LETTERS

We have had a large post-bag this issue and accordingly most letters have been abridged.

More than just a job

***Frank Garlick**, a former missionary doctor from Brisbane, Australia, offers insights on vocation from his experience*

As I read Professor David Short's article (*Triple Helix* 2001; Spring:12-13) two questions came to mind. The first arises from his statement, 'The Christian doctor must be as fully informed and conscientious and skilful as possible.' That is true, though I feel there is more to it. There have been several decisions in life that left me with the question 'Will this result in me becoming a second class doctor?'

There is a distinction between being well informed and making a decision, but often one blurs into the other. The decisions I faced were whether to study on Sunday versus Church responsibilities, clashes in meetings to attend, books or journals that competed for reading, and particularly the decision to work in an overseas country. The fact that Dr Short wrote 'something has got to go' makes me think he has faced similar challenges.

After such a decision has been made, the course embarked upon, when or if life doesn't work out as anticipated, the question seems to contain the answer. 'Yes I am becoming a second class doctor.' That is how I understood consequences as I went through life, much earlier. It is not how I understand life seen now in retrospect. It has turned out differently; better, richer. 'We know that the Spirit cooperates in every way for good with those who love God…' is how F.F. Bruce translates Romans 8:28. But the question raised as one faces a decision means a risk is involved. It is a real risk. Risk and faith go together.

That leads me to the second question which concerns work overseas. Often the norm seems to be progression in professional life in one's own culture, in the security and familiarity of one's own environment. The question could be put like this, 'Am I called to remain where I am?' Jesus models movement from security to insecurity in another culture. The question could be re-phrased 'Have I reason not to work cross-culturally?'

HIV: cheaper drugs for poor countries

***Donald Inverarity** (SpR in Infectious Diseases and Medical Microbiology), comments on our editorial calling for cheaper drugs to combat HIV in poor countries*

I am writing in response to John Martin's editorial ('Aiding Africa', *Triple Helix* 2001; Summer:4). I would like to thank him for raising awareness in the Christian medical community of the considerable inequalities in antiviral provision between African and 'Western' countries. However, I would hesitate to endorse his rallying cry that, 'Christians whose God is demonstrably biased in favour of the poor will surely see the point of making these drugs affordable, and widely available.'

The responsible use of antiviral therapy requires the backing of virological laboratory services to measure CD4 counts and viral loads. Without these, it is very difficult to judge when to start therapy or to assess when therapy is failing. In addition, there must be a guaranteed supply of drug and full compliance by the patient. Currently, many Africans do not have access to a laboratory with a functioning microscope for tuberculosis sputum smears or a reliable supply of essential drugs such as quinine, far less virological tests.

Without patient compliance, and without access to a combination of drugs, antiviral therapy could have devastating effects, in selecting multiply resistant viruses in a population. In order not to cause harm, at present, perhaps the wisest solution is not to prescribe but continue to improve health service infrastructure.

Yes, let us be advocates for cheaper antiviral drugs globally, but let us do so understanding the hazards they may create and being wise and responsible.

***David Clegg**, CMF Overseas Support Secretary, offers a further perspective*

Your editorial ('Aiding Africa', *Triple Helix* 2001; Summer:4) gives valid arguments for reducing the price of the drugs but is pitched at the wrong level for the majority of those with the infection. The average African cannot afford any drug on a regular basis be it insulin for a child with diabetes or treatment for her mother with hypertension. In fact they cannot afford the time or cost of access to a drug on a regular basis even if it is provided free - hence the DOTS strategy (directly observed treatment short-term) to enable those with tuberculosis to be treated effectively.

The only way HIV/AIDS can be stemmed is by a change of heart resulting in honesty, openness, forgiveness and willingness both to live and die for the benefit of others. The kingdom of God can provide the basis for such a culture. But which nations will prove to be Good Samaritans on a global level?

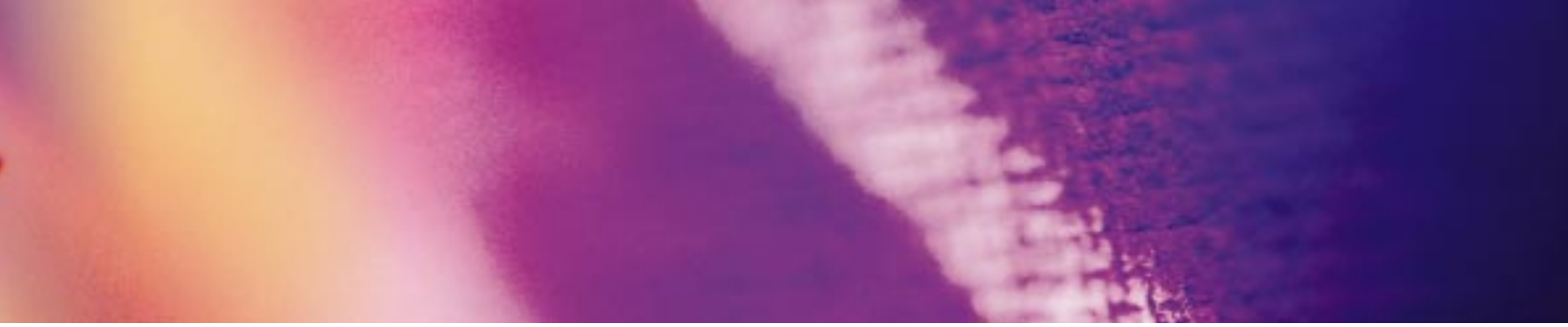
Church hospitals in Africa

There have been a deluge of comments following Gordon McFarlane's article ('Africa's Church Hospitals', Triple Helix *2001; Summer:12-14)*

***Charlotte Plieth**, who herself until recently worked in Congo, comments:*

The author is touching on a number of important issues which cannot be dealt with sufficiently in a single article. I would welcome a series of articles in *Triple Helix* looking in more detail at the questions raised: the theological basis for being involved in health care; whether the distinction between involvement here and abroad is not an artificial one; how to deliver maximum cost-benefit for the most needy; how do we deal with the enormous economic inequalities and the North-South divide; can we find innovative ways to use our medical skills, finances and positions of influence to witness for Christ and 'act justly and … love mercy and … walk humbly with [our] God'. (Micah 6:8)

In a good health care programme the hospital is only the tip of the iceberg of a network of health centres and health posts providing primary care. This has been my experience in the Democratic Republic of Congo. In that country the health care system was reformed in the 1980s creating health districts around existing health care



programmes. The majority of those were run by churches, NGOs and private companies. In our district with a population of around 40,000, there was no government provision of health care. The health centres were all run by the Anglican, Catholic and Brethren Churches. The district medical officer (an official government appointment) could afford not to be paid, because he was a Western mission partner. The hospital served as referral centre and provided the clinical training for our nurse practitioners' school. Many of the health centres are self-financing. The hospital has not yet achieved this and remains dependent on overseas funding. But what would be the point of antenatal and intrapartum care if there is nowhere to send the patient for a Caesarean section if the need arises?

In direct response to McFarlane (p 13: 'The way forward') I would like to point out that there is no biblical justification to regard *any* institution as essential when it may be having a negative impact on the life and witness of the church. Dare I say that theological colleges and other growing enterprises may offer the same temptations of nepotism and corruption as hospitals?

I am grateful that *Triple Helix* has the courage to embark on a controversial debate. However, let us be careful not to throw the baby out with the bath water and use the problems raised as an excuse not to get involved.

Dick Anderson *who worked for many years with the nomadic Turkana offers another view*

I was finishing a year in the King George VI Hospital (now the Kenyatta National) in Nairobi when I met the hospital administrator. He wanted to know what I planned next and I told him, 'I think I'll go north to the Turkana people as a missionary.' He seemed angry as he responded, 'You're throwing away your training.'

Half a century later many Christian health care professionals might echo his accusation - or at least feel that missionary service is no personal option to challenge their prayers. 'Those days are past,' we hear; 'Mature indigenous churches have taken over the traditional responsibilities of missions; independent governments now accept the burden of providing their people with health care so we are no longer needed.'

Gordon McFarlane suggests that the day of the church hospital in Africa is over. He is certainly right in calling us to question whether we should continue an honoured tradition simply because God has so signally used it over the last century.

First we need to face the Bible's missionary mandate and then ask if it applies to people with our training and experience. Through Abraham's seed God plans that 'all peoples on earth will be blessed.'

Working in Kenya's main hospital I had heard of a nomadic tribe, the Turkana, who lacked both health care and the good news of Christ. Concerned mission leaders felt that they should see the love of Christ in care for their bodies as well as hear of it in the Word of God. The challenge became inescapable and I went. Four decades later the leaders of over a hundred churches now attribute their origins in part to that health care.

Huge barriers of politics, religion and environment still keep approximately one fifth of the world's population outside of the range of our saving message. God has given us a key which can unlock some of these doors.

What better way to fulfill the Lord's command to 'make disciples of all nations'?

Sharon Kane*, who is also working in Africa, adds:*

The article … was very pertinent, at a time when this hospital has just had to start charging patients for drugs. We are buying most of them privately and would soon be bankrupt if we couldn't recover the costs. The alternative would be to rely on (diminishing) government supplies, be out of stock of loads of things, and send patients to buy them in town. There are no easy answers, and we are still debating how to make the system as fair, viable and compassionate as possible.'

Jamie Erskine, *working in the Gambia, adds:*

Peter Bewes' robust defence of Christian medical activity in Africa has been an encouragement to me since attending the CMF refresher course for doctors returning from overseas, held at Oak Hill. The need continues and I am afraid my response to McFarlane's article is to say that it would be all too easy for rich Christians to abdicate the last vestiges of their biblical duty to the poorer members of the body of Christ. Medical care remains a huge, unmet need and fees are charged precisely because western churches decline to cover the costs. (Although small fees also serve a positive purpose of giving 'value' to the care provided).

Elizabeth Borlase*, working in Kenya, says:*

Like Gordon McFarlane I have worked for nine years in church hospitals in Kenya. As a part of a hospital leadership team we repeatedly asked ourselves two questions: 'In what way are we as a Christian hospital different from any other hospital?' and 'How can we offer care to the poorest in the community?'

Firstly, we acknowledged that these challenges are universal. All Christians need to find ways to be distinct, as do Christian institutions. Similarly, all Christians need to address the needs of their poor neighbours. Secondly, we admitted that we did not have complete answers to either question. Whilst we attempted to provide quality, affordable care, prayer and counselling; other non-church hospitals were attempting the same. Like all health units we were limited by our own failings and those of our staff. Nevertheless, by asking the question we strove to offer something extra to our patients.

Perhaps God's calling is more to participate in this struggle, than to find complete answers.