, a Boston-based charity now provides email access in 140 countries serving 10,000 healthcare workers by

using low earth orbit satellites and phone lines. With the falling costs and increasing capabilities of computers and imaging systems, a basic store-and-forward telemedicine system (using email, PC and digital camera) can now be set up for little more than \$1,000. (*British Medical Journal* 2000; 321:465-6, 19 August)

Persistent vegetative state...not

There are about 1,500 patients in the United Kingdom who are thought to have been in a vegetative state for more than three months. However, over 40% of them may have been wrongly diagnosed according to research originally published in 1996. A technique developed at the Royal Hospital for Neuro-Disability in London is now able to identify the slow-to-recover patients, and should be available to other hospitals by the end of the year. SMART (sensory modality assessment and rehabilitation technique) records patients' responses to stimulation over two weeks, enabling those who communicate in a consistent and meaningful way to be picked up, and managed more effectively. (*British Medical Journal* 2000; 321:196, 22 July)

'Do not resuscitate' policies

In early September the Department of Health ordered NHS trusts in England to draw up 'do not resuscitate' policies. The proposal first appeared in the NHS Plan in July and follows similar recommendations by the British Medical Association. This is a great opportunity for CMF members to make a contribution - by making use of the guidance published in the July edition of *Triple Helix*. (*British Medical Journal* 2000; 321:588, 9 September)

Getting the point

The British Medical Association has urged the NHS to make acupuncture more widely available, saying that the vast majority of doctors believe that it works. The BMA is recommending that training is made more widely available. It has also called on the National Institute for Clinical Excellence (NICE) to issue guidelines on the use of acupuncture in the health service. Family doctors traditionally have regarded alternative medicine with scepticism but a BMA survey found that 58% had arranged some sort of complementary or alternative treatment. Of these acupuncture was the most popular. (*Telegraph* 2000; 26 June)

Folic follies

It is almost a decade since it was discovered that folic acid could prevent the development of neural tube defects such as spina bifida. The United States acted on the research four years ago by fortifying flour with folic acid, but it has taken until July this year for the UK Department of Health to launch its own three month consultation with the same end in mind. Thankfully now the move doesn't look far off. The main result will be in curbing the growing number of mid-trimester abortions for spina bifida. If only the government had the same enthusiasm for preventing disability as it does for prenatal diagnosis and abortion! (*British Medical Journal* 2000; 321:400, 12 August)

OPPORTUNITIES ABROAD

Specific Vacancies by Country

Posts often require you to raise your own support (though some missions help) and support of your church is generally needed. A longer list of Opportunities of Service is published in *Saving Health* and is available from MMA HealthServe, First Floor, 106-110 Watney Street, London E1W 2QR. Tel: 020 7790 1336, Email: info@mmahealthserve.org.uk, web page www.mmahealthserve.org.uk We would be happy to assist with enquiries or forward messages by email.

AFRICA

Kenya

Volunteer doctor for a community health centre. Target group is the aged and orphan children. Local authority licence to operate a dispensary. Feeding programme as funds are available. Orphaned children are assisted with school clothes and books. Staff includes a nurse and an assistant and equipment includes microscope, minor operation theatre, refrigerator. There is a two bedroom house available. Alternatively the voluntary doctor could be based in Nairobi (60 miles away) and drive to the centre 3-4 times a week. The committee would welcome a retired doctor who could come for a couple of months. A woman doctor would be acceptable.

Contact Bishop John Mahiaini, St Anna Centre for aged and orphans, P O Box 532, Muranga, Kenya.

Kijabe tertiary mission hospital needs **general surgeons** and an **orthopaedic surgeon**. Contact Andrew Hill, Email: andrew-lori_hill@aimint.org Or contact Africa Inland Mission (AIM) as found under Opportunities of Service in *Saving Health*.

Kapsowar is a district-type mission hospital which usually has three doctors including a surgeon. **Medical officer** or **Physician** and **Surgeon** needed. Contact Dr Ann Fursdon Email: annfursdon@aimint.org Or AIM as for Kijabe

Malawi

Doctor for St Peter's Hospital, Likoma Island. Suitable for single person or a married couple without young children. Housing provided. Contact Bishop Jackson C Biggers, Anglican Diocese of Northern Malawi, Email: biggers@malawi.net Information from Dr Pam Douglas (who recently assisted there) Sheeplas, Duke Street, Settle, North Yorkshire BD24 9AN. Tel: 01729 822531

Tanzania

Doctor (GMO) volunteer for Murgwanza Hospital. Needs to have been qualified at least four years, and come for a period of a year or longer to justify the paper work (which may take 6 months to a year). The person must be willing to work for the Anglican church.

Contact Dr Stephan Reaney. Tel: 028 3885 2520 (up to end of December 2000). After December write

either direct to Murgwanza Hospital, PO Box 7, Ngara, Kagera, Tanzania or Crosslinks (see above).

Uganda

Christian **pharmacist** required for a rural hospital. Contact MMA HealthServe for more details.

ASIA

Bangladesh

Lamb Hospital. Cover is sought for the **Medical Director** who is on furlough for **six months** starting February 2001. Lamb is an integrated community and hospital based health and development organisation with a focus on MCH, with 60,000 outpatients and 5,000 inpatients annually. There are six expatriates and eight national doctors. PG medical training recognised. Medical Director has clinical and managerial responsibility and is part of the management team. The main needs are for administration and personnel management but a wide range of clinical practice is possible. Family housing and school up to age 11 available.

Contact Dr Mark Pietroni, Medical Director, Lamb Hospital, Parbatipur, Dinajpur 5250, Bangladesh. Email: lamb@citechco.net

China

Tour to Central China, October each year. Join UK Christian **medics and health professionals** on a lecture tour to Chongqing Municipality. Cost approx £1400.

Also **elective opportunities** with a retired UK consultant, Mandarin speakers preferred.

Contact Medical Services International, 42 Telston Lane, Otford TN14 5JX Email: 113720.362@compuserve.com

Nepal

International Nepal Fellowship requires staff for its District Health Development Programme:

Midwives and nurses (safe motherhood and MCH work including training camps).

Anaesthetists (training programme nurses and GPs central and district).

Radiographer (assessment, training, monitoring on site and camps).

General Doctors (includes hospital, teaching, and community focus.)

Gynaecologist (develop surgical services, service/training camps, interest in safe motherhood and maternal health).

Contact Dr Paul Foster, consultant anaesthetist and Mid-west co-ordinator for International Nepal Fellowship: Email hsp@inf.org.np or contact INF above.

Singapore

Occupational Therapist (Mental Health). For details contact Gail Tyson gtysson@uccf.org.uk or Mr Kamaludin bin Ibrahim, OTR, Woodbridge Hospital, Occupational Therapy Dept, 10 Buangkok Way, Singapore 539747, Fax: 65-389-2175

AUSTRALIA

A Christian outreach family practice (two female doctors) in Sydney is looking for a third doctor (male or female) for a minimum of one year. Contact Roslyn: Tel: 0296 052500 Email: rsuefongs287@dhm.com.au

MIDDLE EAST

Yemen

Doctor/director and **nurse** for a clinic in the Port of Aden. The clinic provides mother and child healthcare and general medical care for the community in an area of population growth. Requirements include a sense of God's call, sensitivity to those of other faiths, a willingness to stay three years and to learn Arabic. Suited ideally to a married couple without children who will join the existing team and live on site.

Contact Sue Knight or Stuart Buchanan at CMS, Partnership House, 157 Waterloo Road, London SE1 8UU, Tel: 020 7928 8681, Fax: 020 7401 3215, Email: sue.knight@cms-uk.org or stuart.buchanan@cms-uk.org

Thanksgiving. Female obstetricians and midwives required for a brand new maternity hospital run by well established team in a small Arab peninsula city. Up to date skills and love of people essential. Long term commitment and willingness to learn Arabic preferable.

Contact Thanksgiving, P O Box 1134, Clacton-on-Sea, Essex, CO16 8EF

RESOURCES

Affordable medicines for Africa

Aims to be a reliable, affordable, essential generic medicines supply program for Christian Mission Hospitals and those who serve the poor.

Contact Tom Wagner, AMFA, P.O. Box 62229, Marshalltown 2107, Johannesburg, South Africa Tel: 27-11-240-6003, Fax: 27-11-836-8919 Email: tomw@holland.co.za

EVENTS 2001

Medical Elective Days

Dundee, Saturday February 17th
Leeds, Saturday March 10th
London, Saturday March 21st

Residential Refresher Course

Overseas Update For Christian Doctors and Nurses working overseas
Oak Hill College, Southgate, London. June 18th-29th

Continuing Medical and Dental Education Conference

Run by CMDS (USA) in Thailand Feb 19th-March 1st
Further details from CMF office

Rod MacRorie asks whether this slogan offers real hope to the poor?

Sustainable Development

*‘You did not choose me, but I chose you, and appointed you to go and bear fruit-fruit that will last.’
(John 15:16)*

The idea of ‘sustainable development’ has become an indispensable justification for modern missions working with an aid agenda. But what is meant by ‘sustainability’? Is it biblically significant? Is it relevant to what Christian development agencies are really doing? If not, why are we doing it? It was to challenge the economic dogma of the necessity of accelerating growth that Tanzanian president Julius Nyerere introduced the concept of ‘sustainability’ in 1974. This approach was adopted by the influential Brundtland Commission in 1987 and defined thus: ‘Sustainable development is development, which meets the needs of the present without compromising the ability of future generations to meet their own needs.’¹

This new concept divided the theologians. The World Council of Churches at Nairobi (1975) took over Nyerere’s term, calling for a ‘just and sustainable society’ by means of empowering the poor.² They accepted the facts of limited local resources and the unlikelihood of mass social change, and sought how to live within the present system unchanged. Yet whereas many western development experts were still seeking to meet needs, many of their southern counterparts were questioning the concept of ‘development’ entirely. So-called ‘liberation theologians’ rejected the assumption that western culture could somehow be fitted into their own. The ‘trickle-down’ approach to aid was simply a means of keeping western donors in control and two-thirds world recipients dependent on them. ‘Development was not...a new word for peace, but another word for exploitation.’³

Christian agencies, under pressure from all sides, have generally responded by adopting the secular modernisation agenda, incorporating sustainable development. Thus Christian community development has been defined as ‘helping others help themselves’.⁴ But the holistic and person-centred emphasis of this concept became overshadowed by its economic implications. As programmes moved away from ‘economic growth’ as an aim, economic self-sufficiency became the perceived need, a necessary strategy, and eventually an end in itself. Once programmes had to rely exclusively on locally available resources, external costs could be reduced. Those charitable agencies with tight budgets became understandably attracted to this kind of ‘self help’. Thus it has been abused by some as an excuse for maintaining the

status quo, and by others as an excuse for cost-cutting. It has contributed to a climate of unilateral self-interest in donor and receptor countries rather than fostering mutual interests.

God Sustains

God’s sustaining activity is an essential attribute of his being as Father and Son. ‘The Son is the radiance of God’s glory and the exact representation of his being, sustaining all things by his powerful word.’⁵ The Fall, however, rendered his perfect creation unsustainable, a decay which affected human lifespan and his environment equally. ‘For the creation was subjected to frustration...in hope that the creation itself may be liberated from its bondage to decay.’⁶ This hope for liberation was not to be fulfilled by the human efforts of the people of God, but through God’s singular act of redemption through his Son. ‘He is before all things, and in him all things hold together...for God was pleased to have all his fullness dwell in him, and through him to reconcile to himself all things, whether things on earth or things in heaven...’⁷

The New Testament Greek word-family for ‘sustaining’ includes several different nuances that may help us assess its relevance to our discussion. ‘Sustaining’ can imply ‘staying put’ in one place, or ‘moving on’ unchanged. Staying metaphors include the frequent ‘abiding’, staying as a houseguest, or indeed, owning a property. Moving metaphors include ‘maintenance’ of hardware, or ‘persistence’ of an action. Jesus himself is supremely a man sustained by his relationship to God as Son to Father. This is anticipated in the messianic prophecies: ‘The Lord says to my Lord, “Sit at my right hand...”’⁸; ‘sit’ is a ‘staying’ metaphor. John’s gospel emphasises the sustenance the Son derives from the Father. ‘I do nothing on my own, but speak just what the Father has taught me. The One who sent me is with me; he has not left me alone.’⁹ He calls upon others to enter the same sustaining relationship. ‘I pray...that all [believers] may be one, Father, just as you are in me and I am in you. May they be in us so that the world may believe...’¹⁰ We cannot endure on our own. We stand firm with him,¹¹ keep watch with him,¹² and stand with him in trials.¹³ Our future is rooted in our ongoing relationship in Christ. This truth is beautifully described in the metaphor of the vine in John 15:1-10 quoted in the introduction. We are sustained as branches of the vine (the Son), tended by the gardener (the Father), maintaining connections with others in a network of interdependent relationships.

KEY POINTS

One of the most pervasive concepts of modern mission development work is ‘sustainability’. Its appeal to western planners is matched by the creativity of programmes in developing countries to try to demonstrate sustainability in its work. In the process, what is meant by sustainability has become muddled and unhelpful. The Bible offers an alternative vision for ‘inter-dependency’, which emphasises sustainable relationships from both sides of the economic divide.

Mutual Society

Out of this central dependence on God, we are to reflect the same sort of sustaining relationship one with another. Jesus anticipated this in the relationship of evangelist and his audience, balancing giving in ministry with receiving in hospitality.¹⁴ Paul, despite a strong personal preference to sustain himself in difficult circumstances,¹⁵ appeared to submit to this reciprocal relationship.¹⁶ Only in this way could he be sustained in ministry against fantastic odds.¹⁷

We in turn are given the responsibility to build and maintain relationships as a means to sustainability. Our proud independence must be buried, to bear fruit in the continuing progress of the community.¹⁸ Sustaining relationships requires the compassion and insight of Jesus and to love in a durable way.¹⁹ We need to grow perseverance, hope and patience.²⁰ Then we shall be able to train in godliness, and comfort one another in adversity.²¹ It is always in the context of a sustained relationship with the living God.

The Bible is clear that this world is ultimately unsustainable. Society as we know it is in the process of passing away.²² The entire natural order is wearing out and will perish.²³ As the Creator made it, so he will dissipate it, leaving behind the sustained kingdom.²⁴ Concepts of sustainability based on natural or social order are thereby misleading.

A Way Forward

It is possible to identify a different approach to sustainability, based values of the kingdom Christ is building. Where do our development efforts fit into this alternative picture? Can our focus be shifted from independent communities to interdependent ones? People networks built between developed and developing countries, in which both sides respect each other's insights and assets. Bridges on which needs are mutual, where self-esteem not self-interest is promoted. In his appeal to help the Christians of Judea, Paul stressed the need for a balance of power in the relationship: 'At the present time, your plenty will supply what they need, so that in turn, their plenty will supply what you need. Then there will be equality...'.²⁵ He looks beyond the current crisis towards a future sustained by a sharing of resources. He denies that charity is unsustainable: 'you will be made rich in every way so that you can be generous on every occasion...'.²⁶

Such a change of focus will have implications for strategy and goals for development. 'The best way forward may not always be to try and ensure that the structures (and the organisation) that we set up continue. What is important is what happens in hearts and minds.'²⁷

THE BIBLE IS CLEAR THAT THIS WORLD IS ULTIMATELY UNSUSTAINABLE.

Such interdependence could contribute to what Taylor has called the 'integrity of development', in which complex interconnections facilitate the good development of all parties, seen in spiritual and cultural as well as socio-economic terms.²⁸

Sustainability is a confusing concept that has led Christian development work astray. Structures and activities will pass away, but sustained relationships between rich and poor, based on interdependency and mutual respect, is part of a biblical worldview. We must question aid efforts that seek fast finite results, and promote communication between individuals, churches, communities and governments. Our model should be the vine with its sustaining branches, fed by the root of faith in Christ and producing good fruit. 'Do not work for food that spoils, but for food that endures to eternal life, which the Son of Man will give you.'²⁹

Roderick MacRorie is Director, Tuberculosis Leprosy Project, International Nepal Fellowship, PO Box 1230, Kathmandu, Nepal, and has been engaged in medical development work with the INF since 1993. These reflections are personal and do not reflect the policy of TLP or INF.

References

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| 1 | Brundtland GH ed. <i>Our Common Future: the report of the world commission on environment and development</i> . Oxford, OUP, 1987. | 16 | e.g. Romans 15:24. |
| 2 | Taylor M. <i>Not Angels but Agencies: the ecumenical response to poverty: a primer</i> . London, SCM, 1995. | 17 | 2 Corinthians 6: 4-10. |
| 3 | Bosch, <i>ibid</i> , page 357. | 18 | John 12:24-25, Philippians 1:25-26. |
| 4 | Pickett RC and Hawthorne SC. <i>Christian community development</i> . In: Winter RD and Hawthorne SC. <i>Perspectives on the world Christian movement</i> . Carlisle: Paternoster, 1992. | 19 | Matthew 15:22, 1 Corinthians 13:7, 2 Timothy 2:10. |
| 5 | Hebrews 1:3. | 20 | Romans 5:3-4, Hebrews 12:1, 1 Timothy 6:11-12. |
| 6 | Romans 8:20-21. | 21 | 1 Timothy 4:8, 2 Corinthians 1:6, Revelation 2:2-3. |
| 7 | Colossians 1:17-20. | 22 | 1 Corinthians 7:29-31. |
| 8 | Psalms 110:1. | 23 | Hebrews 1:10-12. |
| 9 | John 8:28-29. | 24 | Hebrews 12:26-29. |
| 10 | John 17:20-21. | 25 | 2 Corinthians 8:14. |
| 11 | Matthew 10:22. | 26 | 2 Corinthians 9:9-11. |
| 12 | Matthew 26:38. | 27 | Batchelor P. <i>People in Rural Development</i> . Carlisle: Paternoster, 1993. |
| 13 | Luke 22:28-29. | 28 | Taylor M. <i>Good for the Poor: Christian ethics and world development</i> . London, Mowbray, 1990. |
| 14 | Matthew 10:8-11. | 29 | John 6:27 |
| 15 | 1 Thessalonians 2:9. | | |

Review WWWs with Cyberdoc

Cyberdoc reviews cloning online – the words in bold correspond to links on Cyberdoc's website at xtn.org/cyberdoccloning/

There is very little material on cloning on the **CMF website**: a 1998 submission on 'Cloning issues in reproduction, science and medicine' to the Human Genetics Advisory Forum (HGAC) and Human Fertilisation and Embryology Authority (HFEA), a brief article from the Student Journal *Nucleus* and some more general articles on human genetics. But there is much to find elsewhere.

One of the first and best sites I discovered on the subject was one created by an individual- it is always heart-warming to realise that enthusiasts still exist. **Gareth's Cloning Web Site** is light on ethical issues, and perhaps a little dated, but a great starting point. The legal position in various countries is explained, and there are helpful articles and links.

The **Roslin Institute** is where cloning was first successfully performed, but their web site is rather poor. There is minimal discussion of ethical issues, and a rather tacky design. A book entitled 'The 2nd Creation' is strongly promoted, which is enough to stir concerns that scientists think they are playing God with this technology.

Christian sites on this subject appear to be few and far between, with the excellent **Church of Scotland Society, Religion and Technology Project site** a notable exception. Interestingly one of the Roslin scientists had significant input into this work.

Guardian Unlimited has a special section of their site devoted to genetics in general and laced with an healthy air of scepticism. Surprisingly, despite appearing to be generally up to date, there was no mention of the latest suggestion that homosexual fathers could conceive using cloning technology. **BBC News** made up for this lack, and linked from this story to some very useful background information, including audio clips and ethical discussion. The main **BBC** site returned an amazing 186 documents about cloning including several full transcripts of programs like Horizon.

The Government sponsored **Human Genetics Commission** site contains little more of substance than a link (under their 'what's new' section) to the full text of the recent Donaldson report on stem cell research (read 'cloning' in most scientists minds).

Easily the best website on the ethical aspects of human cloning is one which calls itself **religioustolerance.org**. The page on cloning includes arguments and quotations for and against cloning, and an explanation of stem cell research. There is a vast catalogue of references, mostly linked online. If you have time only to look at only one site on the subject this is the one!

This article and links to previous Cyberdoc website reviews can be found at xtn.org/cyberdoc/

Cyberdoc is Adrian Warnock, SHO in Psychiatry and previous editor of *Nucleus*.



BOOKS

The Coming of the Rain:

The biography of a pioneering missionary in Rwanda

Katharine Makower

Illustrated by Caroline Church

Paternoster Press Carlisle 1999

£9.99 Pb 128pp

ISBN 0-85364-968-5



This excellent book is a biography of Dr J E ('Joe') Church (Cambridge & St Bartholomew's Hospital), who worked as a missionary in Rwanda and Uganda, and was at the heart of the

East African Revival from its inception in 1929 when he met a Ugandan, Sitneoni Nsibambi. The two of them studied what the Bible had to say about the work of the Holy Spirit in a believer's life. Not charismatic in the contemporary sense, that Revival, which spread all over eastern Africa, closely resembled the great revivals of the past. Countless Christians have been transformed into vibrant and courageous witnesses and evangelists, prepared even to die for their faith in Christ. Africa has one of the fastest growing churches in the world and the Revival, which still continues in many places with undiminished rigour, earns an honoured mention in the Lion Handbook, *The History of Christianity*.

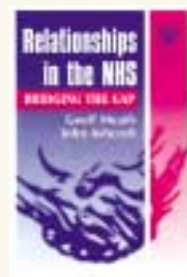
A 'child of the Revival', John Sentamu, Bishop of Stepney, has written the introduction to the book, the style of which is easy and fresh, making you want to read on to find out what happened next. Based on unrivalled documentary material, the author sets Joe in his context amongst the other British missionaries and the Africans involved. Because Joe was not a skilled linguist, local Africans were very important to him in his medical tasks and preaching. He loved working with them as a team of brothers in Christ, and his transparent honesty and genuine valuing of them as people loved by God

earned their enduring respect and warm affection. He was a cheerful encourager of others and great fun to be with, and he enjoyed sports, cars, game trekking and 'messing about in boats'. He was wont to come up with exciting but impractical projects until the realities were gently pointed out by his doctor wife Decie, nee Decima Tracey (Royal Free Hospital).

The value of this book is further enhanced by its highly topical final chapter on the terrible Rwandan genocide of 1994. The author has some interesting things to say, things which are equally relevant to the church worldwide as it continues to grapple with the age-old challenge of how to apply the fruits of personal salvation to the well-being of society at large.

John Billingham is a retired neurologist from Kent, formerly medical missionary in the Gambia.

Relationships in the NHS - Bridging the Gap



Geoff Meads and John Ashcroft

The Royal Society of Medicine Press

London 2000

£17.50 Pb 139pp

ISBN 1 85315 438 5

Michael Schluter of the Relationships

Foundation writes in the foreword to this book: 'Partnership, collaboration, involvement, "joined-up" government: the language of relationships pervades current health policy and practice. The complexity and uniqueness of any relationship means that the reality of this rhetoric must involve more than motherhood and apple pie.'

Cynical commentators may feel that the use by political managers of such buzzwords within the British National Health Service is indeed little more than 'motherhood and apple pie', but if any Christian has hitherto wondered whether the concepts espoused by the

Relationships Foundation qualify for that description too, this book proves them wrong.

Based on relational research conducted in the new NHS between 1995 - 1999, and at a time of an enormous but almost unrecognised shift of power and resources from secondary to primary care, such that the 80%-20% distribution is likely to be reversed, this stimulating book moves lucidly and logically through key concepts. Consecutive chapters cover agenda, policy, resources, strategy, organisation, delivery, development, review, quality, and prospects.

Highlights for me included acknowledgements of 'a widespread disillusionment about the state of relationships in the NHS and their impact on health', that 'relationships are much neglected by the NHS as a resource in both policy and practice' and that 'the new NHS runs the risk of pursuing strategies which outstrip their relationship basis'. In other words, in all the reorganisations and quality initiatives, the NHS is failing to take its million or so staff along with it! The authors also recognise the sense of threat which sadly so often prevails at the moment: 'there are risks to relationships in healthcare arising from the use of quality principles to justify stronger central scrutiny'.

By contrast, at the end of the book there are a couple of paragraphs on 'love' which are explicitly but sensitively Christian. The book is implicitly Christian throughout, but otherwise only explicitly so in that every one of the chapters begins with a quote from Ecclesiastes. The book ends with Ecclesiastes 12:12, 'Of making many books there is no end, and much study wears the body'. You will be slightly wearied reading this book as it is meaty stuff, but it is study well worthwhile not just for those in British primary care but for Christians and others working anywhere in health services throughout the world.

Andrew Fergusson is Head of Policy at the Centre for Bioethics and Public Policy

BOOKS CONTINUED

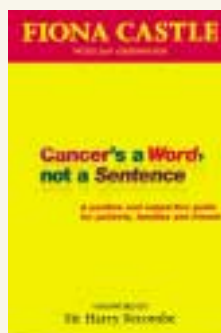
Cancer's a Word, not a Sentence

Fiona Castle

Hodder & Stoughton, London 1999

£6.99 Pb 130pp

ISBN 0 340 74565 7



This is an excellent book to have handy in the surgery to give out when appropriate. Its strength is that it is written sensitively by someone who really understands the cancer

journey, who can lift the mystery of medical jargon and help reduce the level of fear experienced by those affected by cancer. It is comprehensive, realistic and yet full of hope and sound, well-informed advice.

The author's experiences as she shared her late husband Roy's journey with cancer from the day of his diagnosis to his death, are common to so many. Yet, the understanding she brings to the feelings of loss, guilt and anxiety all help to give a sense of control in a world that feels out of control.

Fiona Castle's Christian faith is woven beautifully into the text, without ever intruding or threatening the non-believer. I was surprised that there was little critical comment, from a Christian perspective, on the range of complementary and alternative therapies described. But then, that is not what this book is about and would probably fill another volume anyway.

The best is kept until last. The final section, 'A difficult path' is compulsory reading for all who are ready to face up to their mortality. Why do we always leave this so long and then find we are sharing our uncertainties as we attempt to be alongside the one who is sick?

Don't just buy one copy of this book - invest in several and have some ready to give away!

Gareth Tuckwell is Macmillan Cancer Relief Director for London, Anglia and South East England

Six Modern Myths

Philip J Sampson

IVP, Leicester 2000

£8.99 Pb 182pp

ISBN 0 85111 659 0



This is a very important book. The author cogently argues that behind the six most common areas where Christians are criticised, there has been much misinformation,

some of which has been deliberate.

It has been popularly said that the church in the middle ages was anti-science and suppressed the research of Galileo. Such stories have been spread by the writings of men like the rationalist eighteenth century historian William Lecky, the atheist philosopher Bertrand Russell, George Bernard Shaw and Bertolt Brecht's plays. They all had their reasons to show the church in a bad light and were happy to be very selective about what they said. The author is very persuasive in his review of the evidence and shows that these writers did not present 'the truth, the whole truth and nothing but the truth'.

The presentation of the story of Darwin is even more disturbing. We have all heard of the debate between Thomas Huxley for the Darwinians and Bishop 'Soapy Sam' Wilberforce for the church at the British Association for the Advancement of Science in 1860. The Bishop is often presented as a buffoon whereas the truth is that he was a very learned scientist who was vice president of that association. Far from being ignorant, he had already reviewed Darwin's 'Origin of Species' and there is no evidence that the Bishop was flattened by Huxley's erudition. The bias used in the presentation of much of the evidence in favour of neo-Darwinism is exposed.

This chapter then discusses the way that this theory has been the basis of some horrendous practices, based on 'eugenics'. If human life is simply the product of chance evolutionary forces, then the

elimination of 'low grade stocks' of human beings, even if for political ends, can be rationalised, and then practised. The other myths investigated are:

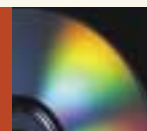
- The environment – is the Bible at the root of global exploitation?
- The missionaries – was Christian mission a vehicle of colonial oppression?
- The human body – is Christianity essentially repressive and 'anti-body'?
- The witches – how true was the witch-hunt as an example of the subjugation of women?

When there is so much adverse publicity today, depicting as irrational those who still believe in a personal creator God who is concerned about how his world runs, it is very good to have such a scholarly paperback that gives clear replies. The book argues that it is not the Christian who is turning a blind eye to the evidence for and the consequences of such modern teaching. It also strongly suggested that there are some that want to alter people's understanding of what is true by presenting very biased evidence and perceptions.

It is written in a 'thesis' mode and subsequently can be a little 'bitty' in its flow, with references everywhere, but I am very grateful to have read it and will use many of the arguments put forward and the quotes used, in future discussions.

Bernard Palmer is a General Surgeon in Stevenage

**The CMF Website
on CD-ROM
£3 (Special Offer)**



The CMF website is now available on CD-ROM: over 30 back issues of Nucleus and 10 issues of Triple Helix together with ten years of CMF government submissions on ethics, the full set of CMF Files, a year's supply of daily devotions, the Confident Christianity evangelism training course, 'Cyberdoc' web reviews, a quarterly newsround of issues in medical ethics and much more. Most queries can be answered within two or three mouse-clicks from the homepage. To order see the insert.

Sinking Slowly?

Hot. Smelly. Busy. Expensive. Such were my friends' recollections of Venice. Not mine, however. I had visions of tall, ramshackle brightly coloured buildings teetering elegantly on stilts above the cool, clear water of quiet, meandering canals. The rose tinted memories of an eager ten year old perhaps (some 20 years on), remembering her first experiences of continental Europe. So I suppose that I might have been disappointed on my recent return there, yet I wasn't. That is, I was neither prepared to be, nor was I disappointed. Away from the crowds of the main tourist areas Venice was just as I remembered, with but one exception. The absence of stilts, already hidden as evidenced by the water lapping at the edges of San Marco square (despite a drought ridden summer) were an all too real reminder that Venice is slowly, but surely sinking.

Like most people, however, not all my childhood memories are so pleasant and carefree. I have my share of heartache with which the past's horizon is marred and the future will be enriched. Yet they are nothing compared with some of the trail of broken hearts and twisted lives that visit my surgery on a daily basis, usually timed perfectly to coincide with my nephew's birthday party or some other family event which, this time as always, I had promised faithfully not to miss.

Not that I would change that. Medicine is not just a science, or even an art. It is perhaps, for some at least, a vocation, but for all of us it is a privilege. The depth of the trust of the young woman who whilst asking for contraception, tentatively discloses a history of abuse. The burly HGV driver who breaks into tears at the thought that his licence and livelihood are about to be lost. The sharing of grief with the recently bereaved who thank you endlessly for doing your best when somehow you can't help feeling this is just when you have failed them most.

Like all privileges however it carries with it burdens. Like rights and responsibilities the two go hand in hand. For some it seems that is too much, as the growing trend of disillusioned doctors only serves to testify, as more and more leave the profession for which they trained so hard. I count myself fortunate not to be among them, as yet, not to be sinking slowly, like Venice, under the burgeoning paperwork and continuing political wrangling. For me medicine is undoubtedly still a privilege, an opportunity to show the human face of the love that God so caringly showed us in sacrificing his only Son. For of that I do not have rose-tinted memories but a divine directive to remember the new covenant:

'This is my blood of the covenant, which is poured out for many for the forgiveness of sins.' (Matthew 26:28).

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