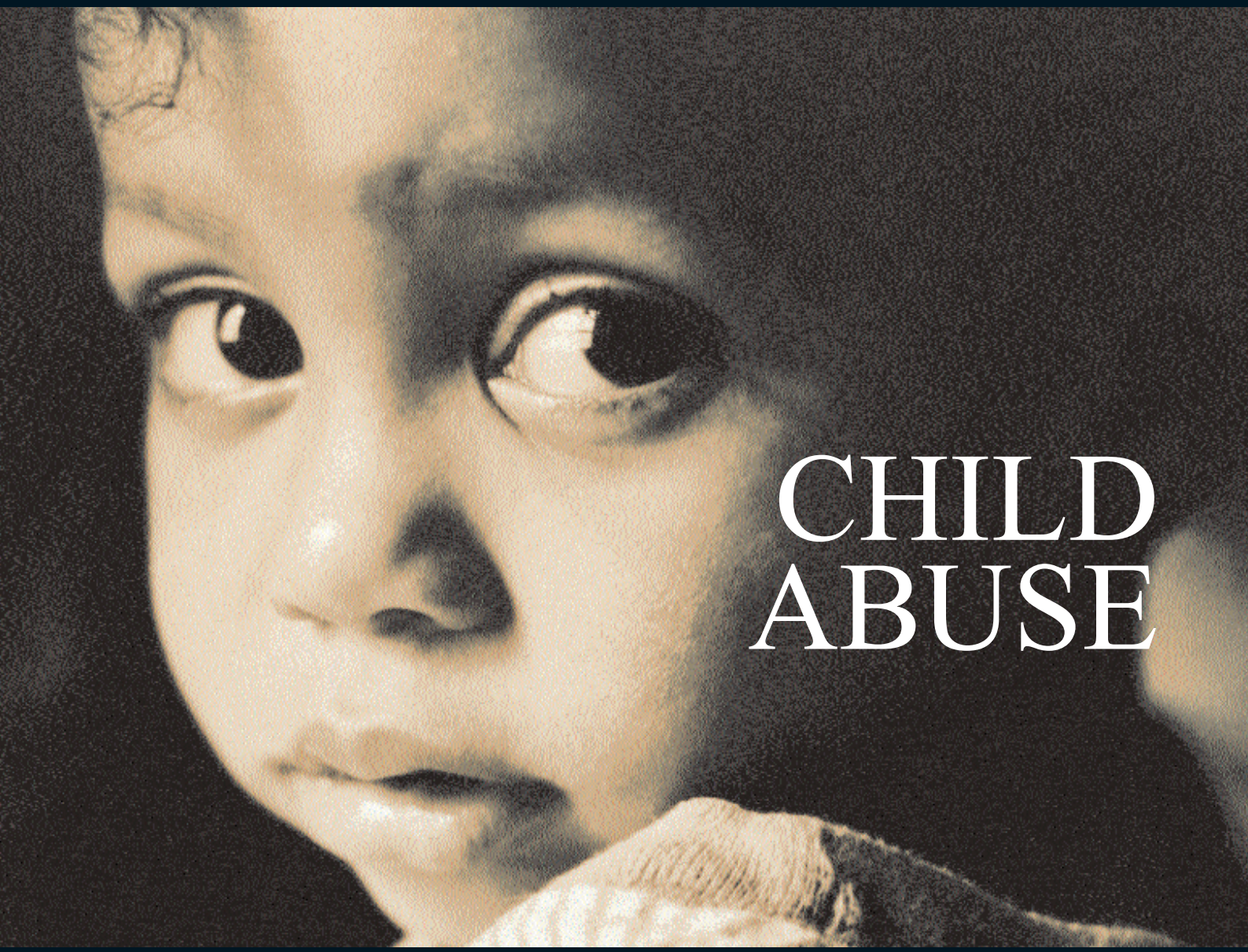
TRIPLE HELIX

Autumn 2003

For today's Christian doctor



CHILD ABUSE

INFERTILITY TREATMENT

SEPTEMBER 11 – TWO YEARS ON

REFLEXOLOGY

CHRISTIANS IN PSYCHIATRY

RENDLE SHORT LECTURE

PAUL BRAND

HEAD TO HEAD

OVERSEAS OPPORTUNITIES

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NO. 25. AUTUMN 2003

EDITORIALS

The end of the postcode lottery
But who will pay?

Photo: PA

Draft guidance from NICE (National Institute of Clinical Excellence), *Fertility: assessment and treatment for people with fertility problems*,[1] has identified a number of issues as priorities for infertility treatment provision on the NHS. Among them is the recommendation that up to three complete treatment cycles should be freely available to any woman who meets the treatment criteria. These criteria include the upper age restriction of 39 and a clearly diagnosed cause of infertility – or unexplained infertility of 3 years' duration.

The media have been quick to jump on the impending costs to the NHS should such a policy be implemented. Each fresh cycle of IVF costs approximately £3,000, and there have been estimates that the annual bill for free treatment could reach £400million – 0.6% of the £64,400million annual NHS expenditure for 2001/2.

The intention of NICE is an apparently worthy one: to eliminate the 'post-code lottery' that currently exists for infertility treatment provision. Health authorities currently decide at the local level the provision they will make for NHS infertility services. Most authorities adopt a policy statement to standardise this across their area. In the 1997/8 financial year[2] expenditure varied from below £100,000 to above £400,000, and some authorities did not fund any infertility treatments at all. A few provide treatment for women over 40. Some authorities already fund three treatment cycles, whilst others provide only one. This leaves some couples selling their homes, or accumulating thousands of pounds in debt to achieve the dream of bearing their own child, while for others it is free.

A worthy cause perhaps, but there will be a price to pay - it seems unlikely that provision will be possible without cuts elsewhere. Infertility is a cause of great distress to many couples, but still we may wonder at the priorities of a society that regards infertility treatments as so important that they should be provided through the funding of the welfare system at such cost. Cost, not only to the taxpayer who may not agree with the policy, but also to those who will experience the brunt of the cuts - or continuing lack of resources - elsewhere.

Two key examples of areas that could benefit from resources are the prevention of infertility and promotion of adoption. Much infertility is preventable – occurring either as a consequence of sexually transmitted disease and abortion or resulting from postponing childbearing until later years. Those who would consider adoption can find the adoption process difficult to access, and the number of baby adoptions has fallen from near 15,000 a year in the 1960s to just 239 in 2002. Rising infertility rates and falling adoption rates, teamed with increased promotion of infertility treatments will likely fuel the attitude that people have a right to bear their 'own' child – at their time of choice. It would seem wiser for the government to address the deeper issues at a national level rather than channelling more public money into a procedure with a 75% failure rate.

Jacky Engel is CMF Research Assistant

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September 11 – Two years on
Let's keep it in perspective

The September 11 terrorist attacks in 2001 were a great tragedy - with just over 3,000 deaths in a single day. And the people killed were infinitely more important than the companies they worked for or the buildings they worked in. The grisly events were witnessed, and will rightfully be remembered, all over the world for many years to come.

But in our remembering, let's not forget those other deaths unnoticed by the Western media – *every day* on this planet in the developing world 110,000 people die, largely from preventable causes:

- 46,000 people die of infectious and parasitic disease
- 27,000 people die of circulatory disease
- 11,000 people die of perinatal and maternal disease
- 10,000 people die of cancer
- 6,000 people die of respiratory disease
- 10,000 people die of other causes including trauma

And about 40,000 of them each day are children. Let's also not forget that between 1991 and 1998, during the period of UN sanctions, there were 500,000 *extra* child deaths in Iraq over and above what would have happened naturally - 5,000 extra child deaths a month for 8 years.

We may debate the causes but many of these children died because of the embargo on food and drugs, the effects of radiation (the US used 300 tons of depeleted uranium weapons in the Gulf War), and the destruction of Iraq's infrastructure resulting from the war. The Western world through its 'management' of the crisis bears not a small part of the responsibility. In fact, ironically, economic sanctions have arguably taken the lives of more people in Iraq than all the weapons of mass destruction in history.

Poverty and injustice kill far more people than terrorism - and if we fight terrorism without addressing poverty and injustice, especially that which we have created, exacerbated or failed to rectify ourselves, then history and indeed God himself, will be asking some very serious questions of us and our generation.

Peter Saunders is CMF General Secretary

George Smith examines a popular touch therapy.

Reflexology

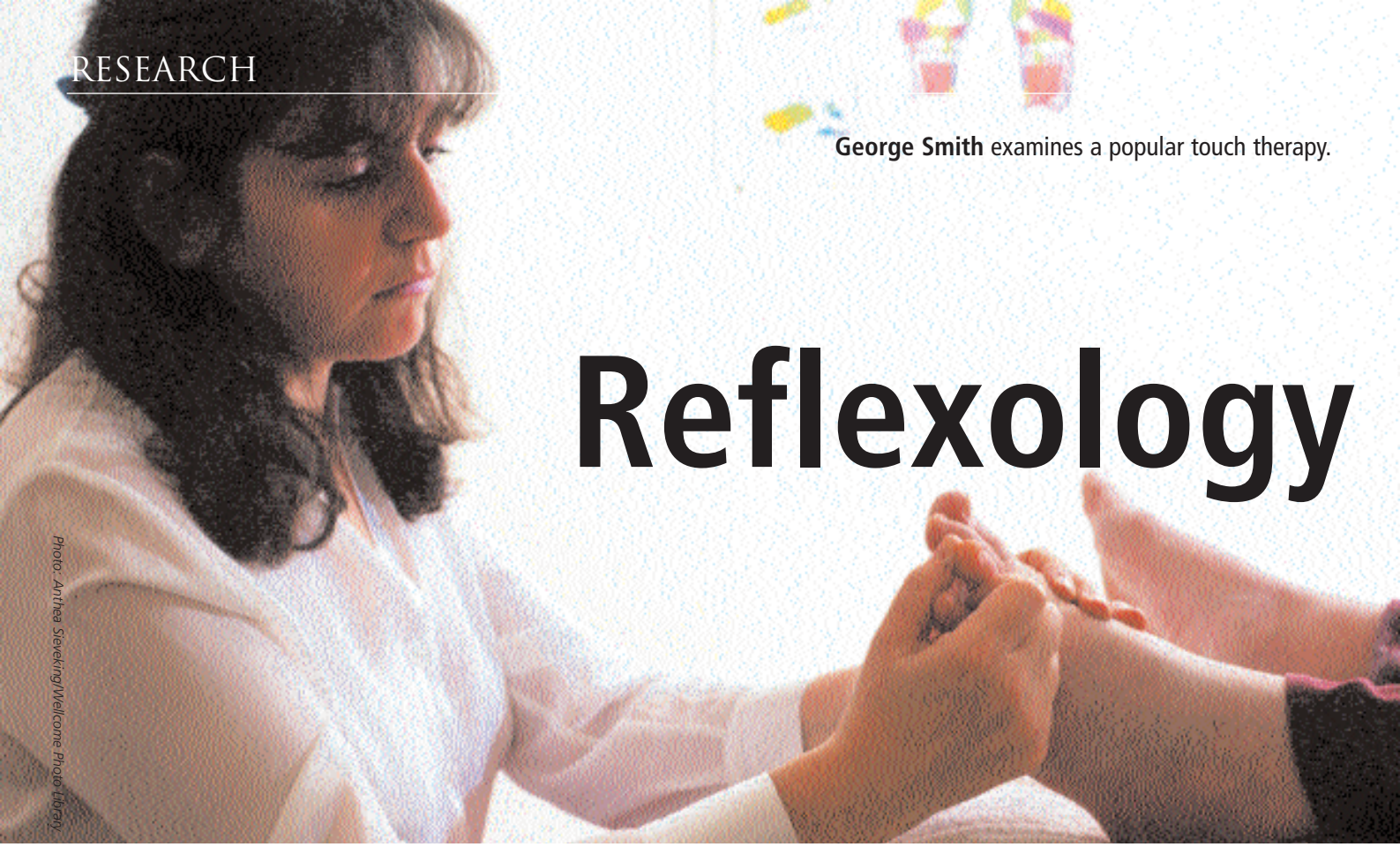

Photo: Anthea Sieveking/Wellcome Photo Library

KEY POINTS

Reflexology is a 'touch therapy' with ancient origins based on the idea that pressure and massage applied to the foot can prevent and treat organic disease. Although relatively safe, it has no rational or scientific basis and randomised controlled trials show no evidence of its efficacy. Whilst a soothing foot massage may play a part in relieving stress, the basic philosophy behind reflexology has roots in the Taoist Chinese view of the life force ch'i and the concept of chakras in the Hindu practice of yoga. These considerations alone make it not a wise choice for Christians.

Reflexology, one of many touch therapies, is enjoying increasing popularity in a 'consumer led boom' in alternative medicine.[1] It is used by ten percent of alternative therapy consumers. Some family practices and hospitals provide it and many health care professionals incorporate it into their work. Over 20 countries have reflexology associations linked to the International Council of Reflexologists, based in USA.[2] There are several British reflexology schools: therapists are usually members of the British Reflexology Association (MBRA)[3] or the Association of Reflexologists (MAR), founded in 1985 and 1989 respectively.[4] However, Britain does not have any specific statutory regulations. There is little difference between reflexology and the less frequently mentioned zone therapy.

Origins

The Chinese probably used a comparable therapy some 5,000 years ago: acupressure emerged from this followed by acupuncture, which then became mainstream Chinese medicine. Ancient paintings on the foot of the Hindu god Vishnu and inscriptions on the foot of a reclining Buddha suggest a representation of reflex points. A wall picture and hieroglyphics on the tomb of Ankhmahor (probably a royal physician), excavated in Saggara in Egypt and dated c2000 BC, convincingly depict hand and foot touch therapy.[5] North American Cherokee Indians still practise a form of foot massage, thought to have originated from South American Incas.[6]

The Florentine sculptor Cellini (1500-1553) relieved pain using finger pressure.[7] Doctors Adamus and A'tartis wrote about zone therapy in 1582. Dr Cornelius published *Pressure Points and their Significance* in 1902.[8]

American ENT surgeon William Fitzgerald (1872-1942) applied clamps and elastic bands to fingers in order to produce arm and jaw anaesthesia, allowing him to perform minor operations. Dr Edwin Bowers, Fitzgerald's colleague, attracted attention with an article in *Everybody's Magazine* entitled *To Stop the Toothache – Squeeze your Toe*. Dr Fitzgerald devised a theory that the body was divided into ten vertical zones or slices ending in the five fingers and toes on each side. No explanation is recorded as to how he reached this conclusion. In the 1930s, Eunice Ingham (1879-1974) – an associate of Fitzgerald - produced extremely detailed maps of reflex areas representing all parts of the body on the hands and feet. She trained Doreen Bailey who introduced reflexology into Britain and founded a School of Reflexology.[9]

Principles and Practice

Reflexology is presented as a holistic therapy in which pressure and massage are applied to the feet or hands in order to remove and dissipate energy blocks, break down crystalline structures, encourage toxin release, stimulate the immune system and prevent ill health.

According to Pauline Wills, reflexology '…is about giving and receiving energy. That energy is transmitted to the patient through the hands of the therapist and information is received from the patient's feet.'[10] Reflexologists do not claim to make medical diagnoses but identify body parts that are 'out of balance' and require removal of energy blocks. A medical history is supplemented by

information gained by foot palpation. Areas of grittiness or tenderness are presumed to identify organs relating to the reflex area or zone involved. Massage, pressure or techniques such as *finger* walking across the foot are used to unblock energy channels, stimulate vital energy and promote healing. Individual reflexologists may combine this with colour therapy, yoga, aromatherapy, homeopathy or astrology.

As with many alternative therapies, reflexology may be practised in NHS hospitals, Alternative Medicine Centres in the High Street, private practices or at New Age Mind, Body and Spirit Festivals.

Medical Checklist

1. Is there a rational, scientific basis?

There does not appear to be a rational basis for Dr Fitzgerald's theory of body zones. Any significant anatomical or physiological relationships between the variously shaped body organs and his geometric vertical segments or reflex areas on the foot is hard to imagine and quite incompatible with *Gray's Anatomy*. Different practitioners' foot maps have similar patterns but show clear variations in the positioning of certain organs. No convincing explanation for these variations has been offered. Reflexologists suggest a cause and cure relationship between minor foot abnormalities (eg corns and bunions) and disease of internal organs.

anecdotal evidence and acknowledgement of the placebo effect cannot substitute for scientific evidence.

Diagnosis of blocked energy channels - said to be causing crystalline deposits - by foot palpation is not backed up by scientific investigation or evidence. In New Age settings, a query over whether this is diagnosis or divination must be raised. *Life force*, *vital energy*, *meridians* and *chakras* all figure prominently in popular reflexology textbooks. The *WHICH? Guide to Complementary Therapies* stresses: 'Few scientific data have been produced to back up the experiences of reflexology devotees or to confirm the existence of zones, energy lines or crystalline deposits'.[11] Inge Dougans - founder of the School of Reflexology Therapy and Meridian Therapy in South Africa – states, 'There is no one correct theory on how reflexology works'.[12]

2. Does it work?

Reflexology is popular: its practitioners are enthusiastic and caring and many patients testify to its positive effects. A soothing foot massage in a caring environment may well diminish stress and patients often feel better. Yet anecdotal evidence and acknowledgement of the placebo effect cannot substitute for scientific evidence. Feeling better does not automatically imply healing from disease.

A survey in *WHICH?* failed to find any conclusive scientific evidence to support reflexology's effectiveness. In a meticulous scientific review in Professor Ernst's *Desktop Guide to CAM*, ten random controlled trials were reviewed without revealing convincing evidence for reflexology's efficiency.[13] Further reviews of clinical trials in FACT did not reveal any satisfactory evidence of efficacy.[14]

3. Is it safe?

Significant harm seems unlikely from simple foot massage but foot tenderness, changes in micturition or bowel function have been reported.[15] Caution is advised in patients suffering from depression, epilepsy or vascular disorders of the legs.[16] The greatest risk with potentially serious consequences is when reflexology is used as a substitute for proper medical diagnosis and treatment.

Christian Checklist

Christians need to consider both professional integrity and biblical guidelines when assessing any treatment, orthodox or alternative. Unproven effectiveness or mode of action cause reflexology to fall far short of the evidence-based principles supposedly required of all modern medical treatments.

From a Christian perspective there is much to cause concern. Reflexologists highlight the spiritual significance of healing through the feet. Inge Dougans comments: 'Feet play a significant part in spiritual well being. The feet connect us to the ground and they are therefore a connection between earthly and spiritual life. They are our base and foundation and our contact with the energies that flow through it'.[17] Referring to the biblical account of Jesus washing the disciples' feet, she adds: 'The Christ washed the disciples' feet in order to awake the crown chakra above the head to awake spiritual energies'.[18] Similarly, many other reflexologists find an association with chakras and elements of the Hindu practice of yoga. Its basic philosophy is related to the Taoist Chinese view of the life force ch'i (ying and yang) or its equivalent in other cultures and religions (eg Universal Cosmic Energy). Reflexology, therefore, may provide an introduction to New Age spirituality and eastern religious philosophy.

The Christian worldview is of a personal Father God upon whom we depend in all aspects of our life.[19] The idea of an impersonal life force governing all living beings is contrary to this and must surely lead to the conclusion that reflexology is not a right choice for Christians.

Choose you this day whom you will serve…God forbid that we should forsake the Lord to serve other gods. (Joshua 24:15-16, King James Version)

George Smith is a Dermatologist and former GP in Berkshire

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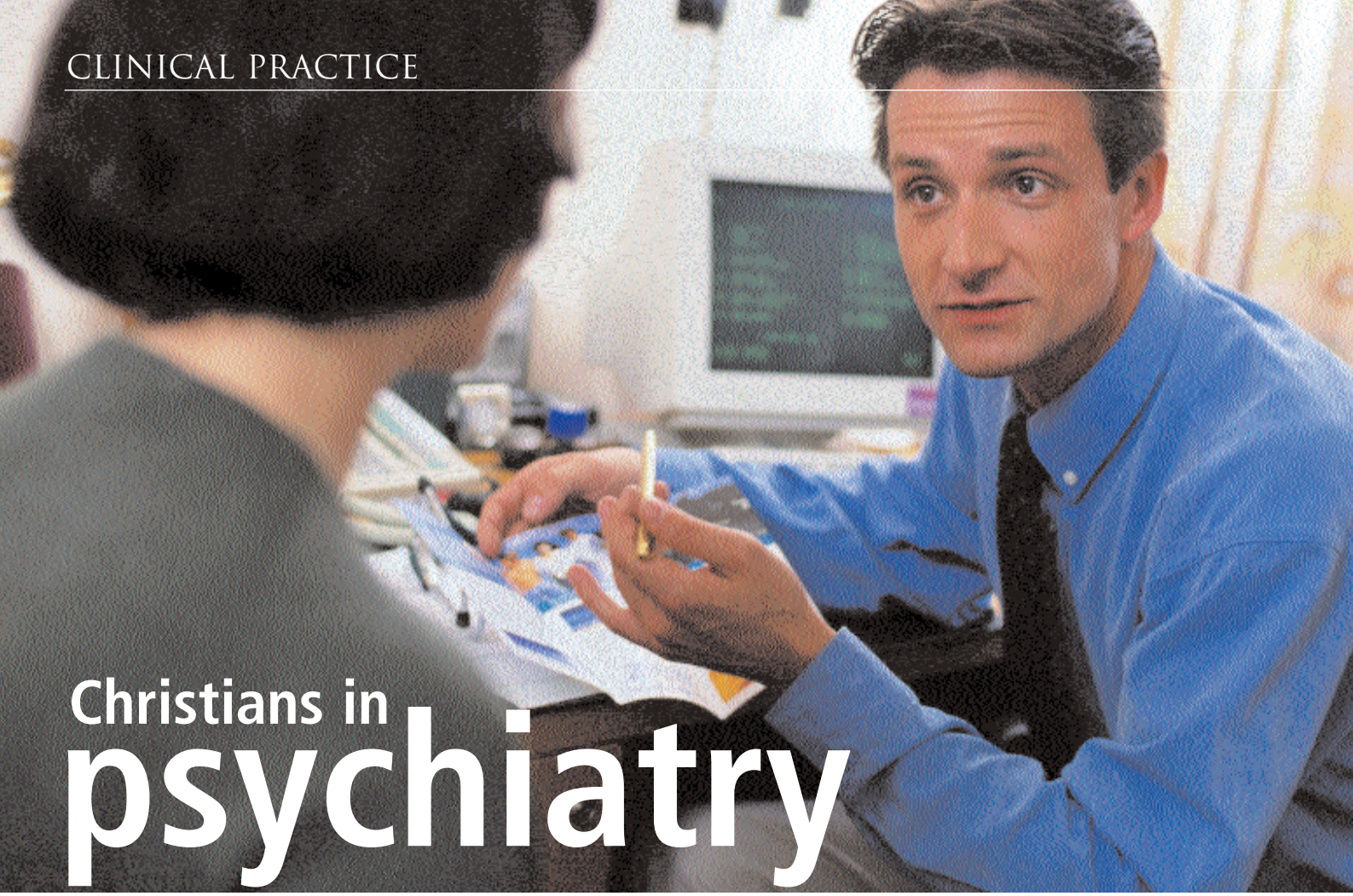

Christians in psychiatry

KEY POINTS

Much psychiatric practice involves 'healing the brokenhearted' and 'setting the captives free'; concerns at the heart of gospel ministry. A proper biopsychosociospiritual framework, in addition to evidence-based traditional treatments, will involve the use of God's word, prayer, restorative community, meaningful relationships and the power of the indwelling the Holy Spirit. Whilst we need to guard against unrealistic expectations in a secular health service, the growing interest in spirituality within medicine may make Christian psychiatric units with a redemptive ethos more of a reality.

I recently had an interesting week at work. I explained true forgiveness to a lady whose depression was being fuelled by intense guilt then was asked about the meaning of life by a young man who had been given a diagnosis of schizophrenia. An older man was in despair due to a chronic painful physical illness; and we helpfully discussed the role of his faith in helping him cope. A woman, with whom I had been working psychodynamically, reported a new experience of peace after spiritual ministry through her local church. At the end of a clinic, a troubled patient revealed the gist of his inner distress: a sense of alienation from a God he once was close to. I encouraged him in his efforts to rekindle his devotional life.

A Sense of Purpose

The call to a purposeful future is one of the blessings of being a Christian. Some usefully think of *mission* as being general ministry direction ('To be like Jesus', 'To help build his kingdom', 'To know him and make him known' etc.) and vision as being the specific, individual task which God has for a person or group.[1]

It is exciting to realise that our everyday work can be our vision. Psychiatry is as much a vocation as full-time pastoral ministry. With God's grace, a Christian psychiatrist in the NHS can be as much involved in front-line Christian service as any cross-cultural missionary.

Christians in psychiatry can make some unique contributions:

- Truly holistic assessment and management of patients due to an appreciation of relevant spiritual factors.
- Dealing with Christian patients who may be more comfortable seeing a skilled practitioner who also understands their faith.
- Liaison with other helpers who may have a spiritual input into the care of the patient, if appropriate.
- Facilitating better understanding and cooperation between mental health services and the church.
- Playing a part in incorporating true spirituality into the healthcare arena through research and evidence-based practice.

A Philosophy of Ministry

All truth is God's truth and it is wholly biblical to welcome science as the systematic discovery of factual truth created by God but not directly revealed in his word. We need not fear psychopharmacology or psychoanalysis if we have an openness to all God's truth coupled with an ability to discern falsehood.

The Bible sees the human predicament in the context of spiritual warfare.[2] Illness and suffering are the consequences of a spoiled creation where the workings of a personal evil, the sinful nature of man and a corrupt world system are evident in distorted biology, broken relationships and deep insecurity. Nick Land has written a helpful article on the aetiology of mental disorder from the perspective of the Fall of mankind.[3]

Through the redemption story God himself has provided a way for sin and separation to be dealt with and has revealed his truth through his word and by his Spirit. For the Christian, the practice of psychiatry can reflect the wider kingdom ministry of healing the brokenhearted and setting the captives free; one of the fundamental objectives of the gospel.[4]

A Model of Working

We have tremendous resources available to do God's work. The indwelling Holy Spirit is our greatest help as we seek to minister healing and restoration. The word of God is the truth that can unlock darkened minds. Prayer can bring life to disturbed souls. In the church, we potentially have a model for the community and meaningful relationships that some believe are at the heart of emotional healing.[5]

We need to extend the traditional biopsychosocial framework into a biopsychosociospiritual one. The extra dimension is relevant to diagnosis, aetiology and treatment. The spirituality we are primarily interested in is biblical; so we need to beware of wholly absorbing the various philosophies of post-modern society.

We should strive to excel as doctors/psychiatrists in general, keeping up-to-date in knowledge and sharp in skills. We also need to be willing to face (and hopefully overcome) the many pressures of busy psychiatry in the real world. The way we relate to our colleagues will say a lot about our values and ourselves.

An Approach to People

Our work is about impacting people's lives for the gospel. Discipleship involves pre-evangelism, evangelism and edification and a good place to start is by learning to see people through the eyes of Jesus; every contact with a patient (or relative or colleague) then becomes an opportunity to be a channel of blessing from God to that individual.

In dealing with non-believers, we need to go about our business in such a way as to make others wonder about the positive difference in our lives. In the process of helping people work through their problems, we can introduce concepts that reflect deeper truth and eternal matters.

I am stirred up when I meet Christian patients and find myself adopting a much more open stance faith-wise. Some people are genuinely seeking the Lord for answers and it becomes a privilege to help them discover a missing kernel of truth. Others may have fallen away and there may be a chance to help draw them back into the fold.

Difficulties and Dilemmas

Any doctor seeking to be a witness at work faces struggles; the ethics and practicalities of on-the-job evangelism are but two issues. Bernard Palmer's uncompromising handling of this subject merits reference.[6] Some would question whether we should be involved in spiritual ministry at all; what is the role of chaplains, pastors, Christian counsellors etc. and indeed of the church itself?

We need to guard against unrealistic expectations about what can be achieved in an essentially secular setting. We must also avoid being overzealous with our faith – 'conventional treatments' may often be the very best. Occasionally, the only and appropriate thing to do is commit someone to the Lord in prayer as we disengage therapeutically.

If we see our secular work as our ministry then we need to expect the kind of opposition that committed Christian service incites. It is important to realise that we do not wrestle against flesh and blood.[7] We need to be ever careful in our personal walk and utterly obedient to the leading of the Spirit.

Looking to the Future

Unity (with diversity) among Christian psychiatrists is perhaps the thing that will convince the most; effective networking can move us towards this. Cooperation with other Christian members of the multidisciplinary team is a thrilling prospect. Working together with local church leaders is very necessary.

This is a time when there is growing interest in spirituality within medicine;[8,9] the Royal College of Psychiatrists' Spirituality in Psychiatry Special Interest Group is one sign of this. Several texts written by psychiatrists are available describing Christian approaches to mental health problems;[10-12] the production of empirical research evidence for the psychotherapeutic efficacy of Christian principles would be awesome.

Could a Christian psychiatric unit with a redemptive ethos become a reality? Certainly there is scope for innovative service provision. Some may be called into ministry outside the usual career setting and we thank God for such visionaries.

Conclusion

Previous articles have usefully dealt with some of the ideological difficulties facing Christians in psychiatry.[3,13-17] I wrote this piece to cast some vision regarding what Spirit-empowered psychiatrists could achieve within the health service as we know it. Hopefully my idealistic musing is tempered with realism. There is much for us to figure out both in theory and in practice; we need wisdom and boldness. Perhaps we will get there quicker if we work together.

Ken Yeow is a Specialist Registrar in Psychiatry in Belfast

WITH GOD'S GRACE, A CHRISTIAN PSYCHIATRIST IN THE NHS CAN BE AS MUCH INVOLVED IN FRONT-LINE CHRISTIAN SERVICE AS ANY CROSS-CULTURAL MISSIONARY.

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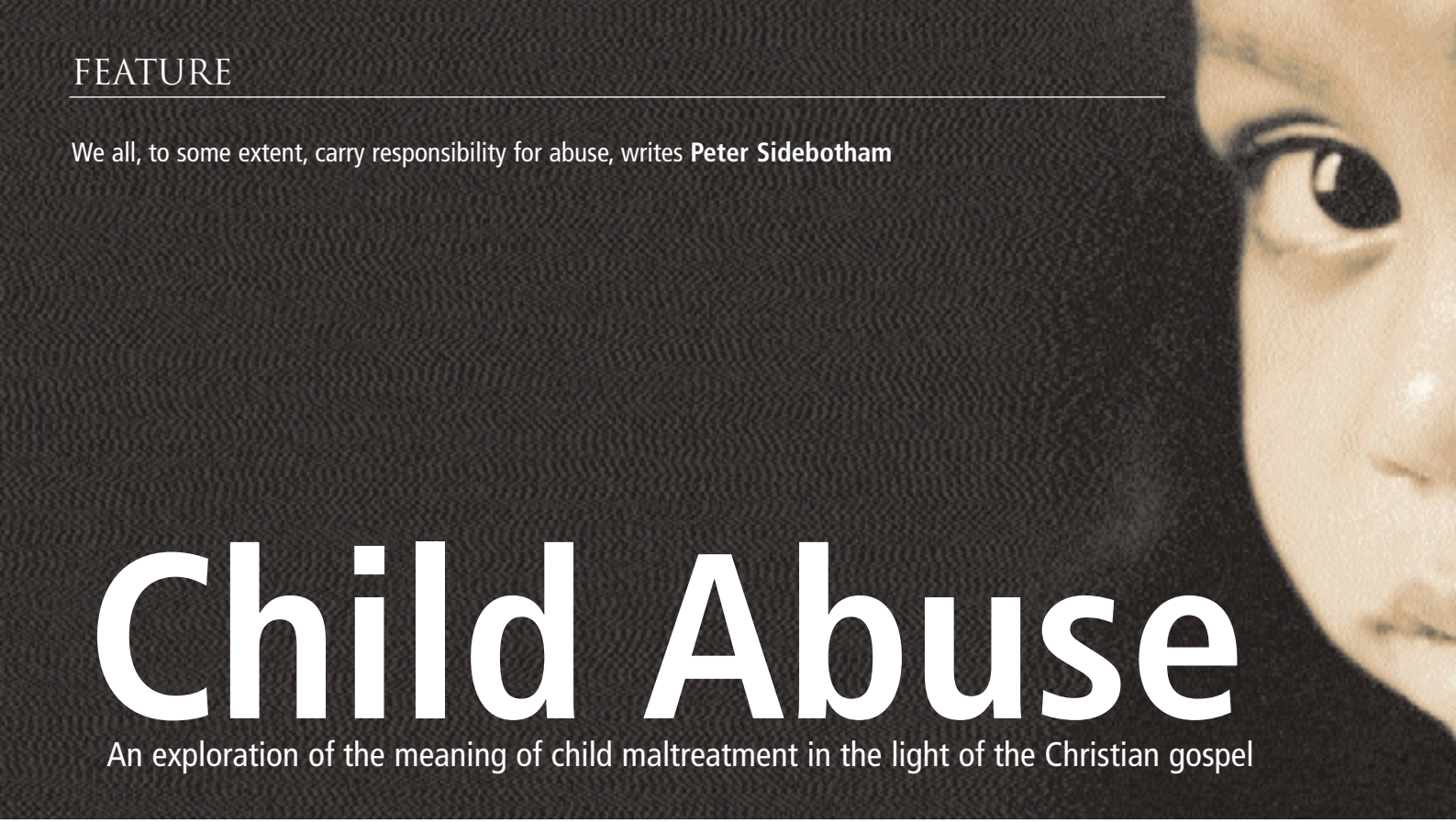
We all, to some extent, carry responsibility for abuse, writes **Peter Sidebotham**



Child Abuse

An exploration of the meaning of child maltreatment in the light of the Christian gospel

KEY POINTS

The long term effects of child abuse on mental health, social behaviour and relationships stem from a loss of trust, hope and self esteem in the developing child. Traditional theories of why child abuse occurs include considerations of parental personality, lifestyle and behaviour and also socio-economic stress; but often fail in acknowledging the role of individual responsibility and choice. Proper spiritual development is dependent on a modelling by parents of God's character and a truly Christian approach to child abuse involves making ourselves vulnerable enough to suffer with the abused and feel their pain. Only in this way can lost hope, faith and love be fully restored.

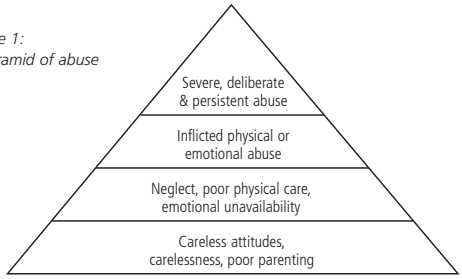
If there were first century child protection registers, Jesus should have been on one. Two thousand years ago, a baby was born to an unmarried teenage mother, which in his culture carried far more stigma than it does today.

As American author Philip Yancey puts it, 'In the modern United States, where each year a million teenage girls get pregnant out of wedlock, Mary's predicament has undoubtedly lost some of its force, but in a closely knit Jewish community in the first century, the news an angel brought could not have been entirely welcome.

The law regarded a betrothed woman who became pregnant as an adulteress, subject to death by stoning.'[1] Jesus was born, far from home, the illegitimate baby of a teenage Mum, cut off from family and community support, with bizarre beliefs about herself and her baby, a sure sign of underlying mental illness.

However there is a far more profound reason why I believe Jesus might have been placed on a child protection register. To understand that we must first explore a bit about child abuse – what it means and why it happens.

Figure 1:
A pyramid of abuse

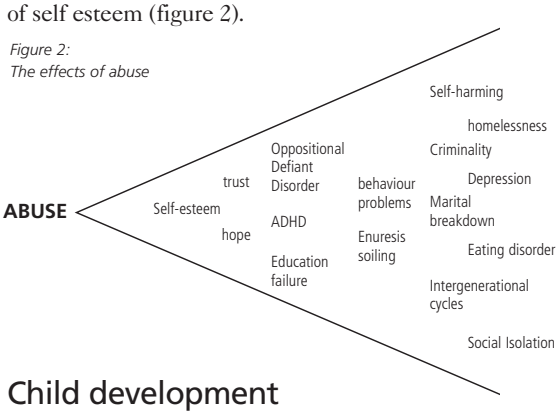


The impact of child abuse

Child abuse can be thought of in terms of a pyramid (figure 1). It is often the extreme end of child abuse that people think about: the severe and persistent maltreatment of children with malicious intent. The immediate effects of such abuse are clearly horrific, whether it is one of the 1-2 babies who die each week, or the much greater number who are left disabled or even just physically hurt at the time. However, the lower levels are of equal concern. These levels make up the bulk of those children seen every day by professionals working in child welfare. At these lower levels the thresholds are not easily defined. When does a casual attitude become neglectful or parental discipline become abusive?

Anyone working within the caring professions will be familiar with the long-term effects of maltreatment, particularly the emotional maltreatment that accompanies all abuse. These long-term effects seem to be found just as much at the middle levels of the pyramid as they are at the extreme end of the spectrum and they form what is perhaps the most concerning aspect of abuse. Many of the long-term effects are well documented, including effects on mental health, social behaviour and relationships; and impacts on child behaviour and development.[2,3,4,5] These effects can be viewed as stemming from three basic impacts on the developing child: a loss of trust, a loss of hope and a loss of self esteem (figure 2).

Figure 2:
The effects of abuse



Child development

As the child moves from a position of vulnerability to maturity, he or she grows and

develops in many different ways. An integral part of that, and overlapping with the other aspects, is the child's spiritual development. We can view our spiritual development as covering three areas: an awareness of ourselves, an awareness of others and an awareness of God.

Probably the greatest influence on a child's spiritual development will be what they see of God in their parents. Most children will learn that their parents are there, even when they can't see them; that their parents love them, care for them and are interested in them. In that sense, spiritual development is not a matter of doctrine, or even of morals, but a modelling by parents of God's character. Child abuse, most of which we know to be committed by parents, flies in the face of this crucial aspect of a child's development.

In 1 Corinthians 13, Paul highlights the three pillars of faith, hope and love, the greatest of these being love. These three can be applied to our understanding of spiritual development, and to the impact of child abuse:

Child abuse destroys faith

I saw Abbie, aged two in the emergency department. She was covered in injuries including over 30 burns from a cigarette lighter. The excuse from the parents was that it happened in play. In Matthew 7: 9-11 Jesus asks, 'Which of you, if his son asks for bread, will give him a stone? Or if he asks for a fish will give him a snake?' He continues, 'If you then, though you are evil, know how to give good gifts to your children, how much more will your Father in heaven give good gifts to those who ask him?' This rings true for most of us, but not for the abused child. As Francis Bridger puts it, 'A child who does not learn how to trust adults now will have difficulty trusting anybody at more than a superficial level later on. This extends to trust in God.'[6]

Child abuse destroys hope

Emma, a 16 year old came with her mother to my clinic. Her stepfather had sexually abused her three years previously. Since then she had become isolated and shy. She had effectively dropped out of school and found it difficult to relate to her friends. In an attempt to overcome this shyness, she had taken to binge drinking to made it easier to cope in social situations. I asked Emma what she wanted to do with her life. Hesitatingly she said she had wanted to be a lifeguard, but she knew that she never could, as it would take too much to change. Emma had lost hope and this had led to the feeling that she could not control her future.

Child abuse destroys love

As a paediatric registrar I saw three year-old Kirsty. She had presented with a minor injury that in itself was not worrying. However, she sat in the A&E cubicle, watching me warily with that aura of 'frozen watchfulness'. What hit me were four words in biro on her arm: 'I'm a little bitch'. This to me sums up the most devastating aspect of child abuse: children grow up feeling unloved and unvalued. The Bible is full of illustrations and references to God's love for his people. But children who have been brought up to believe they are worthless and unlovable, who have never known what it is to be loved and valued, will struggle to believe in such a loving God.

Why do people abuse children?

Early understanding of child abuse tended to fall within two theories: the *psychodynamic* and the *sociological*. Psychodynamic theories saw abusers as somehow different from 'normal' parents: mad, sad or bad. Sociological theories, saw abusers as normal people in extreme circumstances: that stress, especially financial stress tipped them over the edge.

Neither theory is adequate. Most parents I deal with in cases of suspected abuse are normal parents, not much different from me. Since becoming a parent, I am even more aware of this. There were times when I have felt like shaking our babies when they would not stop crying. I have sometimes gone further than I feel happy with in my discipline, too, or spoken harshly and regretted it.

As for sociological theories, it's true that there are social gradients in abuse.[7,8] However, having worked both in the UK and internationally in areas of poverty and deprivation, I am convinced that this isn't the full answer. Most poor people do not abuse their children.

Moving beyond this, most researchers and practitioners now work within the ecological theories of Bronfenbrenner.[9,10] This structure informs the assessment framework within which UK child protection work is based.[11] This ecological framework can be portrayed as a series of concentric circles (figure 3). The child is located within the nucleus of his or her family and home: the microsystem. This in turn is located within a wider exosystem of the neighbourhood and social environment, which in turn is dependent on the wider cultural values and beliefs of the particular society: the macrosystem. Into all this, the parents bring

IF THERE WERE FIRST-CENTURY CHILD PROTECTION REGISTERS, JESUS SHOULD HAVE BEEN ON ONE

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A GOSPEL OF CUDDLES AND SOFTLY SPOKEN WORDS

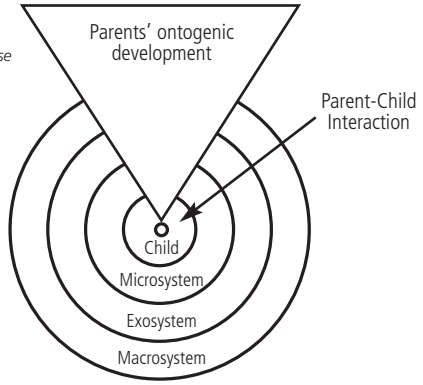

Figure 3: An ecological model of abuse

their own background experiences, each of which will have its own concentric circles. The important thing to recognise here is that this is not a static system, but is moulded and shaped by the actions of all the players.

Thus we can recognise the importance of parental personality, lifestyle and behaviour, but also the contribution of socio-economic stresses and the child's own developmental needs. And perhaps most importantly, the impact of our society on parenting, and the stresses that brings. If you consider child abuse in this light, it is impossible to avoid the conclusion that we all, to some extent, carry responsibility for abuse. By creating and maintaining our cultural values of consumerism, achievement and individualisation, we all carry some responsibility towards those children who are harmed when parenting can't withstand the pressures that imposes.[12]

Individual responsibility

Where all models of child abuse break down, though, is their failure to acknowledge individual responsibility and choice. We all have a choice about how we behave. And we cannot deny that responsibility. If we look at the tragic death of Victoria Climbie,[13] it was Koaou and Manning who were ultimately responsible. Similarly, in Abbie's case her father who was responsible for her cigarette lighter burns. David Southall and colleagues have hinted at this.[14] Whilst at one level, society must take the blame, at the other extreme, where there is deliberate, malicious abuse; the individual perpetrator is responsible and must be dealt with through the criminal justice systems.

Southall's model doesn't go far enough, however, in that at all levels the individual must carry some responsibility and at all levels, society, and therefore you and I must carry responsibility as well. Lord Laming was right in pointing out that the system failed Victoria Climbie. Yet it was not just failure to identify and prevent the abuse. The interplay of structures and inequalities led to a family in the Ivory Coast giving up their daughter to a relative stranger in hope of a better future. We are all guilty.

Evil

Cases such as Abbie above, or Victoria Climbie highlight the evil nature of child abuse. At its most extreme, it is malicious and cruel. It targets the weakest at the point where they are most vulnerable. Above all, it portrays the exact opposite of all I believe about God.

- Where God has a particular concern for the vulnerable, abuse targets them
- Whilst God is loving and kind, abuse is malicious and cruel
- While God wants peace and goodness, abuse brings pain and fear
- Abuse robs people of the full life that God intended
- And as we've already shown, child abuse destroys faith, hope and love, three bedrocks of God's character and dealings with mankind.
- God values each individual but abuse says 'you're worthless'

This evil extends beyond the abused, to ruin the life of the abuser.

God to the rescue

In understanding abuse, we have to acknowledge that we live in a fallen world where evil is at work destroying people's lives, and where we all must share the guilt and responsibility for the suffering around us. Within this, child abuse epitomises that evil and suffering and the guilt of each one of us. We all need forgiveness, healing and rescuing, and we all need hope, faith and love restored. For some mysterious reason that I don't really understand, God chose to tackle this evil and suffering not by erasing it or imposing his love and goodness, but through incarnation, by identifying with it. This may have something to do with the nature of the evil and suffering that lies at the heart of abuse and forms the real problem.

If we believe in an all-powerful God, we must believe that he could deal with suffering and put a stop to pain. But the root of suffering demands something more profound than miraculous erasing. In choosing to love us, God relinquished some of that power, for love makes us vulnerable.

Jesus did not deal with suffering from a distance, but by coming close enough to be touched by it, to feel the pain. John Ortberg has expressed it powerfully: 'In a contagious world, we learn to keep our distance. If we get too close to those who are suffering we might get infected by their pain. It may not be convenient or comfortable. But only when you get close enough to catch their hurt will they be close enough to catch your love.'[15] That is what Jesus did, getting close to those who were suffering, the abused, outcast and vulnerable, and bringing with him acceptance, restoration and hope.

If Jesus was born today, he might not be placed on a child protection register, but I believe he would somehow suffer with the abused and feel their pain, for it is only in that way that they can regain the love that has been taken from them. That same challenge should extend to us. In the words of Bridger, 'it will be a gospel of cuddles and softly spoken words. These are the seeds out of which, by the grace of God, fuller faith may develop.'[16]

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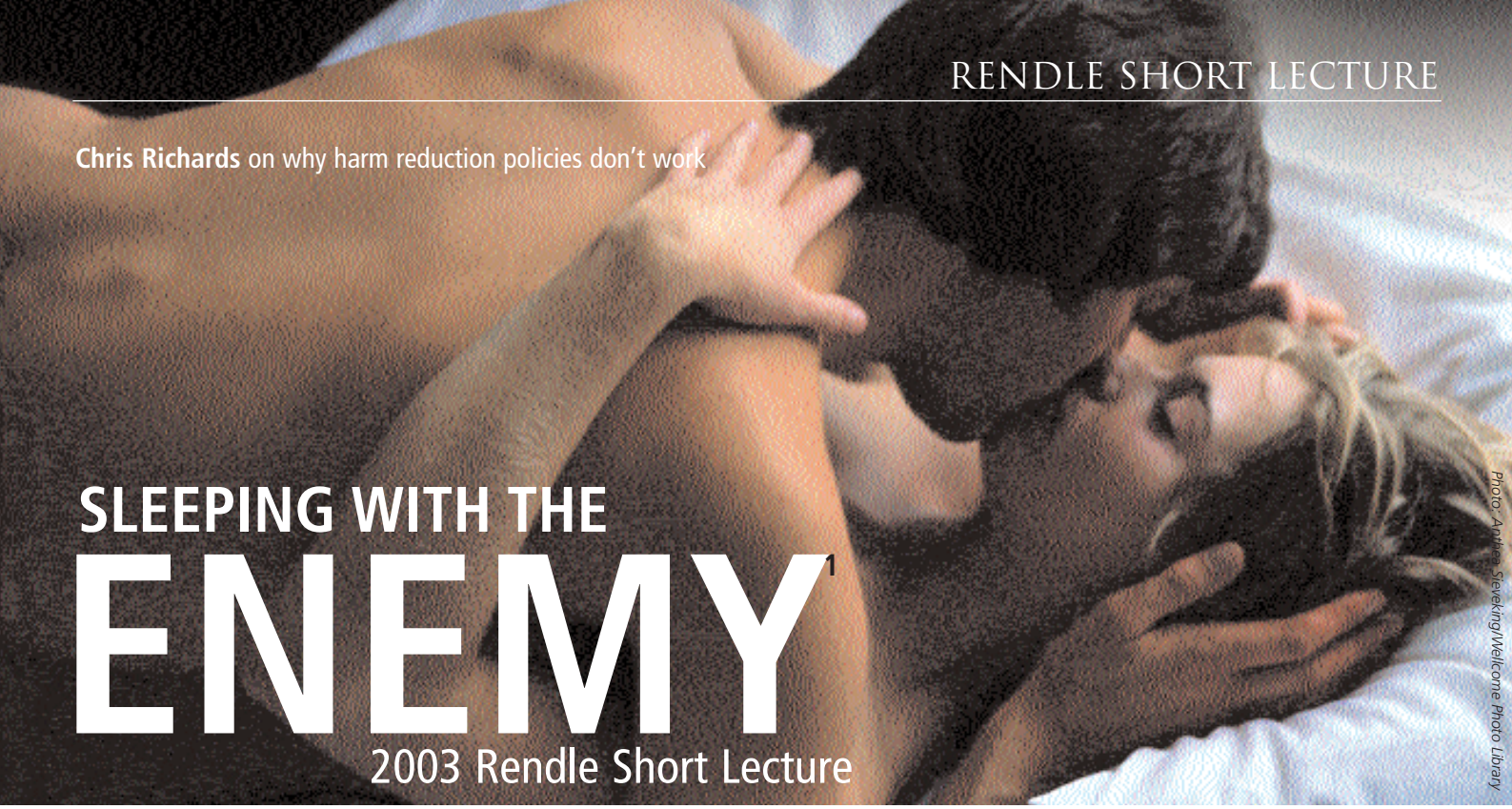

Chris Richards on why harm reduction policies don't work

SLEEPING WITH THE ENEMY[1]

2003 Rendle Short Lecture

KEY POINTS

Much of government health policy is aimed at 'harm reduction' rather than at reducing the behaviours that result in lifestyle related disease. Key examples include those measures aimed at reducing the consequences of teenage sex (condoms, antibiotics, abortion) and drug addiction (methadone, needle exchange, injecting rooms). But the effects of 'harm reduction' are often to increase rather than decrease the incidence of the behaviour that underlies the problem. Christian doctors have a prophetic responsibility to warn patients about the health consequences of sinful behaviour; not to do so is to be unfaithful both to the truth and to the Gospel.

Harm reduction is the essence of a doctor's role. We attempt to reduce suffering and pain caused by sickness. Today our Government is enthusiastically pursuing 'harm reduction' by the promotion and provision of 'safe sex' and drug control programmes, which support those unwilling or seemingly unable to leave their addiction.[1] Such 'harm reduction' programmes raise important ethical questions.

Katie's dilemma

Let us consider a familiar clinical situation. You are a school doctor on your way out of school after a busy drop-in clinic. A sixteen-year-old girl called Katie looking rather desperate approaches you. She tells you that she and her boyfriend Tom have decided to sleep together tonight (rarely is first sexual intercourse in young people so premeditated or rational). In their haste she forgot to discuss contraception, knows Tom would be useless at remembering and asks whether you can help her out by supplying a condom.

I will now set out the arguments to support my conviction that it would never be right to supply her with a condom, based on what the Bible says about sin - its consequences and the role of a Christian in deterring sinful actions. Professor Arthur Rendle Short wrote 'If the Christian has definitely come to the decision that the Bible is the Word of God for him, what follows but that it becomes his unfailing guide, which must at all costs be obeyed?'[2] Often, when we take the Word of God seriously it makes for uncomfortable reading. It disturbs our settled living and practice. At first sight some of my conclusions may seem impossibly demanding to our every day practice. At other times they may seem to border on the legalistic and hard-hearted. However, when you absorb the full implications of the practice and consequences of harm reduction, I hope you will see the desperate need for a radical and, I believe, biblical alternative.

Is Katie morally responsible?

Can you be sure she is morally responsible for her plan? Is Katie's plan sinful? Katie cannot be responsible for what she has never known – at the age of five she knew little, if anything, about sex and was therefore sexually innocent. But as knowledge was given to Katie, her moral understanding has been provided through her conscience, and therefore she became or will become morally responsible and accountable.

The Apostle Paul argued that all humans have 'the requirements of the law written on their hearts, their consciences also bearing witness, and their thoughts now accusing'. (Romans 2:15) I suggest, then, that even someone like Katie, as a non-Christian, has or has had a moral sense of the right context for sex.

Nevertheless, consciences become seared. Katie may no longer realise that extra marital sex is wrong because of the standards of her peers and family or a daily diet of Eastenders and teenage magazines, which all advocate the acceptability of recreational, ex-marital sex. However, this does not diminish Katie's moral accountability. My role as a Christian will include resuscitating Katie's damaged conscience by encouraging her to regain her sense of the right boundaries for sexual intercourse.

Two possible aims

If I accept that Katie has moral responsibility for her plan to have sex, what are the options available to me? There seem to be two main aims I might pursue:

Aim A. To deter her from her sinful plans. Or to express it another way, to convince her of the goodness and rightness of God's command not to have sex outside marriage. **Aim B**. To protect her

Photo: PA

Is there any evidence that 'harm reduction' policies bring about good results?

from the unwanted consequences of having sex – of what we recognise as a sinful act.

Now what would you do in this situation? Would you try to dissuade her from having sex? Would you give her a condom if this dissuasion failed? I suggest that whilst issuing a condom may be quick and easy, the route of dissuasion will often be costly, requiring time and energy to go over the issues with Katie. You will need to explain why it is not in her best interests to have sex with Tom, including the possible medical, social and spiritual implications. You may also need to discuss with her how her desires for intimacy, acceptance and pleasure can be fulfilled in other ways and how she can explain these things to Tom. It may be necessary to find someone of the same sex or nearer Katie's age who can talk convincingly to her about the issues.

If, despite this, she ignores you, there may be further costs involved. You or someone else may have to pick up the pastoral pieces or face her anger, especially if she becomes pregnant or catches an STI. You may also incur the anger of your colleagues who see you as an unloving, religious legalist unwilling to help the vulnerable when they ask you for help.

Should we pursue aim A or B or both?

Before looking at the biblical perspectives on each of the two possible aims above, here are three general observations about them together. Firstly, if you successfully dissuade her, you have also effectively protected her. On this basis Aim B must be subordinate to Aim A. Secondly, you cannot wholeheartedly pursue both simultaneously. If you pursue Aim B and give her a condom, you will encourage rather than deter her from having sex, whatever you say to her in dissuasion, because you open to her the apparent opportunity for sex without undesired consequences. Thirdly, you can never be sure, right up to the point of intercourse, that your dissuasion has failed - never sure enough to be able to say, 'sexual intercourse is inevitable, I must give her a condom'. If at any stage you do give her a condom, you may be influencing her decision in favour of having sex.

Now let's briefly identify some biblical perspectives that might inform these aims:

Aim A: Should we deter people from sinning?

- God lays down commands for us to obey. 'Whoever has my commands and obeys them, he is the one who loves me.' (John 14:21)
- His commands reflect his character. 'Be holy, because I, the Lord your God, am holy.' (Leviticus 19:2)
- God's commands are for both Christian and non-Christian. (see 1 Timothy 1: 8-10)
- We are accountable to God for influencing the sin of others. 'Woe to the world because of the things that cause people to sin!' (Matthew 18:7)
- We are accountable to God both for what we do *and* what we don't do. 'Anyone, then, who knows the good he ought to do and doesn't do it, sins.' (James 4:17)

So we have a responsibility, as within our influence, to dissuade people from sinning, and we will be accountable when we don't. The Old Testament Law puts it clearly enough. 'Rebuke your neighbour frankly so that you will not share in his guilt.' (Leviticus 19:17)

Aim B: Should we soften the consequences of future sin?

- Actions have consequences (see Genesis 3) such as the events following David's adultery with Bathsheba (2 Samuel 11ff), or the harvest of a godly life.
- Bad consequences of sin are contrasted with the good consequences of obedience (see Deuteronomy 30: 15-18)
- God warns us of the bad consequences of disobedience in order to encourage us to obey (as per the above passage). Jesus warned the healed invalid, 'stop sinning or something worse may happen to you'. (John 5:14)
- Denial of sin's consequences is a ploy of the Evil One to encourage us to sin. (see Genesis 3:4)
- God uses the consequences of sin to draw people back to himself and the merciful softening of their consequences as a sign of his compassion, (see the Prodigal story, Luke 15: 11-32).
- Nowhere in the Bible does God reassure us that *in anticipation of sinning*, we can expect the consequences to be softened.

In summary, we have a prophetic responsibility to warn patients that their plans are sinful and will have bad consequences. We are often called to demonstrate God's compassion in softening the consequences of sins already committed. However, in anticipation of a sinful act, we have no biblical mandate to soften the blow of an individual's sin on himself. This undermines the deterrent effect of the consequences

of sin. Accordingly, we have no mandate to provide Katie with a condom. Instead, we must warn her that her plan to have sex is wrong and will have bad consequences. More positively, we need to encourage her to see the goodness of God's ways by keeping sex until the committed relationship of marriage.

Collateral damage in the Provision and Promotion of Safe Sex

A decision to provide a condom would have other consequences:

- You have offered Katie the illusion that the condom will protect her from the damaging consequences of sex with her boyfriend. Condoms are forgotten or break, don't effectively protect her from several STIs including warts and herpes,[3] and don't protect the heart from emotional damage.
- However unintentioned, you have made it known to Katie and her classmates that you are a potential future source of last minute condoms, so long as they hold out for a few minutes against your barrage of dissuasion. You have started on the road from a single pastoral demand to a public service.
- Katie's classmates and school staff may (wrongly) perceive that you, a doctor and a Christian, have blessed the sex act.

There may of course be collateral damage if you *don't* give her the condom. She may get pregnant or catch an STI. But at the risk of appearing concerned about our righteousness at Katie's expense, both Katie and ourselves will be accountable for *our own* actions and must give account to God.

By giving out one condom in a pastoral setting, I suggest we have started a public service. And to be consistent there can be no provision of condoms without publicity about availability and instruction in their use. This line of thinking has lead government organisations like the Teenage Pregnancy Unit to promote safe sex and provide condoms in our schools, youth clubs and wherever else young people (as young as eight) can be given access.[4]

Such teaching gives rise to other collateral damage:

- It directs resources away from a message of sexual abstinence.
- It encourages sexual experimentation through exposure to sexually explicit ideas (also encouraged by holding out the false hope of sex without consequences).
- It associates sex with bad consequences.
- It dissociates sex from a relationship.

Do 'harm reduction' programmes work?

Or to put it another way - is there any evidence that these policies bring about good results even if we don't agree with the means of achievement?

Teenage Sexual Health

Children in the UK have been the subject (and victim) of a huge experiment. Never have the subjects of sex and contraception been so actively taught from such a young age, and contraception made so widely available. If you believe the promise of its advocates, the safe sex approach should have produced a generation in control of their choices. But *are* our young people making informed choices?

A UK study of 2,000 13-15 year olds in 1999 looked at the reasons for first sexual intercourse.[5]

- 19% were drunk
- 9% were under pressure from peers or partner
- 4% said that they had no choice
- 32% were either coerced or not in full control
- 19% were in love with their partner

First intercourse at this age is typically an unplanned and loveless event, often under pressure, always outside the union of marriage. Not surprisingly many look back on the event with regret.[6]

Are they protected? There has been an exponential rise in under sixteen use of contraceptive services[7] and only 12% say that contraception is difficult to obtain.[5] Yet a third of all thirteen year olds, and a quarter of all under sixteen year olds use no form of contraception at first intercourse.[5]

How effectively have unwanted conceptions been contained? The mean age of first sexual intercourse has fallen by four years for women and three years for men over the last forty years.[8] Yet teenage conception rates have been fairly steady in this country.[9] You may see this as a sign of success. However, there has been a steadily rising abortion rate in the 15-19 age group. Over twice as many such pregnancies are aborted now as in 1970. More often now conception occurs in an environment where the baby is unwanted.

How effectively have STIs been contained? Rates of almost all STIs are rising in all age groups. For the commonest of STIs, Chlamydia, there has been a 20% rise in infection rates each year and about one in ten of all sexually active women under twenty-five are probably infected at any one time.[10] STI services throughout the country are struggling to cope with demand.

So, in summary, has the harm reduction approach been effective at softening the consequences of sin? Not at all – rather it has increased sin and its destructive effects. It is as though we have a leaky dam – we stop one hole, and three more holes appear.

This article is abridged. The full text is available on the CMF website at: www.cmf.org.uk/articles/lectures/rsl2003

Chris Richards is a Consultant Paediatrician at the Royal Victoria Infirmary in Newcastle upon Tyne. He has recently helped set up an organisation called 'Lovewise' to provide biblical teaching in church youth groups and schools about marriage and sexual abstinence.

Photo: Kate Darwin/Wellcome Photo Library

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Paul Brand

Paul Brand was characterised by an unfettered originality in his approach to a clinical challenge, but even his immense academic and professional achievements were eclipsed by his compassion and concern for the whole person. Although he was my uncle, I never had the privilege of training or working with him, but he inspired me from pre-medical school days through my later training in plastic and hand surgery. He was always the standard, the ideal, the hero.

Paul was initially a reluctant doctor. Repulsed by the pus and gore he observed as a child while watching his missionary father giving simple medical care to local folk in the hills of South India, he rejected advice to study medicine and instead trained as a carpenter and builder. But his interest was later kindled through the practical teaching at missionary training colony, and he entered UCH London, where he met his wife Margaret, qualifying during the Second World War. After marrying, they followed a call back to South India, to teach surgery at Vellore Christian Medical College.

Starting as a general surgeon, Paul quickly turned to Orthopaedics and within a short time was deeply challenged by an encounter with Dr Robert Cochrane at Chingleput. Cochrane was the leading expert in leprosy but could not explain the pattern of deformity or the reason for loss of tissue from the extremities. Paul had already demonstrated a passion for clinical enquiry and research and threw himself into discovering answers to these and other conundrums . He faced considerable prejudice and opposition to treating these patients within a general hospital setting at first, but gradually barriers were overcome and the first great phase of Paul's career began.

Paul was a free thinker who constantly questioned established dogma and his contributions to the field of Leprosy were enormous. At an early stage he was able to demonstrate the regular and predictable pattern of paresis in leprosy, and identified the influence of temperature on the site of the nerve lesion. In developing tendon transfer operations for high ulnar nerve palsy, his extensive experience gained him worldwide recognition in hand surgery circles, when his work was published. But his reconstructive skills were also employed in a wide range of other procedures in the upper and lower limb, and in plastic surgical restoration of noses, eyebrows and eyelids.

Paul was able to show that fingers and toes do not just fall off in leprosy; they wear away progressively by a process of neuropathic ulceration and secondary infection after often trivial injuries. This finding in itself was revolutionary, but it led Paul on to the conscious realisation that one must give care to the individual as a whole. Prevention of deformity and tissue loss was essential. He became in these early years physiotherapist, OT, orthotist, toolmaker and technician all rolled into one as he set in motion major rehabilitation and retraining projects based around Vellore. He published on the care of the anaesthetic foot and later this work was extrapolated to management of the foot in diabetes.

Many doctors came to Vellore to train in leprosy reconstruction, or were taught by Paul in subsequent years during his extensive travelling to visit mission and government hospitals around the world. Margaret meanwhile had become a leading authority in ophthalmological problems in leprosy and in later years joined Paul in these teaching tours. By the early 1960s Paul's work was being recognised in the United States, and he was invited to speak at international meetings of their Plastic and Reconstructive and Hand Surgery societies.

In 1960 Paul received the Albert Lasker award 'for outstanding leadership and service in the field of rehabilitation'. The CBE followed in 1961. Twice he gave the Hunterian oration at the Royal College of Surgeons in London. Between 1963 and 1966 he was influential in the founding of the All-Africa Leprosy Rehabilitation and Training Centre (ALERT) in Addis Ababa. Several other honours followed, mainly in the USA.

In 1966 Paul moved with Margaret and their six children to Louisiana to take up the post of Chief of Rehabilitation at the national leprosy centre in Carville. Over twenty years there he was able to expand and develop his research interests, to teach, and to inspire numerous visiting specialists and trainees with his humble and passionate approach. His book, *Clinical Mechanics of the Hand* was immediately received as a classic by hand surgeons and therapists, and now into its third edition remains indispensable in this field. His interest in biomechanics was paralleled by a growing fascination with the investigation of pain, and particularly the problems caused by its absence.

After retiring in the mid-1980s, Paul began writing a number of books, often in collaboration with Philip Yancey, reflecting on the Creator's design as evidenced in our physical bodies. *Pain - the Gift Nobody Wants* is perhaps the best of them all, not least because it contains the personal memoirs of his life, as well as some fascinating insights into the gift of pain. He writes in a beautifully direct but gentle conversational style, with a whimsical note pervading even his finest professional publications.

Jesus carried scars and disability even after the resurrection and in so doing identified with the humanity that he loved. Paul loved to preach on the wounds of Christ and followed his master in giving full honour and respect to those afflicted with deformity and disability. May God help us to do the same.

Paul Wilson Brand (b Southern India 1914; q London 1943; CBE, FRCS), died on 8 July 2003 from complications related to a subdural haematoma.

Andrew Wilmshurst is Consultant Plastic and Hand Surgeon at Ninewells Hospital and Medical School, Dundee

how i'd handle it!

In this new column, GPs tell us… 'How I'd handle it'

General practice

Dr Sarah Hoskins - part-time GP principal in Stevenage - dealt with the following situation recently…

Jenny is 15 and thinks she may be pregnant. After talking to and examining her you establish that she is around 20 weeks pregnant. She says that she does not want to have the baby. She is scared to tell her parents and asks if you would tell her mother if she got her along to see you under false pretences.

Dr Liz Walker - GP retainer in Farnborough and former CMF chairman.

This surgery is going to run late! I would get Jenny's BP and urine checked and then talk further at the end of my surgery. I'm praying for the words to reach this frightened girl.

I would remind Jenny that her parents love her; although shocked, they would probably want to help. I would then assess her for Gillick competence. If Jenny really couldn't tell her mum, I would offer an appointment the next day to see them together but not on false pretences. What about the baby's father? Does he know and what are his views? Is abuse or even rape a possibility?

Many pregnant women see abortion as their only way out. Talking about 'the baby' and having an ultrasound scan may help to begin a relationship between Jenny and her baby. I would explain about her baby's advanced development at this late gestation. Next I would explain how late abortions are performed and the regrets that many women feel afterwards. Jenny would need written information and some pregnancy counselling. LIFE or Care Centres Network are excellent where available. I would introduce adoption as a positive possibility. I would let her know that she was entitled to see another doctor in the practice if she still wanted to seek abortion, emphasising that I would be happy to carry on seeing her if she wanted. This consultation would stay with me as I prayed for Jenny, her baby and all who look after them in the future.

Dr J Huw Morgan - Consultant in International GP Education and former Bristol GP tutor.

Two things make Jenny's case more straightforward than it could have been. She is 20 weeks pregnant and so effectively beyond the abortion time frame. Also, though afraid, Jenny wants her mother to know. This gets around Gillick competence concerns.

I would explain that her pregnancy is too advanced for termination to be a realistic option: her baby is fully formed and growing rapidly. Abortion may involve an extremely distressing labour induction. I might mention that as a Christian I personally could not agree to abortion. Earlier in the pregnancy, Jenny could have seen one of my colleagues for abortion referral; at this late stage, most of my colleagues would be very reluctant to sanction termination. Jenny would need time to digest this information, ask questions and clarify concerns. This could be an appropriate time to mention the adoption option. If she decided to continue with the pregnancy, hospital booking would need to be arranged.

If I knew Jenny's mother fairly well I might agree to tell her with Jenny's agreement but not under false pretences. It would be better for Jenny to tell her mum herself prior to coming to see me again together. Failing that, the best compromise might be for me to tell her mum with Jenny present at the next consultation. As with Jenny, her mother would need time to ask questions and come to terms with the situation. If they still wanted to explore the possibility of abortion, I would explain that I could not as a Christian agree to that. Instead, I would give them contact numbers for the local NHS family planning and pregnancy counselling clinics, stressing that I was happy to remain involved in Jenny's care and to support them both through this situation.

Do you agree or disagree? Do you have a scenario to discuss? Would you like to join our panel of GP contributors? Email rachael.pickering@cmf.org.uk

Key Points

20-24 week abortions accounted for 1.4% of abortions in England & Wales in 2000. NHS consultants are much more willing to perform late abortions for fetal abnormality (644 out of 738 abortions) than for supposed threat to maternal mental health. Medical induction predominates in the NHS but surgical abortion is favoured by the independent sector. **Medical induction** after 17 weeks often involves intrauterine urea (as a feticide) and prostaglandin injections, plus prostaglandin pessaries. **Surgical abortion** after 19 weeks can involve two general anaesthetics. The first procedure allows for feticide and softening of cervix and uterine contents; dilatation and evacuation is performed the next day when the fetus is removed piece by piece.

Section 1(1)(a) of The Abortion Act (1967), amended in 1990, allows abortion of normal fetuses on very wide grounds up to 24 weeks gestation. The vast majority of abortions (98% in 2000) are carried out under this section.

Gillick competence: when a child achieves sufficient understanding and intelligence to enable him/her to understand fully what is proposed. Victoria Gillick failed in her House of Lords action against her health authority, which declined to deny her four daughters contraception or abortion services without her consent until they reached 16 (Gillick v West Norfolk and Wisbech Area Health Authority, 1985).

Charities offering Crisis Pregnancy Counselling

CARE Centres Network, 1 Winton Square, Basingstoke RG21 8EN. Tel 01256 477300. Counselling Helpline: 0800 028 2228. Email *cfl@care.org.uk*. Website *www.pregnancy.org.uk* (This site also lists the locations of 150 pregnancy crisis centres nationwide)

LIFE, LIFE House, 1a Newbold Terrace, Leamington Spa CV32 4EA. Tel 01926 421587. Website *www.lifeuk.org*

HEAD T

In this new column, two doctors explain their contrasting positions on different issues.

Is a Christian GP best off in

Jeremy and Ann Franklin present the case for an exclusively Christian GP partnership.

Dr Jeremy Franklin, CMF pastoral secretary, was a GP for 34 years

I wanted to work in a Christian practice for fellowship, mutual support and common aims. A GP partnership is like a marriage: it has great benefits and great dangers! Hopefully the underlying written contract will never be necessary. If it is, the partnership is probably in serious difficulty! There are no guarantees: it should be entered into prayerfully, carefully and with a servant heart. Our partnership worked extremely well but a dysfunctional Christian partnership could be particularly painful. The aim is not financial abundance but excellent medical practice with Christ at the centre.

I was blessed by five successive Christian medical partners who encouraged, challenged and educated me. Our management meetings contained much prayer and Scripture reading. Relations with the other staff - mostly non-Christians - were friendly and excellent. We didn't have overt Christian advertising but a Christian bookstand stood alongside the complaints book in the waiting room!

I tried to deal with abortion and post-fertilisation contraceptive requests sympathetically, tailoring Christian ethics to individual circumstances. If I felt I couldn't proceed, I referred the patient on. Rarely, I have signed abortion forms.

It was our stated policy to 'practise spiritually' with our patients. I found this very encouraging. It is a constant joy to look back and see those who came to Christ through witness at the surgery over the years. In one initial consultation I happened to mention the working of the Holy Spirit: this sparked immediate interest and eventually both husband and wife found Christ. Still, this experience was definitely the exception rather than the rule.

The Saline Solution course is a great help in advising how to share the love of Christ verbally and non-verbally with our patients. I am truly thankful that I have never had a complaint about overt Christian witness.

Ann worked as practice nurse with Jeremy

I joined my husband as practice nurse when the new GP Contract commenced in 1990. My appointment was meant to be a 'stop-gap' but I stayed for eleven years. As a newcomer and the senior partner's wife, I asked the other GPs whether they would be happy for me to speak about spiritual matters or pray with patients, if and when this was appropriate; none of them objected.

As practice nurse, I had longer time slots than the GPs. I saw my job and these contacts with patients as a great privilege. I tried to be aware of the Holy Spirit and the needs of the whole person.

Many opportunities arose during new patient and well person checks. I often asked an exploratory question as to whether the patient had any personal faith. I only broached this subject if it seemed appropriate or arose naturally, certainly not with every patient.

As I got to know patients and confidences were shared, there were opportunities to talk or pray with them, lend a book, give out a booklet – such as Daily Strength from SGM - or even an appropriate invitation. I often explained that this was not from the NHS. I never came across anyone who objected to this and patients were generally very appreciative. I remember one lady who was very fearful of heart bypass surgery: she was very grateful and considerably encouraged when I prayed that she would know God's peace and help.

The GMC's position on patient evangelism

*The Council has hitherto taken the view that **the profession of personal opinions or faith is not of itself improper** and that the Council could intervene only where there was evidence that a doctor had failed to provide an adequate standard of care. The Committee…concluded that **it would not be right to try to prevent doctors from expressing their personal religious, political or other views to patients**. It was agreed, however, that doctors who caused patients distress by **the inappropriate or insensitive expression** of their religious, political or other personal views would not be providing the considerate care which patients are entitled to expect. (GMC Annual Report, 1993:4)*

O HEAD

a Christian practice?

Dr Pete Crookall trained at St Thomas' and is a GP principal in Worcester. He discusses how he works out his faith in a non-Christian setting.

I didn't actively choose a non-Christian practice. My friends and church geographically limited me. I wanted a forward thinking practice that offered top quality patient care and had partners I could establish good relationships with. The practice I joined is secular although there is a Christian salaried partner. I believe God called me to work here.

Christians are called to be distinctive from the surrounding world but not to isolate themselves in a Christian ghetto. Church activities, Christian books and music make it easy to lose touch with the rest of the world's attitudes. Although Christian fellowship is important, we need to be able to relate to non-Christians by witnessing. Many Christians encounter the largest number of non-Christians in their lives at work. Jesus called us to get our hands dirty impacting the world with the gospel. Personally, it would have been wrong to couch myself in the safety zone of an exclusively Christian practice

The danger of exposure to the world's values is that we assimilate them into our thinking and actions. To counteract this, I have a Christian doctor prayer partner and several close Christian GP friends. Having people to be accountable to and prayerfully share problems with is helpful. Being part of a socially aware church provides a useful access point for patients. I have referred several desperate mothers to our mums and toddlers groups. A counselling service run by local churches provides a much-needed service following PCT fund withdrawal for practice-based counselling.

I do not support abortion personally but I do refer women, though this distresses me every time. If I didn't refer then I would have to declare this at the outset of each consultation; these women would then see another pro-abortion partner. My colleagues might not discuss the potential damaging psychological effects of terminations or the possible alternatives. My doctor-patient relationship with these troubled ladies could break down at a time when they need great emotional support. I have directed women to a local Christian pregnancy counselling service and some have decided against termination. I don't sign blue forms as I cannot legally sanction something I morally disapprove of. I am aware that this isn't a tidy solution and that some will see it as compromise. I reached this position with much prayer and consideration.

Evangelising patients is fraught with difficulty. So many patients clearly need to encounter God but confronting this directly could be considered an abuse of our position. There are subtle ways of introducing them to God. Our first duty is to demonstrate Christ-like compassion. Despite huge time pressures, it doesn't take much to demonstrate a real difference in approach. I ask certain patients if they have a faith that helps them and sometimes we discuss spiritual beliefs. I haven't prayed with patients in the surgery as I believe this may lead to confusion over my role. I encourage them to pray with friends and church leaders and pray myself afterwards. I don't have Bible verses or external signs of my faith on display - this is something I should consider - but I do believe that faith in the consulting room is demonstrated by attitude and action rather than words. I would welcome a natural opportunity to share the gospel.

It is easy to be sucked into coffee-time gossip and cynicism with my partners, particularly over heart-sink patients. The Christian GP can be a witness by refusing to condemn and malign people, however difficult they are. I remind myself that God created every one of my patients in his image; it is easier to do this when I am actively praying for them. A joke with the receptionists – trying not to get annoyed about missing notes – is a great witness to God's love for all, regardless of status.

Writing this has made me so aware of my failings as a Christian GP. Yet I am where God wants me and he will use me in spite of my imperfections. We encounter great needs and may burn out if we tackle them in our own strength. Yet our graceful God wishes to free us from guilt and equip us to be effective Christians. Whether in Christian or non-Christian practice, it is on our knees that we become more like the Great Physician.

What position do you take? Is there a particular issue that you would like featured in Head2Head?

Write in to **rachael.pickering@cmf.org.uk** and join in the debate. In the next issue, we will publish correspondence along with the next Head2Head.

EUTYCHUS

Embryo stem cell research

America's doctors have defied President George Bush by putting their stamp of approval on scientists engaged in stem cell research. The American Medical Association (AMA) said that it was ethical to use cloning for research, but not to copy another human being. Michael Goldrich, who heads the AMA's ethics committee, said, 'This is giving guidance to physicians on the science and the ethics. We can't remain silent.' (*The Guardian* 2003; 19 June) Whilst adult stem cell research is making great strides, scientists have just for the first time used cloned stem cells to cure mice with a version of Parkinson's disease at the Memorial Sloan-Kettering Cancer Centre in New York (*The Times* 2003; 22 September)

A 'grotesque obscenity'

The UN and World Health Organisation have condemned western governments for neglecting Africa's Aids pandemic whilst lavishing money and attention on the war on terrorism. UN secretary general's special envoy for HIV/Aids in Africa, Stephen Lewis, denounced as a 'grotesque obscenity' the lack of cheap anti-Aids drugs in Africa and warned that millions of orphans would be left traumatised.

'How can this be happening, in the year 2003, when we can find over $200bn (£120bn) to fight a war on terrorism but we can't find the money to prevent children from living in terror?' Lewis was speaking at the opening of a week-long conference in Nairobi, Kenya, which has gathered 8,000 doctors, researchers, policymakers and activists for a 'conference of war' against the disease.

Of the 42 million people in the world with HIV, about 30million are in Africa. About 15 million Africans have died, a toll likely to soar as HIV infection in southern Africa hits 40% of the population. Despite a steep fall in the price of life-extending anti-retroviral drugs, only 50,000 people in sub-Saharan Africa apparently have access to them. The UN has a shortfall of $3bn in a plan to provide drugs to 3 million people, most of them in sub-Saharan Africa, by the end of 2005. (*The Guardian* 2003; 23 September)

Going back in time

The life of Christ ranks third in the historical events British young people would like to witness if given the chance to travel back in time. Of the top ten in the survey the Moon Landing (1969) and England's World Cup win over Germany (1966) came in first and second, with the big bang and the extinction of the dinosaurs a distant 9th and 10th respectively. The 'birth/crucifixion and miracles of Christ' was the only historical event more than 60 years ago that made the top eight in the survey of 3,000 readers aged 18 to 44. (*Metro* 2003; 15 September:6)

Nanotechnology on the make

The government has announced that it is commissioning the Royal Society to undertake an investigation into the benefits and problems of nanotechnology suggesting that it views this new industry seriously. Manipulating substances at the 'nano' level will impact society in electronics and defence, to energy, agriculture, pharmaceuticals, fabrics and cosmetics. Current global spending on nanotech is in excess of £2.42bn, and by 2015 is predicted to exceed £600bn every year. Over 30 governments have launched nanoscience initiatives and there are around 500 nanotech companies involved. The Select committee reports next Spring. (*The Guardian* 2003; 12 June)

Confidentiality under threat

Doctors are concerned that new powers permitting the CHAI (Commission for Health Care Audit and Inspection) to look at patients' records if it deems access 'necessary or expedient' will undermine patient confidentiality. The proposals form part of the Government's new Health and Social Care Bill, which will create the new commission to oversee healthcare standards, and has just had its second reading in the House of Lords. The General Medical Council and Medical Defence Union have both expressed concern about the new measures which mean that anyone refusing to cooperate could face prosecution. CHAI will replace CHI (The Commission for Health Improvement). (*British Medical Journal* 2003; 327:580, 13 September)

Doctor patient relationship

The doctor patient relationship ranks second in importance only to family relationships and is more important than relationships with coworkers or spiritual and financial advisers according to a major study presented at the World Medical Association's annual general assembly in Helsinki. The telephone survey of 3,707 patients and doctors in the US, UK, Canada, Germany South Africa and Japan gave similar results in all countries. In addition less than 20% of patients in all countries defined the doctor-patient relationship as authoritarian or paternalistic. Doctors were also seen as the most trusted source of health information. 'The doctor-physician relationship is part of the critical underpinning of stable societies', said Mike Magee, WMA senior fellow in the humanities, who presented the data. (*British Medical Journal* 2003; 327:581, 13 September)

We are all disabled

2003 is the European Year of Disabled People, but also the 50th anniversary of Watson and Crick's discovery of the structure of DNA. Tom Shakespeare, Director of Outreach at Newcastle University, argues that many disabled people are reacting with hurt and hostility to the hyperbole of genetics advocates. 'Old genetics focused on stopping certain people becoming parents. New genetics gives people knowledge so that they can avoid the birth of disabled babies.... Genetics has the potential to be a great servant, but it should never be the master of society. It cannot become the basis by which we value one another.' He further points of that we are all disabled. 'Every one of us has genetic mutations, potential genetic disease (and) our similarities are far greater than our differences. Our differences amount to less than a tenth of one percent of our genome.' (*The Independent* 2003; 12 September:17)

Persons or possessions?

One of the two women who lost their legal battle to have their embryos implanted without the consent of their former partners, has spoken of her despair at the decision. Lorraine Hadley commented: 'An embryo is not just a possession to be divided up in the divorce proceedings. It is a baby in the making. I fully accept that men have rights too. But I find it abhorrent that we should be allowed to create these little human beings - and then flush them down the toilet on a whim. Why should one of us have the right to say the embryos should be destroyed simply because it doesn't suit them any more?' (*Daily Mail* 2003; 2 October) There are currently 116,000 embryos frozen in England and Wales.

OPPORTUNITIES ABROAD

Specific Vacancies by Country

Posts usually require you to be **UK-based** with your own **financial** and **prayer** support. The contact details given are to enable you to research the post. For many other current vacancies visit the vacancies page at *www.healthserve.org* which is updated weekly or see previous issues of *Triple Helix*

Bangladesh

BMS World Mission is sending a medical team to the Christian Hospital at Chandraghona from 31 January to 14 February 2004. They are looking for experienced doctors, in particular general surgeons, anaesthetists, orthopaedic and plastic surgeons, urologists, obstetricians & gynaecologists and ophthalmologists. The cost will be approximately £1,100 per person.

Contact: Ruth Robinson, Volunteer Programme Organiser, BMS World Mission, PO Box 49, Didcot, Oxfordshire OX11 8XA. Tel: 01235 517654. Web: *www.bmsworldmission.org*

India

The **Emmanuel Hospital Association** is looking for a Clinical Pathologist to be involved in a new development with a Christian businessman who is setting up a 'state of the art' laboratory near the All India Institute of Medical Sciences. The intention is to be able to provide highly subsidised services to the poor. The contract would be for a year or more.

Contact: *EHA via info@eha.org.uk*

Kenya

AIC Kijabe Hospital is looking for a Consultant Obstetrician to be part of a team at this busy 210 bedded Christian teaching and referral Hospital near Nairobi. Duties include the supervision and training of junior staff. Colposcopy skills and an interest in research would be an advantage.

Contact: *MedDir.kh@kijabe.net* for further details

Niger

A General Surgeon and other doctors are desperately needed at **Galmi Hospital** which is the only Christian Hospital in the Republic of Niger, a mainly Muslim nation of 11 million people. The hospital treats some 200 outpatients daily.

Contact: Roy Gamble, AIM Ireland Director or visit their website: *www.sim.co.uk*

Nigeria

Needed for the **Vom Christian Hospital in Northern Nigeria**, Medical and Surgical Specialists in particular Orthopaedic and Plastic Surgeons, to carry out reconstructive surgery and provide training for local surgeons. There is also a need for Paediatricians and Physicians.

Contact TeleServe at *www.teleserve.org*

Pakistan

Kunri Christian Hospital is still urgently seeking a female Obstetrician. The hospital will provide accommodation. The hospital is situated in Tharparkar and is run by the Diocese of Hyderabad.

Contact: Dr Jacoob Zahiruddin, Medical Superintendent at *jacoobz@yahoo.com* for details.

Uganda

Mission for Vision, whose aim is to take Christian opticians into developing countries to combine evangelism with eye-care, is looking for a doctor to accompany a trip to Uganda that they are planning for 3-15 December this year.

Contact: Ian Squire. In His Service, 11 Station Approach, Shepperton, Middlesex. TW178AR Tel: 01932 226789. Fax: 01932 246623. Email: *ian@isoptician.co.uk*

United Arab Emirates

The Oasis Hospital is looking for an Obstetrician (female), Anaesthetist, General Surgeon with laparascopic skills, Paediatrician with neonatal experience and a Cardiologist. This is a well equipped 45 bedded modern hospital in the oasis city of Al Ain. The staff of some 150 people come from 20 different cultures.

Contact: Dr Larry Liddle at *lliddle@oasis.smart.net*

Zimbabwe

Bonda Hospital is still looking for a third doctor to work in this rural Anglican mission hospital in the picturesque Eastern Highlands of Zimbabwe. It has 150 beds, 50 nurses and two doctors. The ideal candidate would have at least four years experience including medicine, surgery, obstetrics and paediatrics. The job offers a demanding but rewarding experience as part of a small team responsible for all aspects of health care in the hospital and surrounding district.

Contact: Dr Sharon Stone, Medical Superintendent, Bonda Hospital, Box 3896 Bonda, Zimbabwe. Email: *kane@telco.co.zw*

EVENTS

The **Developing Health Course 2004** (previously called the Refresher Course) will be held at Oak Hill College from 5-16 July 2004. Brochures are available from the CMF Office.

Student Elective Days will be held in **Leeds** at South Parade Baptist church on Saturday 6 March and in **London** at Partnership House on Wednesday 17 March 2004. Brochures will be available from the CMF Office shortly.

EQUIP offers a variety of useful courses including a three day course entitled ***New Directions***. It explores the practical issues of settling back in the UK after time spent abroad. The next course runs from 27-29 April 2004.

Contact: The Administrator, Bawtry Hall, Bawtry, Doncaster DN10 6JH.
Tel: +44 1320 710020. Fax: +44 1320 710027.
Email: *info@equiptraining.org.uk*
Website: *www.equiptraining.org.uk*

All Nations Christian College offers **Refresh for Mission** – 5-9 July 2004 (same time as the CMF course I'm afraid). It aims to provide refreshment of spirit, mind and body for those involved in world mission. Pause for reflection on 12-16 July is a companion course designed to provide space and time for waiting on God, reflecting on past ministry and future possibilities
Further info from *shortcourses@allnations.ac.uk*
Website: *www.allnations.ac.uk*

COMET (Children of Missionaries, Education and Training). A Global Connection Forum. Has a list of resources relating to missionary kids on their website; *www.globalconnections.co.uk* or contact Global Connections at Whitefield House, 186 Kennington Park Road London SE11 4BT.
Tel: 020 7207 2156. Fax: 020 7207 2159

ITEMS WANTED

Medical and nursing textbooks to assist in stocking the Medical School Library at the University of the Transkei, South Africa. Texts accepted on pre-clinical, clinical, nursing and midwifery subjects at undergraduate and post graduate levels. The only condition is that they have been printed in the last ten years (exceptions can be made for anatomy). If you have books that you could donate contact Mr Peter Willson, Consultant Surgeon, Kingston Hospital, Gallsworthy Road, Kingston, Surrey KT2 QB.
Email: *peter.willson@ntlworld.com*

HOUSE AVAILABLE TO RENT

We have been informed of someone going abroad at the end of this year for a year's mission service. She is offering a three bedroom property in Liverpool to rent, ideally to other missionary personnel on leave during that time. Interested persons should contact Peter Armon at the CMF Office.

REVIEWS

Working abroad

Good for you and the NHS

In a document published in July by the Department of Health on its website *www.doh.gov.uk*, entitled *International Humanitarian and Health Work – Toolkit to support good practice*, Liam Donaldson tells us that time spent by NHS staff working abroad can 'provide individuals with personal inspiration, refreshment and perspective which can add to their professional development and growth as well as befitting the NHS'. The document outlines the benefits to patients and the NHS as well as listing personal and professional benefits. The guidelines build on the previous guidance (EL (95) 69) which was issued in June 1995.

There are information checklists for individuals to consider when seeking employment overseas and it provides details of sources of further information, including MMA Healthserve (*www.healthserve.org*). Other chapters outline how different skill levels can be developed and sustained for international work and a further chapter looks at 'Quality Assurance' briefly considering such areas as accountability, revalidation, performance issues and registration renewal. The two appendices provide further detail of projects, placements and skills pre-requisites for some of the main agencies. There is also advice on maintaining NHS pension scheme benefits.

Another document of interest on the site is a *Compendium of the NHS's contribution to Developing Nations*. It currently holds details of some 45 volunteer teams within the NHS who are involved with overseas work. It lists the name of the Trust involved, the countries they are involved in, an outline of the work being undertaken and the contact person within the Trust. They would be interested to hear details of work being undertaken by others which is not currently listed within the Compendium.

Both are encouraging and informative documents for those thinking of getting involved in short term work overseas and yet are anxious about the impact on their career prospects. Read together with the new *CMF Medical Mission Handbook* prepared for those contemplating such a period of short term work abroad in a Christian context, you will be well equipped to make an informed and prayerful decision.

Peter Armon is CMF Overseas Support Secretary and MMA Healthserve Medical Director

Where there is no Psychiatrist: A Mental Health Care Manual

Vikram Patel
Gaskell 2003
£10 Pb 266 pp
ISBN 1 90124 275 7

The concept for the manual appears to have arisen from David Werner's book 'Where there is No Doctor', which was published initially in 1977. This book was a great success, being used widely by health care workers especially in developing countries. 'Disabled Village Children' and 'Where there is no Dentist' followed this. With the publication of this manual, Vikram Patel has attempted to meet a similar need for mental health problems.

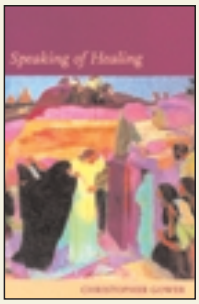
The format of this manual is very different from a traditional textbook of Psychiatry .The approach is more problem and context-orientated. For example, there is a chapter entitled 'Behaviours that cause concern' and another entitled 'Habits that cause problems'. There are multiple boxes, tables and illustrations. The use of boxes and tables certainly helps in focusing on important aspects and things to remember. However it would have been more useful if the material in the boxes were in larger print. The overall impression is of an overcrowded book. The artistic illustrations are not very useful except for giving variety from reading the text. It is difficult to have meaningful artistic illustrations in Psychiatry.

The author states in his preface that the manual has been written with the needs of the general health worker in mind. He suggests that this would include anyone from a community health worker to a general practitioner. It is very difficult to write a manual to meet the needs of such a varied readership. However, from my experience as the General Secretary of the Evangelical Medical Fellowship of India, I agree that this manual would be useful in developing countries and mission hospitals and mission stations. As a Psychiatrist currently practising in Australia, I feel that it has less to offer health workers in developed westernised nations.

Some Christians may have difficulty with parts of the manual, for example the section on sexual problems. Apart from this, the content is mostly non-controversial and the author has done a good job in attempting to meet a great need in developing countries where mental health professionals are scarce.

Kuruvilla George is Deputy Chief Psychiatrist of Victoria, Australia and formerly General Secretary, Evangelical Medical Fellowship of India

Speaking of Healing



Christopher Gower
SPCK 2003
£8.99 Pb 118 pp
ISBN 0 281 05539 4

This book arose from a conference held in conjunction with the College of Preachers at St Marylebone Parish Church where the author is Rector, and is based on his MTh dissertation. It reviews the contemporary health and healing scene succinctly and sensibly, meeting medical concerns for truthfulness and for realism.

The book's main purpose is to advise preachers how to preach about healing. Four models of biblical interpretation are presented. These are not mutually exclusive and there is overlap, but the book highlights how the preacher's model inevitably colours what is preached:

- Literal – 'based on a firm belief in the historical truth of the miracles recorded in the Gospel healing narratives'
- Liberal – 'likely to be suspicious of any kind of supernatural miraculous healing, expecting God to work through normal means'
- Metaphorical/spiritual – 'texts on blindness or deafness may be used to talk about being deaf to the word of God or blind to spiritual realities or sin'
- Social/community – 'this focuses on the reintegration back into society of the sick and disabled who had previously been marginalised'

These four models are then applied to the thorny issues of 'sickness as a punishment for sin' and 'healing and the

demonic' with lengthy quotes from a range of Christians such as John Wimber, the founder of the Vineyard movement, and Rico Tice, curate at All Souls', Langham Place. Finally, the author illustrates what he believes to be the essential synthesis of all four models with his own example 'preaching the Gadarene demoniac'.

I cannot be as enthusiastically ecumenical as the author Christopher Gower, but this is a very stimulating book that anyone with an interest in Christian healing should read.

Andrew Fergusson has a portfolio career which includes being Chairman of the Acorn Christian Foundation

The Edge of Life: Dying, Death and Euthanasia

John R Ling
Day One Publications 2002
£8.99 Pb 288 pp
ISBN 1 90308 730 9

This book takes a distinctively scriptural approach to the issues of death, dying and the ethical crisis in which we find ourselves in the early years of the 21st century. The biblical underpinning of our traditional ethical position is reviewed, the nature and origins of many of the recent changes are examined and the relevance of the gospel of the Lord Jesus Christ to these areas is well set out. It is refreshing to have such a clear foundation laid before the three primary issues of abortion, infanticide and euthanasia are examined in more detail. The link between these is well established and the grey areas of suicide, persistent vegetative state, eugenics and 'quality of life' are addressed with sufficient clarity for much of the 'greyness' to be dispelled.

Some of the legal principles are critically examined in the high profile cases reviewed, such as those of Anthony Bland, who was left in a persistent vegetative state following the Hillsborough tragedy, and John Pearson, a baby born with Down's syndrome who was rejected at birth by his mother and sedated until he died by the paediatrician looking after him. Set against the background of the Nazi holocaust experience, the sequence of events following the decriminalisation of euthanasia in the Netherlands is used to illustrate the progression of thinking there once principles were set aside.

Help and support in dying and bereavement are well handled. Palliative care and the hospice movement, so often led by committed Christians, are brought into focus not simply as an end in themselves, but as examples of positive alternatives to the 'Culture of Death'.

It is significant that this book has been released even as further efforts are being made to legalise euthanasia and assisted suicide. It is a most effective stimulus to Christian thinking in a field in which it is assumed so often that the Christian has nothing to say except to object to change. The chapter entitled 'So what must we do?' expresses well the concern that we must turn first to God. Only he can motivate, empower and resource his people. Only he can make it possible for us to care, educate, lead, assert truth and stand as witnesses to his way, his view of life and his salvation freely offered to all.

The Christian is thus challenged to avoid slipping into the current worldly mindset by standing clearly upon biblical ground when considering these critical issues. The healthcare professional is challenged to see life in a deeper and broader perspective and to consider the person as more than the vehicle for their pathology.

George Chalmers is a former Consultant Geriatrician and Clinical Director at the Glasgow Royal Infirmary. He is President of the Scottish Council on Human Bioethics

Man of Compassion: Man of Prayer – the Guiding Hand of God in the Life of John Harris

Doreen Sharp
Paternoster Press 2001
£7.99 Pb 114 pp
ISBN 1 85078 431 0

John Harris had a long and distinguished career as a medical missionary on two continents. Although he was most closely associated with the Leprosy Mission, he and his wife Elsie first served with WEC (Worldwide Evangelization for Christ) alongside Helen Roseveare in the then Zaire. Later unable to return to war-torn Zaire, they moved to India. The family then made yet another move to fill a vacancy in Nepal, and learned a third language. As it happened, their final move was back to Zaire where John died in an accident in 1995, five years after his official retirement age.

As a general rule, missionary biographies are written by close associates of their subject, and tend to give a somewhat one-sided view. This one is no exception as John Harris' sister wrote it. Despite this, it is actually a very readable story of a remarkable couple. There isn't too much by way of medical detail, but I found the description of his prayer life inspiring. An attempt is made to give more insight with statements from a wide variety of people connected with the Harris family over the course of their work. Since my wife Julie and I are also going to serve with the Leprosy Mission in Nepal, this book was of special interest, but I would recommend it to anyone with an interest in medical missionary work.

Tim Lewis is a Medical Missionary in India/Nepal and former CMF Student Staffworker in Ireland

AIDS and You

Patrick Dixon
OM & ACET International Alliance
Kingsway Communications 2002
£4.99 Pb 138pp
ISBN 8 17362 470 4

Available free of charge for developing countries from isdixon@dircon.co.uk

The Truth about AIDS met a pressing need in the late 1980s for clear information on the unfolding HIV epidemic. Many Christian doctors grappling with its grave implications appreciated the distinctively biblical approach of Dr Patrick Dixon's book. Any book on AIDS dates rapidly and *AIDS and You* is the third edition and a shorter, more accessible version of *The Truth About AIDS*.

Former Archbishop Desmond Tutu estimates that churches and Christian organisations are providing over 60% of HIV community programmes in Africa. Dr Dixon and ACET (AIDS Care Education Trust) have played a part in mobilising the response of Christians in the UK and supporting the response of many Christian groups internationally. The book summarises the role of followers of Jesus as those who should

REVIEWS

provide unconditional, compassionate care for all affected by HIV/AIDS and teach effective prevention while respecting and upholding the historic teachings of the church.

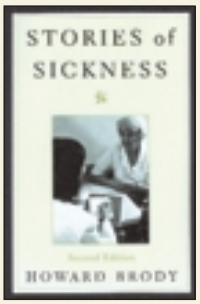
These principles are used to address issues such as the use of condoms, HIV testing, the relative risks of transmission, stigma, the secret of a good sex life and dealing with death. Dr Dixon's skill at communicating without medical jargon makes the book suitable for a wide audience. Health care professionals involved in education and developing HIV prevention and care initiatives will find it a useful tool.

Such a book would be incomplete without some advice on how to make a practical response and a new chapter has been added on 'Good practice in HIV/AIDS projects'. Inspiring case studies and a valuable section on principles for mobilising a church response were the highlights for this reader. However, the chapter has the look of an overlong appendix and would benefit from being reorganised and trimmed for the next edition.

Royalties from sales of the book are being used to make it more widely available in the countries most affected by HIV where it will undoubtedly be a valuable asset to many communities. The full book text may be found at *www.acet-international.org*

John Day is a Specialist Registrar in Infectious Diseases at King George Hospital, Goodmayes, Essex

Stories of Sickness



Howard Brody
Oxford University Press
2003
£22.95 Pb 295pp
ISBN 0 19515 140 2

The author of this book is a Professor of Philosophy and Family Practice at Michigan State University. With chapter headings such as: 'Sickness, Life Stories and Self-Respect'; 'Sick Roles: Practices and Life Plans'; 'How Sickness Alters Experience'; 'Stories of Life with Disability', and 'The Patient - Health Professional Relationship as a Narrative' the author sets out to explore the many dimensions of what illness means to the sufferers and those around them. He refers to depictions of illness in classical literature and other non-fiction accounts as the basis for his approach.

This is not a Christian book, although it is a scholarly and weighty addition to the growing field of what might be called 'narrative based medicine', a useful and timely counterpoint to the evidence based approach beloved of exponents of performance management who currently seem to dominate health service thinking. Two quotations perhaps sum up the main message of the book, both from the final chapter: 'We could do much worse than to graduate physicians who resemble Berger's English country doctor in having always about them *the air of one trying to recognize* - trying to make a link between their own anguish and the humanity of the anguished individual before them (Berger and Mohr 1967).' The last sentence of the book says: 'As physicians and other health professionals pay more attention to the stories of their patients, their ethical quest to enhance personal autonomy and self-respect in the wake of sickness will be aided by an increased awareness of the richness of human response to illness and anguish.'

Whilst containing a detailed and powerful analysis, it is a difficult book to read, perhaps reflecting the philosophical training of the author. It also lacks any spiritual perspective on this important area, and whilst agreeing with the author's emphasis on the importance of what he calls 'narrative ethics', for these reasons I found it slightly disappointing.

Huw Morgan is a Consultant in International GP Education

Still bored in a Culture of Entertainment: Learning to Live with Passion and Wonder

Richard Winter
IVP 2002
£7.45 Pb 156pp
ISBN 0 83082 308 5

A book on boredom – how…boring? Actually, the more one thinks about boredom the more interesting it becomes! What causes boredom? Why are some people more prone to boredom than others? What's the difference between being bored for a short period and being chronically bored with life? Is boredom always bad or can it be a stimulus to search for true satisfaction? Is there an antidote to boredom or is boredom a 'normal' part of life?

This book by psychiatrist and theological seminary professor Richard Winter seeks to answer these and other questions by examining the historical, sociological, psychological and cultural roots of boredom. Winter explores the philosophical contributions of postmodernism and the loss of meaning to the experience of boredom and the 'bitter fruits' of sexual addiction, aggression and risk taking that so often follow.

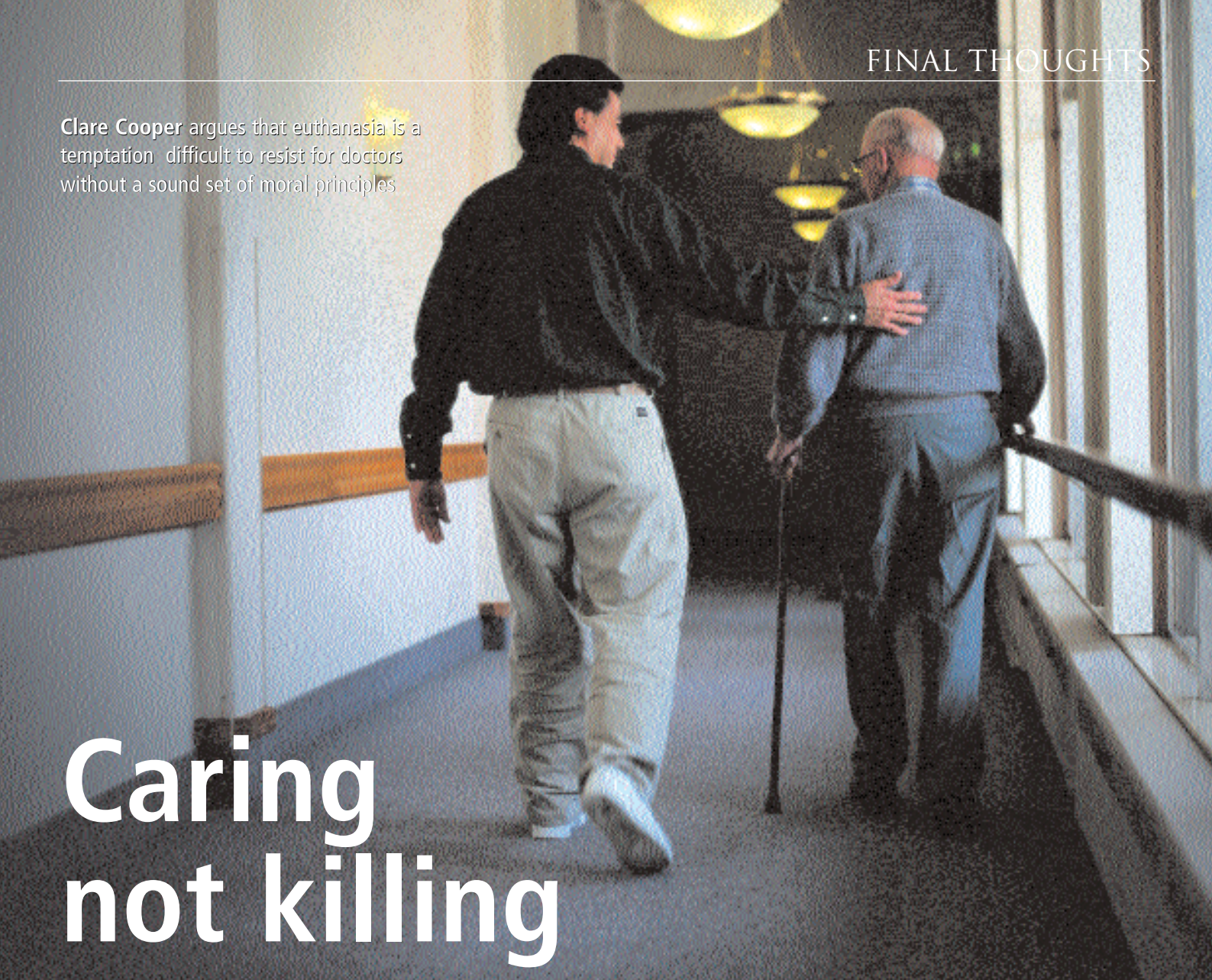
A wide range of perspectives is covered and there is much that will interest, whether reading it for professional or personal reasons. I particularly enjoyed the chapter dealing with the psychological research data and also those discussing the relationship of boredom to our present culture of leisure, overstimulation, entertainment and consumerism.

In the final chapters, Winter moves from an analysis of boredom to ways of counteracting it. He provides general advice and also argues for the necessity of discovering the 'bigger picture' of passion and wonder for God and his world.

The Christian reality is present throughout this book, always challenging but never obtrusive or jarring with the flow of the argument. This makes the book accessible to non-Christian and Christian alike and I certainly wouldn't have any hesitation giving this book to an interested (or bored!) enquirer. I think anyone who works in a pastoral role whether doctor, nurse, psychologist or church worker, will find the book informative and helpful to their practice.

Jim Paul is a Specialist Registrar in Palliative Care in the North Thames region and former CMF Student Staffworker

Clare Cooper argues that euthanasia is a temptation difficult to resist for doctors without a sound set of moral principles



Caring not killing

'Stop listening to instruction, my son, and you will stray from the words of knowledge.'[1]

A new GP in the Netherlands treated a 78-year-old patient with a chronic illness and increasing breathlessness. Her life expectancy was two months. She asked him for euthanasia but he didn't like the idea of taking a life. Then, having prepared her family, she took an overdose. It failed. So again she asked her GP to end her life.

He knew he could refuse but believed that if he said no she would try suicide again, causing her more suffering should the attempt fail. So he agreed to her request and followed the correct procedure precisely. He came under considerable pressure from her family who wanted the death soon and at a convenient time. All his free time was taken up with the case and he felt stressed. On the day for her death he set aside the afternoon and sat with her family. He gave his patient a barbiturate potion to drink. He told her it was her decision whether or not to take it; he was merely offering it to her. As he saw it, she chose to end her own life and 45 minutes after taking the drink, she died.

A GP in the Netherlands can expect to carry out euthanasia about once every five years. The doctor in this case commented that he hoped it would be many, many years before he had to do so again. He had felt trapped into supporting the request because he had come to know her very well. He did not disagree with her decision but thought a person should have access to the means to take their own life without involving a doctor.

Another Dutch doctor told me she had decided she would not conduct euthanasia but after joining a practice she changed her mind. A patient with cancer had asked her about euthanasia and as she wanted to be involved in all aspects of the patient's care, she supported the request. She expressed a hope that she wouldn't have to do it again.

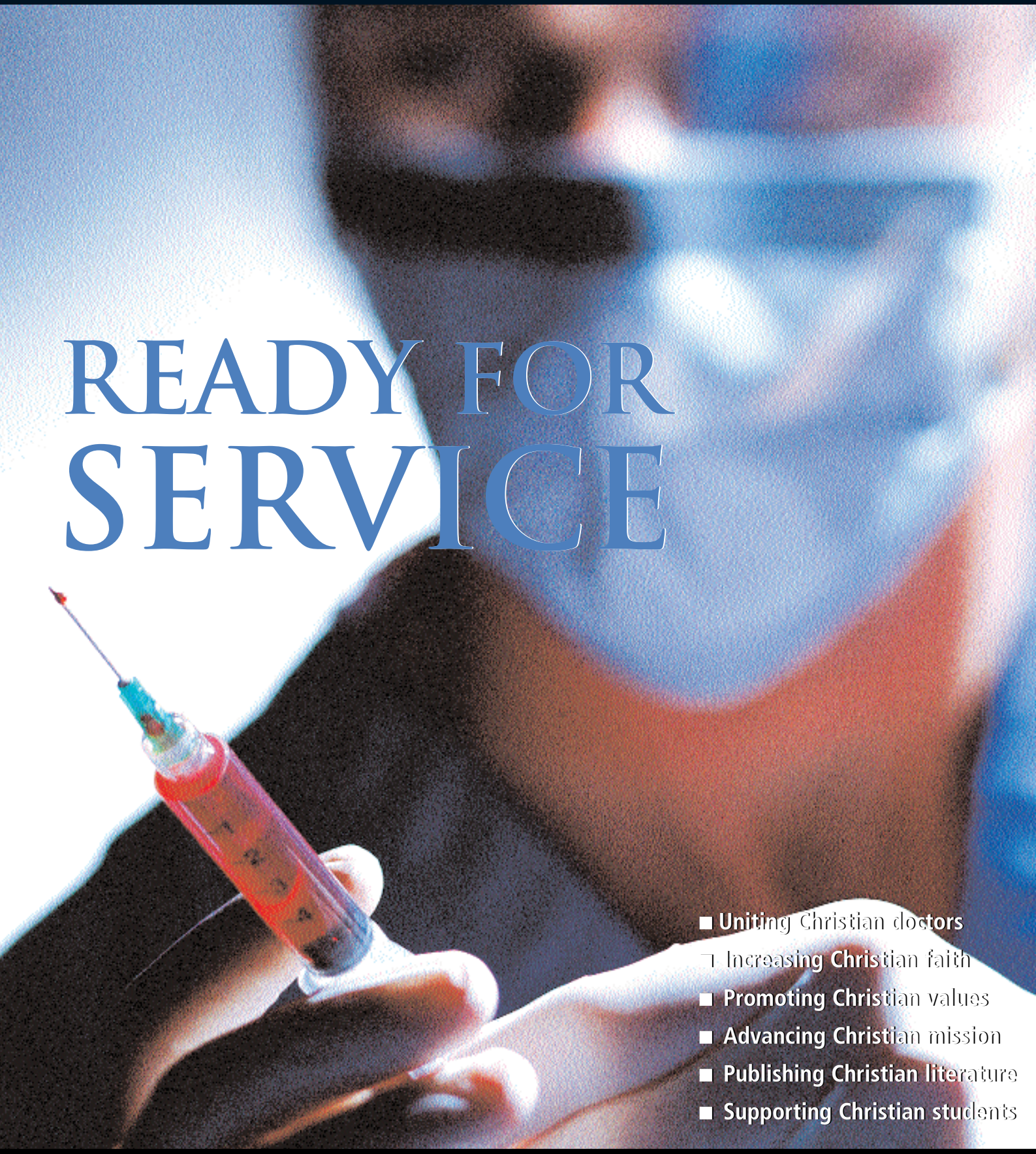
Without a sound set of moral principles to live by both these doctors found it impossible to resist the practice of euthanasia which had become acceptable in their society. Surprisingly, these GPs changed their view once the doctor-patient relationship was established. Once they had befriended a person, helping that person to die became a task they were willing to do. It became the compassionate option, a normal part of medicine.

If our medical practice is not built on the firm foundation of Christian teaching and a relationship with Jesus Christ we shall most likely follow the prevailing worldview and fail to uphold the sanctity of life. As Christians, we must learn to 'Trust in the Lord with all your heart and lean not on your own understanding'.[2] In the New Testament, James promises a blessing to all believers who look intently into God's perfect law and continue to follow it.[3] Caring, not killing, is the way of Christ.

References
1. Proverbs 19:27
2. Proverbs 3:5
3. James 1:25

Clare Cooper was formerly an associate specialist in Dermatology but now works for CMF

CHRISTIAN MEDICAL FELLOWSHIP



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