TRIPLE HELIX

Autumn 2001

For today's Christian doctor

AGEISM IN THE NHS

BRISTOL
WHAT LESSONS?

CRISIS IN GENERAL PRACTICE

JUNIORS' STRUGGLES

COINCIDENCES

SUPPORTING REFUGEE DOCTORS

MEN OF ISSACHAR

OVERSEAS OPPORTUNITIES

ISSN 1460-2253

Triple Helix is the quarterly journal of the
Christian Medical Fellowship
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London SE1 8XN

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Website www.cmf.org.uk

A Registered charity no 1039823

Subscriptions
Triple Helix is sent to all members of CMF as part of the benefits of membership, but individual subscriptions are available to non-members at £2.95 a copy including postage (UK only).

For special offers see the coupon enclosed.
Enquiries: Tel 020 8559 1180 (Monday-Friday, 9am-5pm).

Contributions
The editor welcomes original contributions which have both a Christian and medical content. Advice for preparation is available on request.

Authors have reasonable freedom of expression of opinion in so far as their material is consonant with the Christian faith as revealed in the Bible. Views expressed are not necessarily those of the publishers.

Design S2 Design
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Supporting refugee doctors
Real opportunities for Christians

It's all too easy to write off asylum seekers as scroungers or economic opportunists. Among the asylum seekers who find themselves in Britain are highly qualified professionals, many of whom possess experience and skills that could be put to good use. Included among them are a surprisingly large number of doctors.

The exact numbers are not known but the *Student BMJ* reports that estimates range from 500 to 2,000. These are people who suffer a form of bereavement – loss of country, loss of family and friends and loss of status that goes with being a respected professional. They also have to contend with living on or below the poverty line in a country and culture that is unfamiliar.

What is certain, however, is that most refugee doctors want to make a contribution to their host community. Most have a strong sense that they would like to put something back into the community that has offered them a home. Few want to live off social services handouts or allow their professional skills to lapse. The NHS suffers an acute shortage of doctors, to a point where recruiting from abroad is on the agenda. It makes lots of sense to ensure that the resource of refugee doctors is tapped as much as possible.

All this sounds straightforward, but there are obstacles. Genuine refugees often did not have the time to collect references or all the needed documents to prove their status and qualifications. It is possible for refugee doctors to undertake clinical attachments in order to acclimatise to the British system and hone and update their skills, but not all refugee doctors can afford the fees involved. To register with the General Medical Council they need to pass English-language examinations. Where there are serious financial pressures these can prove very difficult.

It is therefore encouraging that the government has taken up the issue of refugee doctors in two important documents[1] that report on the scope of the issue and suggest strategies for the integration of refugees. This is not a problem that can be solved overnight and a lot depends on the willingness of members of the profession to get involved in practical ways. There are opportunities here for Christian doctors. One way might be to offer to mentor a refugee doctor, the first step being to join the BMA register of volunteers.

John Martin
Associate Editor of Triple Helix

1 Home Office statistics. *www.homeoffice.gov.uk/index.htm*; Department of Health. *NHS plan*. London: HMSO,2000

Where is your treasure?
Why debt relief is not enough

Critics of the Jubilee 2000 campaign opined that remission of international debt would give the green light for corrupt governments to fritter away the proceeds. This has not proved to be true. There is powerful evidence that debt cancellation is already directly helping the poor. In Uganda debt relief has helped double primary school enrolment. In Mozambique half a million children have been vaccinated against killer diseases. Extra schooling has been provided in Honduras and money saved from servicing debt has financed half of Guyana's national development plan.

We should not be complacent, however. Some 22 countries have had debts cancelled and a further 14 are in the pipeline, but this is well short of the 50 or so that Jubilee 2000 has been campaigning for. They include some of the world's worst-off countries including Bangladesh, the Philippines and Nigeria. Moreover, while debt relief has reduced repayments of the 22 countries by one third, these countries are still spending more on debt repayments than, for example, health.

Then it is clear that debt repayments by some countries are set to increase by the end of the decade through the combination of new loans and the end of concessional periods. Some observers have suggested that there may be a case for a new Jubilee 2010 campaign. But we need to get the issue fully in perspective. A recent World Bank document has warned that the current debt initiative is not a long-term solution to the world economic crisis. Countries with fragile economies will always be vulnerable to spiralling debt and their hopes lie not from piecemeal action but from sustained economic progress.

Christians should welcome the direct interventions in the debt campaign by organisations such as Medact, MedSIN and even the BMA. They have certainly succeeded in raising general consciousness on this issue. But we also need to be willing to take stock of lifestyle issues. Do we really need to invest all our financial surpluses for maximum return? Do we have to accept without question the general mores in Western society with its ever-present spur to live to ourselves rather than living simply (as the old saying goes) that others may simply live?

John Martin
Associate Editor of Triple Helix

Maintaining trust in the doctor-patient relationship is key, writes **Huw Morgan**

Photo: Wellcome Photo Library

The Crisis in General Practice

Most readers of this journal will be aware that UK general practice is in crisis. The recent BMA ballot confirmed that 86% of responding GP principals were in favour of submitting undated resignations from their NHS contracts next spring, unless the government agrees to negotiate on a new contract for General Medical Services.[1]

This crisis has been building for more than a decade. The 1990 contract, imposed without negotiation by the Thatcher administration, was the first in a series of major changes that have continued ever since.[2] More and more governmental edicts and frameworks have radically changed the amount of time GPs can spend in their traditional role of face-to-face contact with individual patients. Higher public expectation of what the NHS should provide has coincided with a real decrease in resources - staff shortages, growing waiting lists and discontinued services, all of which have added further stress to the GP's position as 'gate keeper' to the NHS.

In addition to this, changing patterns of work favoured by a new generation of doctors have meant that the traditional model of a full time doctor spending thirty or more years in a practice has gone.[3] It has been replaced by more part time doctors spending five years or less in one place and then moving somewhere else, perhaps out of medicine and probably out of general practice, reducing long term GP numbers. Also, the perceived lowering of morale since 1990 has reduced recruitment and, in the last few years, dramatically increased the numbers of actual and intended early retirements.[4]

Christians in general practice are certainly not immune to all this and have their own concerns about the current state of affairs. Central to these is the threatened destruction of the long term doctor/patient relationship that has been the cornerstone on which the previous success of British general practice (and similar models in Holland and Scandinavia) has been built. This has enabled compassionate and skilled doctors to use the therapeutic potential of this relationship keeping unnecessary investigations and treatment costs to a minimum. This unique understanding of individuals and their physical, psychological, social and spiritual needs in the context of their family and environment is likely to be swept away by the National Service Framework. This approach demands measured outcomes of care in quantifiable figures, in clinics run by nurses and others who are necessarily focused on numbers and measurements rather than on individuals and their uniqueness.

Another related concern is the increasing lack of trust in general practitioners by government and (to a lesser extent) public. We are no longer seen as trustworthy professionals but as inadequately accountable public servants who require more central control to meet the demands of government policy. Whilst some of the reasons for this are understandable, it is a factor that can undermine the essential nature of general practice. For Christians (and indeed most other GPs) this feels like an impugning of our professional and personal integrity. We are no longer trusted to get on with our work in the way we consider to be in the best interests of our patients as their advocate and medical advisor.

I do not think there is a simple Christian response to these things, but I do believe that Christian GPs need to defend above all the doctor/patient relationship and the necessity for it to be based on trust, as a central feature of general practice. In the end, general practice is about people. Unique, distressed, concerned, suffering or anxious individuals made in the image of God who need a trusted medical advisor to turn to, whom they know they can rely on. Someone who has medical skills and knowledge, yes, but also someone who knows their family, their relationships and their working situation. Above all someone who knows them and can integrate that individual knowledge with their symptom presentation, tease out any hidden agendas, explore their concerns and provide appropriate reassurance, treatment or onward referral for them. In the end, loss of this special and privileged role would result in spiralling health care costs, increased litigation, an increasingly demoralised medical work force and a dissatisfied public.

The writing is already on the wall. Let us hope and pray that our political masters heed the warning signs before it is too late.

Huw Morgan is a General Practitioner and GP tutor in Bristol

References

1 British Medical Association General Practitioners Committee, June 2001. Online at *http://www.bma.org.uk/gpc.nsf/archnews*

2 Smith R. Why are doctors so unhappy? *BMJ* 2001;322:1073-4

3 Vaughan C. Career choices for generation X. *BMJ* 1995;311:525-6

4 Taylor DH, Leese B. Recruitment, retention, and time commitment change of general practitioners in England and Wales, 1990-4: a retrospective study. *BMJ* 1997;314:1806

Dominic Beer analyses a recent mental health tragedy

No Care, No Hope?

A daughter is killed by her father, who receives a suspended sentence for manslaughter. One of the many issues raised by this sad episode is the adequacy of care provided by the mental health services.


Photo: PA

What are the 'facts' of this case, in so much as we know them from the media? Sarah Lawson (centre photo), 22, was admitted to Homefield Hospital, Worthing, on 20 April 2000. She was discharged the following day and died in the early hours of the next morning. Her father had 'helped his daughter take a drugs overdose and held a pillow and plastic bag over her head until she suffocated'.[1]

What was the young woman suffering with and what do we make of the care offered by mental health services? According to one source[2] she left school prematurely, became anorexic and was drinking half a bottle of vodka each morning. At 16, she was put on Prozac and then given electro-convulsive treatment. She was under continuous psychiatric treatment at Worthing. She was diagnosed as having a personality disorder characterised by repeated episodes of self-harm. The psychiatrists referred her to two specialist out-of-district centres for treating such patients, including the Cassel Hospital in London. However, Sarah did not accept a place there. Eventually, she disengaged from Worthing psychiatric services in October 1999. She then re-presented[3] to Accident and Emergency six months later, having cut her wrists. She was re-admitted to Homefield as a voluntary patient, despite her GP's request for her to be detained under the Mental Health Act. She was given a new care plan and re-referred to the Cassel. She was discharged the following day and died shortly after.

Sarah's mother[4] and her GP[5] stated that she was let down by services. However, patients such as Sarah pose a considerable challenge to the NHS. It is uncommon to detain them under the Mental Health Act. Firstly, the acute symptoms usually resolve in a few hours or days and secondly, there is rarely a treatment that has been shown to be effective on a compulsory basis. Therefore it is customary to offer brief admissions to general psychiatric wards when patients with personality disorder present with suicidal thoughts or self-harm. There is evidence that longer term inpatient treatment in a therapeutic community, such as that offered by the Cassel, is effective[6,7,8] and that some group and individual outpatient psychotherapies are helpful. It is important to state that these are offered on a voluntary basis.

The patient's GP states that she was 'let down by the mental health team because she was discharged for a relatively trivial offence'.[9] However, she was caught handing cannabis to a severely mentally ill patient. Psychiatric wards need to set certain regulations; otherwise the job becomes even more difficult.

Because of the persistent nature of ingrained behaviour patterns, the treatment of patients with personality disorder is complex and difficult. It appears that in this case, the psychiatric services did offer many treatment options and the tragic outcome of this case was not due to lack of services. This seems to be confirmed by a well known psychiatrist who has discussed the case in the media.[10]

What can we say about the father's part in this tragedy? Legally, he was judged to have been wrong to act as he did. Any precedent that might have been set by not imprisoning him for murder has, to a large extent, been averted by a guilty verdict. The judge recognised the severe degree of suffering experienced by both Sarah and her father, so gave a suspended sentence for the lesser offence of manslaughter. In English law, there is a separate offence of aiding and abetting suicide. By not charging him with this, the legal authorities appear to be attaching a higher degree of gravity to the offence.

Ethically, the case inevitably raises the issue of euthanasia. There have been other cases of people assisting in the death of relatives. Usually, the latter have been suffering from incurable physical illness. The same principle is pertinent to the Christian objection to the practice of euthanasia for both physical and psychiatric conditions.[11] It is derived from the biblical view that it is God's prerogative to give and to take away a person's life.

Alongside the Christian principles of justice and truth, however, are those of hope and mercy. The Christian mental health professional will want to offer hope to patients and their carers. This hope may be medical in emphasis or psychological, social or spiritual. To give up hope may lead to despair both on the part of sufferers and their carers, and may open the floodgates to acts of desperation by relatives, as seems to have happened in this case.

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References

1 Charter D, Bale J, Freeman A. Mother's fury at care of suicidal daughter. *Times* 2001:16 May:6
2 Browne A. Did Sarah Lawson have to die? *Observer* 2001;20 May:21
3 Anonymous. GP says his suffocated patient was let down. *Pulse* 2001;61 (21):1 (May 26)
4 Browne A. *op cit*
5 Anonymous. *op cit*
6 Dolan B, Warren F, Norton K. Change in borderline symptoms one year after therapeutic community treatment for severe personality disorder. *British Journal of Psychiatry* 1997;171:274-279
7 Norton K, Hinshelwood RD. Severe personality disorder: Treatment issues and selection for in-patient psychotherapy. *British Journal of Psychiatry* 1996;168:725-733
8 Norris M. Changes in patients during treatment at Henderson Hospital therapeutic community during 1977-1981. *British Journal of Medical Psychology* 1983;56:135-143
9 Anonymous. *op cit*
10 Persaud R. Smothering the truth. Did the NHS fail Sarah Lawson? *BMJ* 2001; 322:1311
11 Saunders P. Euthanasia. *Nucleus* 2000; April:11-23

Many common ways of dealing with old people are unacceptable and inadequate, contends **Mark Cheesman**

Ageism in the NHS

The most telling statement we can make about the worth of … people who society does not hold in high esteem is to spend time with them

Few of us think of ourselves as old. Inside, we feel much as we did 10-20 years ago, or even longer back. We don't thank people for reminding us that we're ageing, and whilst jokes about the middle-aged remain fairly good-humoured, those about the elderly usually have a darker edge. One of my patients said to me the other day, 'Old age is not for cissies!' She was right, although the way she wagged her finger at me was evidence enough (if you needed it after ten minutes with her) that fighting spirit is by no means confined to youngsters.

There have never been so many old people in our society. Nor have people ever lived (on average) so long. Although Europe is now the 'oldest' continent, the greatest percentage-rise in elderly people is occurring in the developing world. The numbers of very elderly people (80 and over) in the UK will nearly double in the next five to ten years. Some of this extra life expectancy is bought at the expense of living with disability: at age 75 nearly half have some disability, and at 80 two-thirds do. We are not really prepared for this and it fills politicians and their accountants with dismay. What are we going to do with them all?

Traditionally, our society has not valued elderly people very highly. This has been particularly true in the last few decades where youth and freshness have taken precedence over experience and wisdom. Middle-aged persons, not just elderly men and women, have found themselves having a crisis of identity. Many feel less than useful, unsure of their niche in society. Even the automatic deference to elders common to Asian families in the UK has slipped to some degree, especially if the children choose British rather than Asian ways of running their lives.

It looks as though we are in the midst of a revolution, forced by events and scandal (as, unfortunately, progress often is in the NHS). Overt

rationing by age is becoming difficult to sustain and, indeed, may even be found unlawful under the Human Rights Act. Many elderly care departments are still housed in poor buildings with poor staffing and resources: and it is the public who are now beginning to force the pace of change, finding many common ways of dealing with old people (and the resources for that) unacceptable and inadequate.

Things are already changing quite fast. 'Dinosaur' attitudes to elderly people are only expressed in private. Most coronary care units no longer have an age ceiling and most intensive care units have much older patients than before. In my hospital, the average age of the patients in the medical emergency intake is 73 and the average age in the medical beds is 77.

Many hospitals have a central admissions ward, through which all sick patients pass, regardless of age. We have an old person's 'Tsar' in Professor Ian Philp, and the National Service Framework for elderly people will no doubt be published eventually. Critical reports on elderly health and social care from the Royal College of Physicians, the Audit Commission, Age Concern and the Stroke Foundation have added their stir to the pot.

Welcome as these changes are they do not address many of the day-to-day problems. Battles over resources go on. The problem of intensity of treatment as life approaches its end, requires the

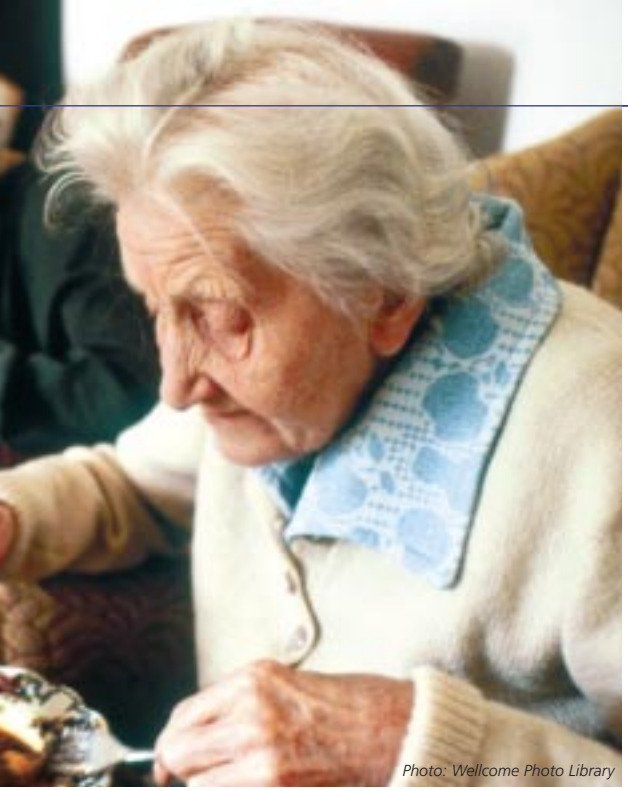


Photo: Wellcome Photo Library

wisdom of Solomon and the kindness that reflects the compassion of our Heavenly Father. This is immensely challenging and often painful for those concerned. Finding out what old people really want for themselves means time at the bedside, and that means not going to useless meetings or filling our lives, as healthcare professionals, with paperwork and committees. For perhaps the most telling statement we can make about the worth of any group of people who society does not hold in high esteem is to spend time with them.

Dying elderly people are the most unwelcome to many of our colleagues - and perhaps the ones we should be most seen with. The Lord spent his time with the real and social lepers of his day (and was roundly condemned for it), and it would be good if we generated the same criticism. Living prophetically in this way will cost us, both in time and probably also in prestige. This will not earn anyone a discretionary point or a merit award - but who cares about that, if it causes joy in heaven?

Elderly people have a knack of exposing hypocrisy and unreality, for which we owe them thanks. If you believe only in evolution and natural selection, then supporting the weaker and vulnerable is a wasteful and counterproductive activity: but after five minutes chatting to a sparky old lady, none of us in our heart of hearts can go along with that.

If you value people in terms of their economic usefulness, then old people score negatively again: but we are human beings, not human doings, and few people really believe that this is an adequate way of looking at an old person. Humanists often have a caring and compassionate outlook on elderly people, wanting to make life as good as possible, and to celebrate the moment. But humanists have little to say to the person who is dying, other than to celebrate their life, and make their end comfortable.

Christians have a different agenda, although they share many common points with humanists. The biblical concept of a person is the 'image (*ikon*) of God' - that we bear the mark and some of the characteristics of our Creator, however much these may be marred by a fallen world. Once you begin to think like that, the frail person in front of you looks different: there is a new dignity and status in such an image.

Death and dying are coming out from the closet. The recent picture of bodies on a hospital chapel floor shocked people much more than one would expect from yet another under funding story. Death 'in your face' has always been difficult, but is a rare subject of conversation. It has replaced sex (not such a rare subject in conversation) as an unmentionable. Try it at the next dinner party to which you are invited.

Christians themselves often need to come to terms with their own mortality, whatever their head-knowledge of the resurrection and heaven. How will Christian healthcare professionals fare in the bewildering speed of change? How do you feel adequate in the face of large amounts of unmet need? It would be good to discard, at an early stage, the notion from 1960s and '70s Christianity that the Christian doctor will be the best one around technically, in competence and in availability. It is most surely more important to be like the Lord Jesus than to have all the answers. In any case, if you think you have all the answers it will usually only take one elderly person to disabuse you of the notion.

Compassion and kindness is a language the deaf can hear and the blind can see. People around us need to see Jesus in us. No, there is no substitute for competence in medicine - nor any substitute for spending time in God's presence so we can reflect him. The only way we as Christian doctors will spend time in our Heavenly Father's presence is by timetabling it in: and, probably, dropping some activites in our work administration and in our local churches.

The Bible says that there is a tragic grandeur about us: we are immortal beings made for our Creator and forever unsatisfied without him. It teaches that God so loved us that he sent his Son Jesus to be one of us, talk with us, teach us, die for us and rise again: so that we could not only walk with him in this world but rise from the dead and be in his presence for eternity. And the Bible assures us that, inadequate as we are, we can bring the grace and presence of God to each other.

Old people are often kind, patient, and understanding: and often delighted to interact with us if only we will slow down to be with them. The Christian concept of seeing the Lord in other people and caring for them out of love for him is a powerful driver for good, if we will embrace it.

A bit different when you look at it all like that, isn't it?

Mark Cheesman is a Consultant Geriatrician working in Southmead Hospital, Bristol

KEY POINTS

Our society does not value elderly people very highly, but with the growth of old age charities, the appointment of an old person's Tsar and more media coverage of non-treatment 'scandals', overt discrimination against old people is much more difficult to sustain. However, attitudes change more slowly and Christians need to take the lead in living prophetically. Treating elderly people as beings made in God's image involves more than just showing clinical competence. It means slowing down to spend time with them. And as we do we will find they have much to teach us.

Andrew Fergusson's challenge from the 2001 CMF National Conference

Men of Issachar

The 2001 Rendle Short Lecture

KEY POINTS

Arthur Rendle Short, like the Men of Issachar in 1 Chronicles 12:32, understood his times and knew what to do. Understanding our times involves seeing that the seismic changes in healthcare that we all struggle with are but symptoms of a deeper worldview shift. Postmodernism means spirituality without Christianity, words without meaning, individuality without belonging, image without reality and the present without a future. Christians who know what to do will recognise the importance of being established in prayer and the word, and take seriously the Bible's warnings about hypocrisy, greed and worry. May God help us to be Men of Issachar.

'Men of Issachar, who understood the times and knew what Israel should do'.[1] We first hear of Issachar in Genesis 30:18 as the fifth son of Leah, the older of Laban's two daughters. She 'had weak eyes'[2] and although Jacob preferred her younger sister Rachel who 'was lovely in form, and beautiful'[3] and thought he was earning the right to marry her, he was tricked into marrying Leah first instead.

The sons of Jacob were the ancestors of the tribes of Israel and this is the context in which we read this brief description of the men of Issachar who joined David as he took over Saul's kingdom.

There are two concepts concerning the men of Issachar, and they form my twin themes: understanding the times and knowing what to do.

Arthur Rendle Short: a man of Issachar

Dan Graves[4] describes Arthur Rendle Short (1880-1953) as 'The Surgeon Who Defended Christianity':

…it would seem there was little danger that Rendle would lapse into secularism or Darwinism. However, as an intellectual among Christians who were not rigorous in their thinking, he craved reasonable grounds for his faith. This was the heady first era of the Darwinists and of German textual criticism, both of which attacked the Bible. Rendle had to know for himself what was true.

Becoming convinced of the authenticity of Scripture through an analysis of Luke's writing as a doctor in his Gospel and in Acts, Rendle Short went into medicine to live out his faith. Frustrated in his plan to become a missionary, he realised that the Lord intended him for work in England:

He undertook that work with vigour, speaking regularly to groups about Christ, giving here a devotional and there a defence of faith in the living Lord. From his own early struggles to believe, he knew apologetics to be necessary, and he was eager to help others over the hurdles of faith.

Rendle Short coped with the twin threats to biblical Christianity of his time - with the medical/scientific threat of Modernity and with the liberal theological threat of Higher Criticism. He understood those times and knew what to do.

CMF members as men (and women) of Issachar

We need to understand our times and know what to do. On my first medical job, I remember my registrar saying: 'There are two sorts of doctors – those who know things and those who know what to do'. Although these two categories are not mutually exclusive, I knew which sort of doctor I wanted to be. But to know what to do we have to understand the times.

The principles of medical practice are (largely) unchanging - history, examination, special tests, diagnosis. Likewise the principles of Christianity are entirely unchanging. If we understand the changing times, then we work out how to apply those principles in our culture and times. So, what are the times?

The 'medical' times

(This section was contributed by the audience and concepts called out included: pace of change, blame culture, revalidation, new consultant contract, loss of caring, guidelines and protocols, defensive medicine,

loss of control, fighting over the same slice of cake, lack of affirmation, no time for education and reflection, no time for students, giving more and more for less and less.)

The times for our culture

We are told the times are post-modern, and there are all sorts of intellectual explanations of what that means. Rather than 'Loss of an overarching meta-narrative' I prefer simpler accounts like 'No big picture that makes sense of all the little pictures' so let me quote from a *Christian Research* critique: Here are some of the characteristics of a post-modern world.

Spirituality without Christianity
Many search for meaning, but often look elsewhere than the Christian faith
Environment without a Creator
Caring about the natural world, but not recognising the hand of God in creation
Words without meaning
If you say something means this and I say it means that, it doesn't matter – we're both right! And we don't disagree
Individuality without belonging
I'm my own person; I don't have to belong to you or any organisation or do what you say
The present without a future
It's what we do now that's important; never mind tomorrow – it may never come
Behaviour without consequences
I can do what I like, and I will; I'm not responsible for the results
Image without reality
What you think of me is more important than what I am really like
Single issues without the big picture
I'm focusing on what matters to me; I don't care how it fits in with everything else'[5]

This little poem sums it all up:

I find it hard
I'm hard to find
Oh, well, whatever
Never mind[6]

Cynicism is destructive. Men of Issachar are not cynical because they understand the times and know what to do.

Our response

My original letter of invitation to give this lecture talked about 'How to convey God's truth to a multicultural society' and I suspect there are hopes that I will offer some technical tips, handy hints and some pithy soundbites for particular problems. I could say, for example, 'always challenge relativism' or 'use stories whenever possible'.

Rather, I want to end by offering some principles that are about what we do, but even more importantly, who we are. Jesus himself once spoke to a crowd about the importance of interpreting the times[7] but earlier in Luke 12 he had issued some specific warnings to the disciples. These leapt out of the page to me as being particularly relevant to doctors. My experience, pastorally through CMF, and punitively through sitting on the General Medical Council, is that doctors - Christians not excepted - do need to be warned about:

- Hypocrisy - 'There is nothing concealed that will not be disclosed, or hidden that will not be made known' (v2)
- Greed - 'A man's life does not consist in the abundance of his possessions' (v15)
- Worry - 'Do not worry about your life' (v22)

Being is more important than doing. Post-modernity in its disregard for programmes and achievements may be acknowledging that. If we are the right people we are more likely to know what to do, and more likely then to do it. We need to be disciples of Christ and Rendle Short is an inspiration:

Rendle spent much time in prayer and Bible reading. Did this make him self-righteous? Quite the contrary. It was probably with himself in mind that he wrote these words: 'The nearer you are to light, the darker is your shadow. Thus the one who has the greater light is often the most conscious of wrong in himself.'[8]

And finally

The numbers recorded in the 1 Chronicles 12 passage 'are the numbers of men armed for battle who came to David at Hebron' (v23). Those from all the other tribes listed are in thousands or tens of thousands. How many men of Issachar were there? There were '200 chiefs, with all their relatives under their command' (v32).

Matthew Henry says 'The men of Issachar were the fewest of all, only 200, and yet as serviceable to David's interest as those that brought in the greatest numbers, these few being in effect the whole tribe. They were weather-wise. They understood public affairs, the temper of the nation, and the tendencies of the present events... They knew how to rule, and the rest knew how to obey.'[9]

A man of Issachar is worth ten ordinary disciples. May God help us to be men of Issachar.

Andrew Fergusson was CMF General Secretary from 1990-99 and now has a portfolio career at the interface of medicine and Christianity

Based on the 43rd Rendle Short Lecture given during the CMF National Conference on 28 April 2001. Full text available on request.

A MAN OF ISSACHAR IS WORTH TEN ORDINARY DISCIPLES

References

1 1 Chronicles 12:32
2 Genesis 29:17
3 *Ibid*
4 Graves D. *Doctors Who Followed Christ: Thirty-Two Biographies of Eminent Physicians and Their Christian Faith.* Grand Rapids: Kregel Publications, 1999: 185-189
5 Brierley P. *12 things about Society that impact the Church.* London: Christian Research, 2001
6 Anonymous
7 Luke 12:54-56
8 Graves D. *op cit*
9 Church LF (ed). *Matthew Henry's Commentary in One Volume.* London: Marshall, Morgan & Scott, 1960: 441

David Clegg reflects on the Overseas Update course

Refreshment
with a difference

Most were tired. Some had left young children with relatives or friends. A number were dependent on others to provide a temporary home base whilst in the UK, and many had a programme of deputation to fulfil. The course fee, though subsidised, was a heavy chunk out of their resources. So why did some 30 doctors, nurses and midwives, from many backgrounds and nationalities, with various degrees of training and experience, gather at Oak Hill College during June? They were attending Overseas Update, an annual course run by CMF and MMA HealthServe for healthcare professionals, particularly those from a missionary background.

Professional Refreshment

Sessions ranged from hospital-based medicine to ethics, from family planning to hospital finance, from trauma care to health education, and more besides! Speakers turned up like clockwork, sometimes even from long flights. Many were at the top of their UK careers and spoke with understanding of the work situations of their audience. They taught the best and the most relevant practice for the situations being experienced. To summarise one speaker's ethos: 'True academia is being aware of financial restrictions, personal limitations, and the expectations of those being served, and taking these into account when selecting from various options on how to do something.'

Most participants were working well outside typical 'home' job definitions but found their work professionally satisfying in spite of resource limitations. The lecture format was appreciated because most were starved of information. Interestingly, even those who heard talks on their own subject often found themselves stretched. Lectures were also relevant and informative for those unfamiliar with a particular topic.

Spiritual Refreshment

'I have had enough, Lord,' said Elijah when he fled to Horeb from Jezebel (1 Kings 19:4), and many participants identified with this emotion, related during the communion service. The formal teaching sessions, morning prayers and other times of worship, were varied and all equally relevant. Using passages from Job, Habakkuk, 2 Corinthians and Philippians, participants were encouraged to consider world injustice (so evident in the places where many were serving), in the light of the almighty, wise, just and loving God they knew. Through the distress of Elijah to the hope found in Christ, faith was renewed, pain understood and the reality of God's kingdom experienced away from the influences of a cynical, materialistic world.

PARTICIPANTS FOUND THEMSELVES AMONGST OTHERS WHO COULD TRULY UNDERSTAND AND APPRECIATE WHERE THEY WERE COMING FROM

Some participants felt unable to discuss meaningfully the frustrating issues of unstoppable evil and folly that they had witnessed, with other Christians who had never worked in low-income countries. It was around these themes that the course came into its own. The times of informal fellowship, over meals and between sessions, were as important as the lectures and times of worship in

KEY POINTS

Overseas Update is for all healthcare professionals currently working, or thinking of working, in developing countries. It provides professional education tailored to a low-resource environment and is recognised by UK professional bodies for postgraduate education. Spiritual input gives renewal and direction whilst fellowship with colleagues in similar scenarios is a vital ingredient, all in an ideal setting near London. The next course is 24 June – 5 July 2002; for details contact Joan Arnold in the CMF office on 020 7928 4694.

regard to exchanging ideas and providing support and encouragement. This was probably because, as one retired health professional remarked, participants found themselves amongst others who could truly understand and appreciate where they were coming from, and what they were facing.

Some time was set aside in the programme to hear from colleagues about their work in various parts of the world. These sessions were both terrible and wonderful because of the way in which so often the oppressed are coming to faith in Jesus, and continuing to remain faithful despite extreme circumstances.

Come the end of the course, much had been exchanged in terms of knowledge and experience. Importantly, however, all at some level had found refreshment for their souls, strengthened by the Word and presence of God. This was reiterated through mutual empathy and understanding from fellow colleagues. Such solace was difficult to leave and departing at the end of the eleven days was 'painful', but participants knew they had to return to the 'real world'.

David Clegg is CMF Overseas Support Secretary and General Secretary of MMA HealthServe

2002 Course Details

The next course is scheduled from 24 June to 5 July 2002. It is registered with the UKCC for nurses and midwives and with the Royal College of Physicians for Continuing Medical Education on behalf of all the colleges covering hospital medicine. GPs can register their own attendance locally for PGEA.

The following groups would particularly benefit:

1. Those currently working in low-income countries. New ideas are constantly being developed to help isolated workers do their difficult job in imaginative ways. Extra money or technology is not always necessary. This course is almost unique in the world in offering these ideas. Similarly, on a personal level, missionaries who are weary can find the vital spiritual refreshment they need.

2. Those hoping to go to developing countries for the first time. Much can be learnt from the speakers and experienced participants.

3. Those who have worked abroad in the past and returned to a developed country but intend to return overseas, perhaps in retirement. This course can bring people up to date with the status quo on the 21st century missionary field.

During the course there is time to browse over bookstalls provided by TALC (Teaching Aids at Low Cost), CMF and MMA HealthServe, and to look at videos of operative procedures.

Both the beautiful location of Oak Hill College (only 20 minutes walk from the nearest London tube station), and the ideal facilities, make it a perfect venue. Why not come along and experience for yourself this 'refreshment with a difference'?

Do it anyway

In the evenings we looked at the gifts of the Spirit in Galatians 5. At one the following passage from an unknown source was read and seemed to sum up so much of the motivation to medical mission.

People are unreasonable, illogical and self-centred,
Love them anyway,
If you do good, people will accuse you of selfish ulterior motives,
Do good anyway,
If you are successful, you will win false friends and true enemies,
Succeed anyway,
The good you do today will be forgotten tomorrow,
Do good anyway,
Honesty and frankness make you vulnerable,
Be honest and frank anyway,
The biggest people with the biggest ideas can be shot down by the smallest people with the smallest minds,
Think big anyway,
People favour underdogs but follow only top dogs,
Fight for the underdog anyway,
What you spend years building may be destroyed overnight,
Build anyway,
People may need help, but may attack you if you help them,
Help people anyway,
Give the world the best you've got and be undoubtedly misunderstood by most,
Give it anyway,

Christ did it for you.

Source unknown

Why go?

I struggle on in a country bereft of meaningful or conscionable government, where most of the junior staff are on strike and consultants few and far between (the indigenous ones having just 'sort-of' returned to work after a month's strike in my absence), where suture boxes are practically empty, and only two or three antibiotics available (and I realise we are well off compared to other parts of Africa and the world) yet, I have managed to do four times more operating in one week here than five weeks in Yeovil! People ask me if I am thinking of going back to the UK. I retort 'What for?' This is where the Lord called me: should I give up (and get thoroughly bored and frustrated in Somerset) just because of some evil men in power in Harare? No, the Lord will deal with them in his good time, and our task is to carry on and do the work he has set before us. Anything less is to let him down, to walk away from his cross and turn our backs on his suffering, and to his appeal of love.

Michael Cotton

The NHS is still failing to learn from things that go wrong. Could it happen again? **Michael Keighley** senses a feeling of *déjà vu*

The Spectre of Bristol

Never before has the medical profession been under such close scrutiny. The media love it, surgeons (or maybe surgeons and gynaecologists) take centre stage; blunders, botched procedures, mistakes, irreparable damage hit the headlines. Only foot and mouth and a general election stemmed the flow.

Many would agree with the editor of *The Lancet*, Dr Richard Horton, when he said that the profession as we had known it would never be the same again after Shipman, Alder Hey and Bristol. All three were emotive; murder in the afternoon in the doctor's chair, organ snatching from the dead and babies dying after surgery. Society expects perfection; they see it on three or four hospital soaps a week so that any perceived imperfection is definitely the result of human failure.

The Bristol enquiry lasted three years, it involved the examination of 2,056 case records, evidence from 577 witnesses and has cost the taxpayer £14 million. Few will forget the flysheet of the June 1998 *BMJ*; pictures of grey shoe boxes bearing white crosses carried by weeping relatives. The issues are complex but the excess mortality in paediatric cardiac surgery (PCS) at Bristol seems undeniable and confirmed from the UK cardiac surgical register.[1]

The report begins by stating 'It is an account of people who cared greatly about human suffering and were dedicated and well motivated' but, 'some lack insight, there was evidence of flawed behaviour, poor leadership, an inability to work in teams and there was poor communication.'

The causes

These are general and local. The general feelings of the NHS are appropriately highlighted, 'the inadequacy in resources for PCS in Bristol was typical of the NHS as a whole'[2] - but Professor Kennedy does not think that the Bristol affair was wholly caused by lack of resources because units elsewhere in the country performed more successfully. The report highlights insufficient safety, poor buildings, defective equipment,

Photo: PA

SOCIETY EXPECTS PERFECTION; THEY SEE IT ON THREE OR FOUR HOSPITAL SOAPS A WEEK

inadequate IT to capture accurate data; 'in the NHS there are no clinical standards, no benchmarks, no system for collecting or monitoring data'.[2] Then there was the new Trust culture. The competitiveness of the internal market so that babies from the southwest would no longer be shipped to the capital; 'Bristol had to be at the leading edge'.[3] For me, the most frightening statement was that the surgeons just kept going, hoping that things would improve (that a paediatric surgeon, an ITU and a children's hospital would materialise) rather than stopping so that the politicians and the health economists would do something. Nobody did anything.

There were concerns as early as 1986. The whistle blowing started in 1990 but everyone passed the buck; it went from the College of Surgeons to the Department of Health (DOH), back to the Trust and on to the Supraregional Advisory Group. At the DOH, Dr Doyle was given the data, 'he did not read it, but put it away in a filing cabinet without further scrutiny'.[2] An investigation did not start until July 1994 and PCS in Bristol was only stopped in 1995.

The local issues included inadequate facilities; two sites, no paediatric ITU, nursing shortages, poor organisation and management; in short, Bristol was 'frankly not up to the task'.[2] No wonder they were unable to appoint a paediatric cardiac surgeon of calibre. The outcome was that they expected adult cardiac surgeons to secure the contract for the Trust, one of whom was of an age when many of his colleagues would be wanting to wind down.

Bristol's catalogue of failure

- Failure in the duty of care
- Failures of safety
- Poor communication
- Inadequate counselling
- Errors and no process of learning from them
- Lack of surgical skill
- Lack of accountability or assessment of competence
- Failure to keep learning up to date
- Learning on the job, not by training
- Lack of transparency
- Irresponsible management
- Many, many more


Photo: PA

It could all happen again

As I observe NHS planning, or lack of it, and as I sit on appointment committees, I have a feeling of déjà vu, another Bristol waiting to happen. 'The NHS is still failing to learn from things that go wrong'.[2]

Nor does the report entirely go to the heart of our failing NHS.[4] There is only tacit reference to an under-resourced service. Despite 'the NHS plan' we still spend less of our GDP than any other EU country (with the exception of Greece) on healthcare. There are still far too few doctors to provide comprehensive care for our ageing society. Our buildings are old and dirty, our equipment often defective and we still have inadequate numbers of ITU beds.[5] No wonder morale in the NHS is rock bottom. We are likely to be silenced if we write to the Chief Executive pointing out glaringly obvious defects in (a) facilities, (b) the process, and (c) safe staffing levels. Most doctors keep on going to try and make it work but this is exactly what Wisheart and his colleagues were criticised for in Bristol.

The political agenda

Bristol provided an opportunity for the media and the public to blame the profession for a failing service. Wisheart was interviewed on the *Today* programme and wrote in the *BMJ*, 'In a sense the problems experienced at Bristol are like a microcosm of the NHS, doctors, surgeons, battling against difficult circumstances with inadequate resources and in a culture where finding a scapegoat appears to be put before the finding of solutions …'.[6] John Studd in a commentary in the *Telegraph* said 'The NHS is now lurching from one disaster to another with the politicians deflecting the blame onto anyone but themselves. If there is no money they will find scapegoats. It is just like Admiral Byng who was shot for neglect of duty, on his own quarter deck … two consultant cardiac surgeons from Bristol and one medical man were publicly humiliated and destroyed as scapegoats (by the GMC) for a rotten under funded Health Service'.[7] I believe that the GMC action was heavy handed. The surgeons were not deliberately failing and they were being expected to take on work outside their training brief.

A Christian response

Our first concern must be to our patients and our example is Jesus. His life was one of service despite living in a corrupt police state. He cared for those he met. He loved all people irrespective of their background, their past failures, their age, their race or intelligence.

Our workplace will never be perfect but we can still do our best to lead by example and to ensure that the candle keeps alight. It will splutter when we fall and when we are buffeted by evil, but we have a responsibility, a calling to shine as a light in the world. Humility is not a bad quality, although it may not come easy to cardiac surgeons or any surgeons for that matter. 'For everyone who exalts himself will be humbled, and he who humbles himself will be exalted'.[8]

Christians should certainly be in the forefront of standard setting and be concerned about quality. Many Christians feel they must do their best and run the extra mile by taking on work and a whole host of extra responsibilities. But we will not do these tasks well and we will not give patients the time that so many require unless we stand back from time to time.

We cannot distance ourselves from the Bristol issues.[9] We must be players in a better service giving an example of care and dedication to others be they patients or colleagues or tomorrow's doctors, because those we treat are created in the image of God.

Christians should not be afraid to speak out against what is unjust, what is clearly a lie, when the public are assured of competence and the facilities on offer are unsafe. Christians should constantly remind those in authority that health is not just a business. The NHS may have replaced a culture of care by a culture of economic expediency, but those who work in it can take a different perspective. Individuals can and still will share a sense of hope and love. 'I am the Lord.'[10] 'I the Lord search the heart.'[11] When the workplace is frustrating, when we seem constantly to battle against impossible demands, poor facilities and a run down service; when we seem to lose our way through lack of vision; when we ignore God's grace and love, it is important to remember some of the Bible's many promises: 'Trust in the Lord with all your heart and lean not on your own understanding; in all your ways acknowledge him, and he will make your paths straight'.[12]

Michael Keighley is Professor of Surgery in Birmingham

KEY POINTS

Locally, both individual and organisational failings were responsible for the undeniable excess mortality in paediatric cardiac surgery at Bristol. But this high-profile scandal is also a microcosm of the wider NHS where the blaming of already under-resourced and overworked staff takes precedence over the finding of just solutions. As Christians our first concern must be for our patients. Jesus' life was one of humble service despite living in a corrupt police state. But service involves more than being prepared to walk the second mile; it also means speaking about against injustice and exposing deception when economic expediency has compromised care.

References

1 *BMJ* 2001; 323:125 (21 July)
2 Final report: The Bristol Royal Infirmary Inquiry, July 2001
3 *Times* 2001 (19 July)
4 A Patient Service. *Times* 2000 (25 July)
5 *Sunday Times* 2001 (11 January)
6 *BMJ* 2000 (June)
7 *Telegraph* 1999 (2 Nov)
8 Luke 14:11
9 *BMJ* 2001; 323:179-180 (28 July)
10 Isaiah 42:8
11 Jeremiah 17:10
12 Proverbs 3:5,6

Sarah Ross offers some biblical wisdom on juniors' issues

Juniors' Struggles

Life as a junior doctor can be difficult. We have all seen Christian friends and colleagues struggle, even abandon their career, or worse, their faith. Is there anything we can do?

In our first years, frequent job moves keep us in a state of change. Long hours and stressful conditions, difficult situations and sick or dying patients (and their relatives) drain our physical and emotional energy. Where do we find resources to deal with this and recharge our batteries? Church might be such a place but circumstances conspire to make it difficult to attend regularly and have fellowship. We may not think that this is important but we are vulnerable when isolated from other Christians. Add in colleagues' cynicism and our ideals and faith can begin to erode. As if that is not enough, most SHOs know what it is to be completely swamped by work, study and membership exams.

GOD HAS EXPERIENCED LIFE ON EARTH AND IS ACQUAINTED WITH SORROWS, TEMPTATIONS, STRESS AND A LIFESTYLE NOT DISSIMILAR TO OUR OWN

The best person to turn to is God himself. There are plenty of scriptural precedents, especially the psalms and prophets, for complete honesty with the Most High; we should feel encouraged to address our concerns and complaints to him.[1] The Incarnation shows us that God has experienced life on earth and is acquainted with sorrows, temptations, stress and a lifestyle not dissimilar to our own.[2] Have you ever read the gospel accounts of Jesus' work in healing and thought it familiar? Of course, he never turned anyone away, lost his temper or sulked with the nursing staff over an unnecessary bleep! Still, he does understand pressure, lack of food and sleep, and emotional demands.[3] There may not always be an obvious answer to prayer or a perceptible presence to let us know he is near. Nevertheless, we are assured of continuing care, commitment and an ear always ready to listen. He knows us well so we don't need to hold back, hide the truth or explain.[4] Who else has written our name on the palms of his hands?[5]

We should regularly re-evaluate life and work. What, if anything, distinguishes us from our colleagues? What are our priorities? Are we running the race of faith or the rat race?[6] It is so easy to be pressured into career-based steps, sitting exams and doing things the accepted way. This may or may not be in keeping with the Maker's plans; we must remember whose will we are doing.[7] The quality of our character, the fruit of the spirit, our relationships with patients and colleagues should be of greater concern than steps up the career ladder. When another step up the ladder means better hours, or less time resident on call, it is easy to forget that the kingdom of heaven places the servant first and the lowest highest.[8]

Trials and difficulties have a purpose.[9] Right from Job to Jesus, the Bible teaches us that God doesn't tempt us but does use trials for our good.[10] Paul speaks of a progression from struggle to hope.[11] If we can persevere through our trials, we will develop more of Christ's character and gain a hope that will not be disappointed.[12] We are not expected to do this by ourselves. Jesus exhorts us to ask in his name for what we need;[13] he even assures us that these things are already known.[14] We should concern ourselves with the Kingdom and let God worry about everything else. More than that, Jesus tells us that he is always with us.[15] We must prioritise time with God, support and encourage each other and pray.[16] Our faith, refined by experience, is described as 'worth more than gold'.[17] Ideally we should come through our time as juniors having gained a stronger faith along with medical experience and membership.

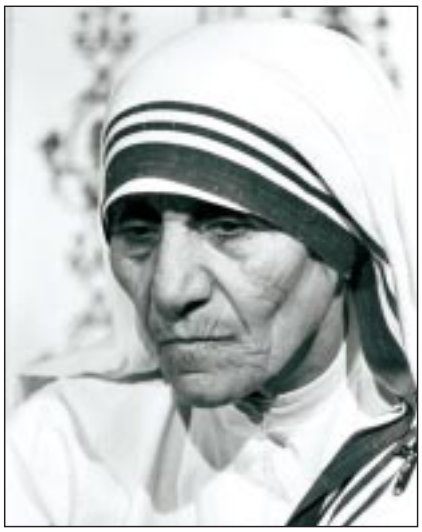
Sarah Ross is a Research Registrar in Clinical Pharmacology in Aberdeen.

References

1 Psalm 10:1; Jeremiah 20:7-8; Habakkuk 1:2
2 Hebrews 4:15
3 Matthew 4:1-4
4 Psalm 139:1-4
5 Isaiah 49:16
6 Acts 20:24; 1 Corinthians 9:24
7 Acts 5:29; Romans 12:2
8 Matthew 19:30
9 James 1:2-4
10 Job 1:6-12; Hebrews 12:5-11; James 1:13-14;
11 Romans 5:1-5
12 James 1:12
13 Matthew 7:7-8; John 14:13
14 Matthew 6:25-34
15 Matthew 28:18-20
16 Hebrews 10:24-25
17 1 Peter 1:6-7

Derek Jenkins reminds us what a big God we serve

God's Coincidences



In 1971, I was medical leader of the 'War on Want' team flown by the RAF to help with the cholera epidemic among Bangladeshi refugees. Working with Mother Teresa, next to Calcutta airport, several things happened. My setting-up duties ended and I was about to leave to visit South India where I had previously worked as a medical missionary. Firstly, a film producer turned up who had somehow got permission to join the team. Young and medically trained, she had been intending to help but was not needed due to the arrival of doctors from Calcutta. She asked if she could come with me to the south and Mother Teresa was happy for her to do so. We talked of the possibility of making a film of the work of the cancer centre that I had helped to build in my last few years with the medical mission.

To cut a long story short, a telegram to the director of the centre resulted in him finding a cameraman in Madras. This man was free to come at one day's notice and had enough 16 mm film for the job. We all met up at the centre, only 24 miles from the southern tip of India, 48 hours later. Within five days we had planned, scripted and filmed the work of the centre, and of the cancer registry and follow up programme running then under the British Empire Cancer Campaign. The film producer returned to Mother Teresa and I returned to my hospital in Kent. The BBC film-cutter, who edited the film to the script, was amazed at the accuracy of the filming, reducing his cutting to about one fifth of his normal work. A friend hearing of the film introduced me to Donald Swann who arranged the music, whilst Michael Flanders did the voice over.

I tell you this, with its small coincidences, by way of introducing the most amazing 'coincidence' that has ever happened to me. Trying to find additional sponsors for the above centre, I was encouraged when an Indian doctor who had worked under me thought I might get help from Finlay's, a tea estate company. The recently retired managing director was a friend of his family. He suggested I rang his friend in Scotland. The retired director told me that Finlay's had been taken over by Tata's, the steel conglomerate that ran Air India before it was nationalised - possibly the largest consortium in India. It was now Tata-Finlays! The only hope of making any meaningful contact would be to meet someone very high up in this vast organisation. I gave up the idea.

Two weeks later, my wife and I stopped for a meal at an inn about five miles from our home in Kent. An Indian man and women came in, ordered their food and, as the room was full, sat on the seats opposite to us on our table. He turned out to be the president of Tata-Finlays! A year or two later my wife and I stayed at his home in Calcutta and we had the privilege of taking his wife round Mother Teresa's work which, with Mother's permission, we were filming for her co-workers in Kent.

This was not the first time I had experienced this type of 'coincidence'. During the 16 years I worked as a missionary surgeon in South India we did a lot of gastric surgery. I had operated on a very poor patient with a peptic ulcer who had told us that he came from Bombay, 900 miles away. When he was well we gave him the maximum travelling allowed, his fare to the railroad terminal 60 miles away. I was very sceptical that he had come all the way from Bombay. Six weeks later I had to fly to Bombay to buy some urgently needed surgical instruments. Someone called out to me in the street – the very patient! Even in those days Bombay was a city of around nine million people. I felt really rebuked for not believing his story.

We have all experienced ways in which God leads, guides and encourages us in our lives, but there are times when these truly verge on the miraculous. We all know that God can and does 'do immeasurably more than all we ask or imagine' (Ephesians 3:20). Sometimes, however, it is only when we 'meet the miracle' directly that it hits home and stays with us for the rest of our lives, deepening our faith.

Derek Jenkins was a missionary surgeon in South India

Sometimes, it is only when we 'meet the miracle' directly that it hits home

EUTYCHUS

Two-faced on tobacco

Antismoking groups and doctors' leaders have attacked the government for delaying the introduction of a ban on tobacco advertising, after the Tobacco Bill was excluded from the Queen's speech, thereby meaning no legislation for at least 18 months (*BMJ* 2001; 322:1564, 30 June). The reluctance to make the ban a priority may well reflect personal vested interest in both parties. The unsuccessful Conservative leadership candidate Kenneth Clarke has admitted to profiting to the tune of £100,000 pa through his involvement in British American Tobacco (BAT). By contrast, *BMJ* editor Richard Smith and East Midlands MEP Mel Read, have recently resigned academic appointments at Nottingham University after the institution accepted a £3.8m grant from the same company. (*BMJ* 2001; 322:1506, 23 June)

Abortion in Ireland

The Family Planning Association in Northern Ireland has been granted a judicial review of medical practices in the province relating to abortion, which they say is aimed at getting the Northern Ireland Health Minister 'to issue best practice guidelines for the medical profession and advice for women on the services available'. Abortion is still illegal in Northern Ireland as the 1967 Abortion Act does not apply there. The move follows a furore in the Medical Council of Ireland after a council meeting to relax the country's abortion law. Decisions are expected on both issues in September. (*BMJ* 2001; 323:1507, 23 June)

Slippery slopes to designer babies

Scientists at the Reproductive Genetics Institute in Chicago, who last year controversially selected an embryo to provide a bone marrow donor sibling for a child with Fanconi's anaemia, are now extending the technique to prevent the birth of babies with a predisposition to cancer. A New York couple affected by the Li-Fraumeni syndrome, which due to a mutation in a tumour-suppressing gene p53 predisposes sufferers to a 50% risk of cancer by age 30, recently had treatment. The move has raised fears about a slippery slope to designer babies driven by parents' desires to give birth to 'normal' children at any cost. (*BMJ* 2001; 322:1505, 23 June)

Further folic foot-dragging

The incidence of neural tube defects such as anencephaly and spina bifida has fallen by 20% in the US following the mandatory addition of folic acid to pasta and bread in 1998. But the UK government is still 'waiting a final decision from the health minister' despite all the relevant committees having recommended that the UK should also fortify flour with folic acid. Professor Wald, of the Wolfson Institute of Preventive Medicine in London, who strongly supports the move says, 'I don't know why there is a delay in implementing such a policy'. Current policy of advising women to take folic acid is not working. (*BMJ* 2001; 322:1510, 23 June)

Chinese profit from organs

Harvesting of organs for transplant from executed prisoners in China is still continuing apace according to evidence given by a Chinese doctor to the US subcommittee on International Relations and Human Rights. Committee chairman Ileana Ros-Lehtinen said that China had 'found a lucrative industry in the field of organ transplantation, which not only yields great financial rewards, but provides the regime with a powerful tool to coerce and intimidate the population'. (*BMJ* 2001; 323:69, 14 July)

Bush fights back on abortion

The Bush administration has drafted a new policy that would allow American States to define 'an unborn child' as a person and thus make it eligible for medical insurance coverage (*BMJ* 2001; 323:66, 14 July). The US House of Representatives earlier voted by 218 to 210 to ratify President Bush's ban on taxpayers' funds going to overseas groups that perform or promote abortions (*BMJ* 2001; 322:1324, 2 June). There are currently about 1.5 million abortions per year in the US.

The price of 'love'

Up to ten billion condoms are now used worldwide each year, but despite this the global number of sexually transmitted infections is estimated to be in excess of 150 million, in addition to about 50 million abortions. 36 million people worldwide now live with HIV or AIDS, of whom 90% live in developing countries. (*BMJ* 2001; 322:1253, 19 May)

Saved Sex?

In response to the upward trend in sexually transmitted diseases since 1995 the UK government plans to spend £47.5 million in the next two years on a national strategy for sexual health and HIV promoting 'safe sex'. The strategy focuses on 'integrated care', 'one-stop shops' and targeted access to information. It seems unlikely that promotion of sexual abstinence before marriage and faithfulness within marriage will play a prominent role (*BMJ* 2001; 323:250, 4 August). 'Safe sex' clearly isn't safe enough. 'Saved sex' - sex saved for marriage - would seem a better option.

Mixed messages on cloning

The Royal Society has called for an international moratorium on reproductive cloning on the grounds of the technique's low success rate (1% in animals) and the fact that the great majority of successfully cloned embryos develop abnormally. But it has reconfirmed its support for the continuation of research involving therapeutic cloning, the production of cloned embryos for research, despite recent work showing promising results with adult stem cells. (*BMJ* 2001; 322:1566, 30 June)

OPPORTUNITIES ABROAD

Specific Vacancies by Country

Posts often require you to be **UK based** with your own **financial** and **prayer support**. These brief entries could be gateways to fulfilling professional service. Many are advertised at the request of CMF members. The Overseas Support Secretary often can give more information. Enquire locally for visa, work permit and registration requirements. Overseas emails should be considered to have no more privacy than a postcard.

A much larger multidisciplinary list of specific vacancies and general opportunities with mission societies exists in *HealthServe*, the magazine of MMA HealthServe, and on their web site www.mmahealthserve.org.uk

Contact Barker House, First Floor, 106-110 Watney Street, London E1W 2BR. Tel: 020 7790 1336. Email: info@mmahealthserve.org.uk

AFRICA

Uganda

Mildmay International is looking for a **senior medical officer/lecturer**.

Are you looking for a change and a challenge? Do you have:

- a special interest in HIV/AIDS in developing countries?
- some experience of caring for adults and children living with HIV/AIDS?
- good communication skills?

Are you:

- excited at the prospect of training others to provide good holistic care in hospital or community settings?
- willing to work on local terms and conditions, based in Uganda?

If yes, you may be the one we are looking for. Mildmay is an international, not-for-profit, interdenominational Christian organisation that specialises in the development of innovative programmes of care for people with AIDS in resource-poor settings. It trains healthcare professionals, local and international (doctors, nurses, counsellors and others) to provide such care for adults and children. Opportunities are increasing for training and care programmes in many African countries and elsewhere.

Contact Veronica Moss or Sue Bonner for further information and an application form at Mildmay International UK. Tel: 01702 394450. Email: veronicamoss@compuserve.com

ASIA

India

Christian Medical College, Ludhiana require the following:

- Senior **neurosurgeon** with experience in stereotactic surgery
- **Cardiothoracic surgeon** with paediatric experience
- **Radiologist** with experience in invasive work
- **ENT specialist** with experience in microvascular work

Contact Friends of Ludhiana, 157 Waterloo Road, London SE1 8UU. Tel: 020 7928 1173. Fax: c/o The Anglican Communion Office 020 7620 1070. Email: foluk@charis.co.uk

Pakistan

Kunhar Christian Hospital (see Summer 2001 issue). Medical superintendent still requires a **surgeon** or **doctor with surgical experience** to help set up surgery and work with him initially. Also for a **woman doctor interested in obstetrics**, a **midwife** and an **ultrasound technician**. An **accountant** is also needed.

Contact Dr Haroon and Miriam Lal Din at KCH, P O Box Garhi Habibulla, Dist. Mansehra, 21240 Pakistan. Tel: +92 985 450350. Email: kcc@kcc.isb.sdnpk.org

RESOURCES AND REQUESTS

Hospital Equipment Needed

Medical Missionary News has established a warehouse for the collection and freighting of surplus medical equipment to mission hospitals in containers. If you know of any equipment that is in good condition and useful in a developing country situation please contact them. If you can arrange for its transport to the warehouse so much the better. They would also like to hear of mission hospitals that could use the equipment they collect. It must be dispatched in containers that are full (but need not be limited to medical equipment) with transport costs met and the documentation for customs clearance arranged locally before it is sent. If customs duty is to be charged the sending of equipment is unlikely to be worthwhile.

Contact 1 Victory Close, Fulmar Way, Wickford Business Park, Wickford, Essex SS11 8YW. Tel: 01268 765266. Fax: 01268 764016. Email: Medicalmiss.news@compuserve.com

Olympus Upper GI Endoscope Needed

Michael Cotton, CMF member and government surgeon in Zimbabwe writes that in the UK these are being replaced by videoscopes and they are desperate for a no-frills endoscope. The means to repair the ones they have are just not there. He can lay on transport and importation.

Contact 59 Circular Drive, Burnside, Bulawayo, Zimbabwe. Tel: +263 9 245 2402862. Email: mikeytha@acacia.samara.co.zw

EVENTS

Healthcare Mission Forum, a new **Global Connections** forum planned in association with CMF and MMA HealthServe to look strategically at how the UK missionary movement can address the health needs of the poor in the 21st century. 10am-4pm, Tuesday 27 November 2001 at Partnership House, 157 Waterloo Road. London SE1. For further details see www.globalconnections.co.uk/groups.asp

Contact Global Connections for booking form at Whitefield House, 186 Kennington Park Road, London SE11 4BT Tel: 020 7207 2156 or book online.

Overseas Update, the residential refresher course for **Christian doctors**, **nurses** and **midwives** working overseas. 24 June – 5 July 2002 at Oak Hill College, Southgate, London N14 4PS. Brochure available from CMF office. Provisional dates for 2003: 7-18 July.

BOOKS

Palliative Care Ethics: a companion for all specialties (2nd edition)

Fiona Randall & RS Downie
Oxford University Press
2000
£21.95 Pb 312pp
ISBN 0 19 263068 7

This book is written by a Consultant in Palliative Medicine and a Professor of Moral Philosophy. The first edition was well received, judging by two reprints since publication in 1996, and three new chapters have been added to this edition.

It is remarkable that it does not include a discussion of euthanasia and physician-assisted suicide. Euthanasia is dismissed on the grounds that it 'is not part of palliative care'. As many people are confused in their thinking about both issues, an incisive chapter would have made the whole book more relevant.

The discussion about double effect (an intended good effect with a foreseen risk that bad effects could occur) is also disappointing. Double effect is central to medicine and stems directly from the fact that all treatment carries risks with it. Thus, for the authors to say that double effect is not recognised in law is nonsense.

In the chapter on emotional care, communication skills and counselling are parodied and misrepresented. We are told that compassion and genuine concern is all that is needed, and that training will lead to obstructive non-genuineness. In the preface, for example, it states that, 'There cannot be a specifically professional expertise in emotional care', and furthermore, 'The normal fears, anxieties, regrets, or guilt of human beings facing their death are not appropriate subjects for professional techniques'.

I am writing this from India where palliative care is available for only 3% of the 1.6 million cancer patients who need it annually. I know from world-wide experience that communication skills training releases doctors from avoidance behaviours acquired through their cultural upbringing and from the innate fear of death present in all people. Only then, are they enabled to be genuinely warm and supportive, and thereby interpret the complex physical and psychological interactions in their patients. Pain, *par excellence*, is a somatopsychic experience, and its evaluation requires the application of both *taught* physical and *taught* psychological examination skills.

The value of the book is further reduced by lack of discussion on the tension between deontology (duty ethics) and consequentialism (the rightness of an action being determined by its consequences). There is, however, frequent reference to 'utility' which is differentiated from social justice (the equitable use of available resources). Reference is also made to the fact that respect for patient autonomy is so out of hand in the USA, that some American commentators maintain that there is an obligation to supply treatment requested by the patient even if the physician considers it to be grossly inappropriate. As is stressed in this book, the middle way is partnership between the patient and professional.

These incredible misunderstandings and misrepresentations place a major question mark over the validity of the whole book. *Palliative Care Ethics* can therefore be recommended only for intellectually robust individuals and should carry a prominent public philosophical health warning.

Robert Twycross is a Consultant in Palliative Medicine in Oxford

Born to Serve

Peggy Burton
King's Highway Books
2001
£ 6.99 Pb 208pp
ISBN 0 95410150 2

Have you heard of ECHO and OYSTER? I have certainly come to understand them better through reading this account of the work of Dr James Burton and his wife Peggy, a nurse. Their call to medical work as dedicated Christians led to a demanding spell starting up a new mission hospital in the then Belgian Congo. The difficulties and dangers are graphically recounted and most doctors would probably find themselves unable to cope with the absence of facilities and equipment that are described. After two terms of service there they had to return to the UK for health reasons, but this gave them the opportunity and experience to pursue support for medical mission.

After a spell in General Practice and running a conference centre they were confronted with an offer of redundant but very useful medical equipment from closing NHS hospitals and the military. There was so much equipment that an organisation was required to arrange its warehousing and dispatch to mission hospitals around the world. We are thus taken through the formation of the Joint Mission Hospital Equipment Board and its enormous growth into a major charity ECHO (Equipment for Charity Hospitals Overseas). ECHO now buys bulk purchases of supplies and organises training workshops for equipment maintenance overseas, in addition to its original work. In earthquakes and other disaster situations their expertise is often called upon to transport supplies to the needy areas.

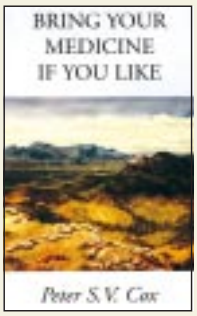
Retirement age came and Dr Burton had to leave the direction of ECHO to others, but not before his work was acknowledged by the conferral of an OBE. However, there is no retirement from the Lord's service, and the Burtons went on to do a mission locum in Liberia and then raised funds to support Christian work in Eastern Europe. The book goes on to describe the development of OYSTER (One Year's Service To Encourage Recruitment), the Medical Missionary Association (MMA) and HealthServe, a Christian medical resource centre dedicated to mobilising healthcare professionals to serve Christ in the developing world. Dr Burton is currently President of MMA HealthServe.

This is a very personal but informative account showing how much dedicated lives can accomplish. It is divided into easy to read chapters and is well illustrated, making it attractive in appearance. It is a challenge to young Christians, especially those with a vocation to any sphere in healthcare, to use their talents to serve Christ. It would be a

helpful gift and should find a place on your Church bookstall or library.

Arthur Wyatt, formerly Consultant Surgeon, Greenwich, now Medical Adviser MSI Professional Services

Bring Your Medicine If You Like



Peter S V Cox
E Cox, Oaklea House, Leeds 2000
£9.99 + £1.60 p&p
Pb 302pp

This very readable book is about the dusty deserty northern parts of Uganda and Kenya in the 1960's and 70's. This is where the author, a doctor, spent 22 years of his working life with Liza who travelled out with him; where they were married and brought up their four children. The backdrop is that of a timeless tribal Africa, having to co-exist with the modern ways of the 20th century during the last days of the colonial regime and the coming of independence.

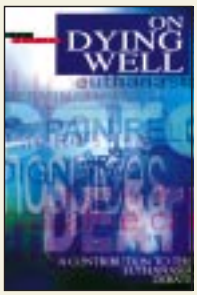
Peter was advised 'Don't write a history – tell the stories'. As he says some stories remain harmless tales but others insist on becoming parables and open a window of comprehension. And like the throw-away illustrations in a learned lecture they are what is retained in the memory. The same is true for the tribal memory with stories told round the campfire.

He claims that much of what resulted from those years did so just because he was there. Professor Maurice King, who wrote the foreword, once did a locum for him. This resulted in a conference at Makerere medical school and from which the seminal book 'Health Care for Developing Countries' was born. Maurice King, the author, and others mentioned in the stories come from the St Thomas' tribe in London.

Peter worked both as a mission and a government doctor in three hospitals. Much of the book is about the lessons, which were learned, aided by an open heart and an open mind. Some of the conclusions drawn concern questions such as 'should we be here at all?', the debate between a community and a hospital approach to healthcare and whether the cause of an illness was physical, mental or demonic. They are answered or left open with a blend of common sense and Christian conviction. The book is pervaded by a sense of fun. Learning was mutual. The communities he served came to have no doubt that he should be there and were reluctant to see him go. When he first came they had told him he could bring his medicine if he wanted but as for sending a son to school that would be a waste of a good herd boy. In later years he saw many of those who did go to school and did come to share his faith now in positions of leadership. Many were remaining faithful at their work years after he had left. He is very aware of all the others including his family who shared this life with him but this book is about his bit of Africa as he saw it.

David Clegg is CMF Overseas Support Secretary

On dying well – an updated contribution to the euthanasia debate (2nd edition)



Ed. Stuart Horner
Church House Publishing 2000
£4.95 Pb 112pp
ISBN 0 715 16587 9

I often get the feeling that the Christian church thinks that being 20 years behind the times is a virtue. It was therefore a pleasant surprise to find that this book by a Church of England working party was not a new publication, but rather an updated edition originally published in 1975.

There are many contributors to this book and its scope is wide, covering moral, theological, medical and legal considerations in the euthanasia debate. It includes the submission from the Church of England to the 1993 House of Lords' Select Committee and an updated bibliography. The material sensitively engages with the complexity of the issues, and is accessible to both the layperson and health professional.

I found that the sections on moral and theological considerations gave me the most food for thought. The working party wanted to shy away from 'simple or absolute moral conclusions', yet they also stated that, 'To declare it is not always wrong to kill the innocent…would be to deprive the principle of the sanctity which we feel it possesses'. I enjoyed the discussion and found it thought provoking and refreshing, although some might find it to be a typical example of the Church of England taking the middle ground. Proof texts were avoided and a comprehensive biblical framework attempted. While the discussion of the principle of responsibility-based rather than rights-based ethics could have been expanded, the conclusion of the working party was never in doubt: 'The good and simple principle that innocent human life is sacred has influenced profoundly our conviction that the old and the dying should be cared for and consoled, no matter what their condition.'

Is a book published 25 years ago still relevant today? The chapter on medical considerations needs some updating, but, as the introduction rightly observes, it is not the issues that have changed but rather, 'society has moved further down the road of individual autonomy and choice'. What the authors had to say 25 years ago is therefore still vital in today's debate. The saddest thing is that it still needs to be said.

Jim Paul is an SpR in Palliative Care in London

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?

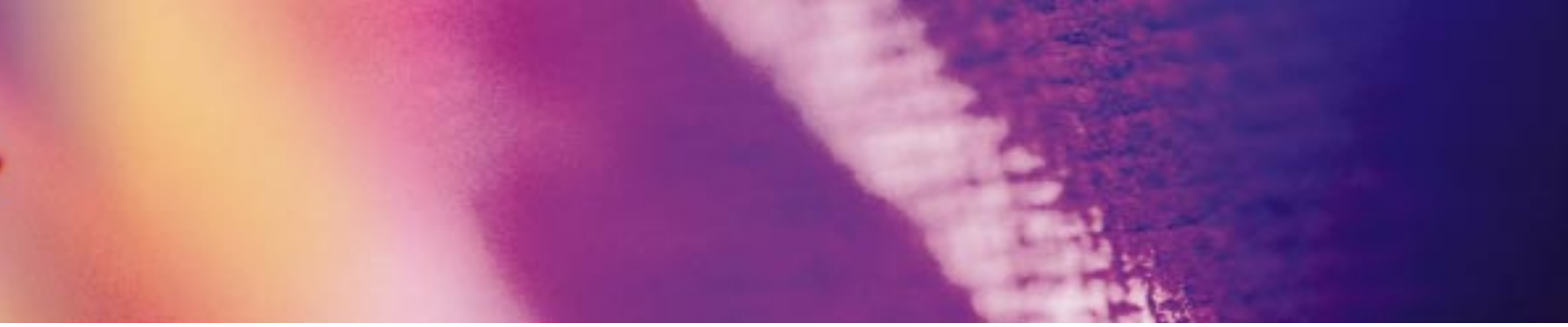
Church hospitals in Africa

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.

RevieWWWs with Cyberdoc

Cyberdoc reviews Missionary doctors, Ageism, Depression and the Crisis in General Practice – the words in bold correspond to links on the CMF website at www.cmf.org.uk/cyberdoc/md

Missionary Doctors

I wrote this piece with the terrible news of planes being flown into American buildings echoing in my ears. My thoughts were going out to by our American doctor colleagues with the horrors they no doubt were facing. I heard early reports of imminent and significant retaliation being planned and was saddened to think of suffering growing further. How many people will die? How will our colleagues cope with such a volume of casualties?

But I also wondered how this atrocity would further distort our view of the suffering millions of other nations- particularly Muslim ones. Fear, enmity and hatred are not especially useful prompts for missionary effort whether medical or otherwise.

It was therefore of great comfort to me to see doctors and airplanes being brought together in a much happier way on the **MAF** website topping the list of my search for missionary doctors. In an small but eye-catching site the idea of the flying doctor was almost glamorised.

The **Faile Foundation** has an interesting photo gallery that portrays a realistic view of what seems like a typical missionary hospital and gives an idea of the benefits that missionary doctors can bring to poor communities.

The **MMA HealthServe pages** are extensive including many testimonies of medics working overseas with links to many health and missionary organisations.

Ageism

Linda Woolf of Webster University has an enlightening personal homepage which defines ageism and outlines research (including her own) into the subject. It makes the very valid point that all of us will one day face this form of discrimination. A government group '**better Government for older people**' has produced an interesting article which points out some of the effects of ageism on healthcare. **The NHS plan** is clear in its commitment to stamp out ageism although it seems to focus largely on resuscitation policies.

Details of a forthcoming **King's Fund** report into NHS ageism together with a briefing report is available online.

Depression

Gospelcom has what seems to be an interesting and useful website aimed at Christians with depression. For a list of links to secular sites about depression **Dr Ivans Depression Central** site really seems to have almost all you are likely to need including links to US National Institute of Mental Health guidance.

The Crisis in British General Practice

The title sounds dramatic; I wondered would this idea be reflected on the internet. Well, the Royal College of General Practitioners have buried the idea in a report '**Valuing General Practice**' in response to the NHS plan. The idea of a recruitment and retention crisis is definitely there but in rather understated terms. Bizarrely I could find nothing at all on the **BMA website**. on the subject. **The Times** published a bleak article in May 2001 but there is little else on the internet. It seems that the crisis, if it comes- although with the events in America crisis seems an inappropriate word- will creep up on us suddenly as GPs retire and are not replaced.

Cyberdoc is Adrian Warnock, SpR in Child Psychiatry in London.

This article and links to previous Cyberdoc reviews can be found at http://www.cmf.org.uk/cyberdoc/

Spiritual Skills

'Spiritual Skills for Health Care Workers' - the title of the leaflet lying on the nurse's desk caught my eye. A free one-day seminar promised 'to explore the practical application of spiritual skills in a working environment'. Opening the leaflet I learnt that 'spiritual skills…are concerned with our deepest thoughts and feelings'. Furthermore I read that 'successful practitioners, consciously or otherwise, use their own spiritual skills to encourage and sustain a positive attitude in interactions with their patients'.

It all sounded quite laudable but a little reading between the lines, and a visit to the organiser's website, soon confirmed my suspicions that this was, of course, a New Age sham. This was not the brave initiative of the local CMF group but a seminar that would offer a mish-mash of quasi-Hindu philosophy, based on such underlying ideas as the essential goodness of all people, reincarnation, meditation and yoga. How disappointing that such an interesting concept should be hijacked, and even more disappointing that the local Postgraduate Medical Centre should allow its facilities to be used to add credence to the event.

Any recognition of the spiritual aspect of our nature by health care workers is certainly welcome. In the moments of ultimate need that serious illness may bring we realise instinctively, both as patients and carers, that there has to be more to life than the bleak finality of the here and now. Christians see this as evidence of a spiritual longing, for we are all made in God's image. The problem that confronts us as post-moderns is that a sensible acceptance of the limitations of conventional medicine has opened the door to a myriad of 'feel good' therapies that masquerade as help for our 'spiritual' needs. In our practising lifetime many of us have seen the medical pendulum swing from the arrogant confidence of scientific rationalism to the surprising gullibility of much so-called complementary medicine. Neither, of course, has the answer to our true spiritual problems.

All would surely agree that Christian doctors in particular should hope to use 'spiritual skills' as they interact with patients who reveal their 'deepest thoughts and feelings'. The tragedy is that our proffered solution is often considered unacceptable in an age that maintains that truth is relative, and that there are numerous ways to God – and hence presumably to spiritual health.

Many patients seek help and support in the fears they have about their illnesses, and many doctors long for peace and contentment in the stress and uncertainty of their professional lives. When Jesus spoke to a group of his disciples with deeply troubled hearts he comforted them with the promise of a spiritual Counsellor. But the spiritual help offered, with its ultimate promise of future peace and freedom from all anxiety, can only be ours when we accept his astonishing claims. 'I am the way and the truth and the life. No-one comes to the Father except through me' (John 14:6). There is increasing antagonism to any claim to certainty today, but we need more than ever to proclaim that there is a sure way to spiritual health that is open to all. Not just one of many ways but THE Way.

Andrew Brown
Consultant Maxillofacial Surgeon in Sussex

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