TRIPLE HELIX

Autumn 2004

For today's Christian doctor

OBESITY

LESLIE BURKE

JOFFE BILL

CHOOSING THE FUTURE

ASYLUM SEEKERS

SEXUAL ORIENTATION

MENTAL CAPACITY BILL

WORKING OVERSEAS

HERBS IN MEDICINE

SPIRITUAL TEAMS

OVERSEAS OPPORTUNITIES

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Christian Medical Fellowship
157 Waterloo Road
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Tel 020 7928 4694
Fax 020 7620 2453

Email admin@cmf.org.uk
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Government consultations
It is our duty to be involved


Photo: PA

Hilary Benn

One of CMF's aims is 'to promote Christian values, especially in bioethics and healthcare…' and to this end we issue press releases and contribute to government consultations.[1,2] We are currently awaiting the Government's response to three consultations, all of which closed over the summer.

The Department of Health's *Choosing Health?* consultation covered a range of public health issues, including diet, exercise and alcohol consumption as well as more general questions about the balance between the state and individual responsibility, and how changes could be implemented. The Government plans to publish a White Paper later in the year, which will shape future policy and legislation.

The consultation comes at a time of increasing national concern about 'the obesity epidemic', addressed in this issue of *Triple Helix*.[3] In contrast to the developing world, Western society's main health problems are those of abundance rather than poverty. Perhaps our search for solace in food, alcohol, sex, drugs or material things is a symptom of a greater spiritual problem.

The new Department of Health proposals, *Excluding Overseas Visitors from Eligibility to Free NHS Primary Medical Services*, appear to be an over-zealous response to public fears over 'health tourists' draining NHS resources. But whilst there are undoubtedly some wealthy visitors receiving free treatment at our expense, the main group of people to be affected will be failed asylum seekers. We have argued in our submission that this is both unjust and foolish: it is not in the interests of individuals, the general public or primary health professionals to create a marginalised semi-illegal group of people with no or limited access to primary health care services.

The Select committee on Lord Joffe's *Assisted Dying for the Terminally Ill Bill*,[4] which is attempting to bring in Dutch-style euthanasia in the UK, is now hearing oral submissions. The full transcript of evidence is available online.[5]

The arguments for legalising euthanasia have shifted since a Lords' committee recommended no change in the law in 1993. Then the focus was compassion for the suffering; now it is on patient autonomy. We have argued that euthanasia is unnecessary because compassionate alternatives exist, dangerous because of the slippery slope and morally and ethically wrong. Far from protecting patient autonomy, allowing assisted dying will undermine it, by creating pressure on vulnerable people, whether real or imagined, to request early death.

Although oral submissions have begun Christian doctors are still urged to write to members of the Select Committee with their views. An open letter and briefing paper on the bill along with links to CMF's submission and the full text of the bill itself are available on the CMF homepage.[6]

In a democracy we are all in one sense rulers who are responsible for the laws which end up on our statute books. It is our duty both individually and corporately to respond by being informed, praying, educating others and trying to influence the political process.

Peter Saunders is General Secretary of Christian Medical Fellowship

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New DFID paper on sexual health
Foolishness on a grand scale

On 6 July, the Secretary of State for International Development Hilary Benn (pictured) published a Department for International Development (DFID) position paper on 'sexual and reproductive health and rights'.[1] This sets out what the DFID believe should be done to improve sexual health in the developing world and forms the basis for planning future investment and activities.

The political philosophy permeating the document is borrowed from the United Nations Population Fund (UNFPA) and similar population control groups. It asserts the 'right' to sexual and reproductive health. The language of 'sexual and reproductive rights' means the 'right' to sexual activity with whoever one wishes (whatever age or gender) without causing or receiving harm. There is no mention in the 10,000 word document of any need to support the family based on marriage. There is no acknowledgment of the need for children to be protected from sexual predators or 'educators' whose jobs rely on the very existence of early sexual experimentation. Abstinence is dismissed in a sentence with one reference to a dubious United Nations resource. There is no recognition of the success of an abstinence-based approach of driving down HIV rates in Uganda, or abortion rates and teenage pregnancy rates in the US. There is no moral framework at all behind the assertion of these arbitrary 'rights'.

Scattered through the document are references to 'integrated' HIV and sexual and reproductive health services. This means bringing together surgical abortion, sterilisation, injectable contraception, IUD insertion, maternal and child care and STI treatments in facilities all over the developing world. A series of papers published in 2003 describe underestimation of a substantial iatrogenic component to the spread of HIV in Africa via medical injections and other procedures.[2,3,4,5] According to one estimation over half of HIV infections in adults in Africa could be due to health care exposures. There appears to be a discrepancy between observed HIV prevalence in women undergoing 'reproductive care' and the expected prevalence in such a group from heterosexual transmission alone.[2] Manual vacuum aspiration for example is the commonest method of surgical abortion in Africa. The kits are designed to be used and re-used with virtually no testing done for HIV beforehand.[6]

This document ignores the only successful primary preventive approach to HIV and promotes policies that are inherently dangerous such as integrated HIV-reproductive health clinics. It endorses the UNFPA - purveyor of forced abortion in China - and it undermines the family and marriage. Its determined and myopic ideology is foolishness on a grand scale.

Trevor Stammers is a General Practitioner in West London

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EDITORIALS

Leslie Burke v the GMC
Good news for vulnerable patients

God has a heart concern for the defenceless and vulnerable (Psalm 82:3-4). It is a high calling to care for such people, but temptations to fail in this area are surprisingly great. The intensivist trying to run a service with limited beds or the physician with a budget deficit face organisational and financial pressures that make it difficult to focus on the needs of the vulnerable patient. 'Best interests' can subtly be corrupted to 'most expedient'.


Photo: PA

Leslie Burke

Mr Leslie Burke, who suffers with a progressive neurological condition, has recently challenged the GMC guidance to doctors in these situations in the UK.[1] The judge found in his favour and has made a ruling that significantly raises the standard of protection for vulnerable people who cannot direct their own care. Previously decisions regarding nutrition and hydration were based on a doctor's view that providing such treatment would '*cause suffering or be too burdensome in relation to the possible benefits*'.[2] Now doctors must show evidence that a patient's life has become '*intolerable*' before such treatment can be withdrawn or withheld. Most importantly however, decisions about treatment in general must now be referred to the courts '*where there is any doubt as to either capacity or best interests*'.

In particular the judge referred to specific instances when doctors should seek the Court's guidance: for example, where there is doubt or disagreement about a patient's capacity or where there is evidence that a patient even if incompetent resists or disputes the proposed treatment. Also where friends or family present evidence or assert that a treatment plan is not in the patient's best interests then the court should be consulted.

The ramifications are huge. This judgment signals a dramatic shift from bedside decision-making to the courtroom, away from the everyday pressures of bed management and finances. Christian doctors should welcome this judgment. It provides a means of resisting the pressures of expediency and truly considering what is best for vulnerable patients. Two caveats need to be sounded, however.

Firstly, going to the Court is expensive, diverting valuable resources away from patient care, and may be distressing for families. The legal process may be cumbersome. Christian doctors should seek a more accessible and cost effective way to implement this judgment or it will simply be seen as unworkable or even paradoxically unjust.

Secondly, the judgment makes no mention of how clinicians should resolve the dilemma of the competition for resources. The Burke judgment must be balanced against the need for equity of access to treatment for all. Christian doctors need to take the initiative in driving this debate forward in a godly way, or the latter state could be worse than the first.

Stephen Sturman is a Consultant in Neurology and Rehabilitation in Birmingham

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Poaching health professionals
A growing injustice needing urgent solutions

At the Bangkok World AIDS Conference in July 2004, it was highlighted that the fight against HIV in Africa was imperilled by the severe shortage of trained doctors and nurses.[1] The grim reality is that even where the drugs and funding are available, there are no skilled health professionals to provide the care.

One of the major causes of this shortfall is the migration of health professionals to the wealthier nations of the world. The UK is now one of the largest recruiters, second only to the US in the number of doctors we recruit from the developing world, and the largest importer of nurses.[2,3]

The reality is that there is a global shortage of trained health professionals and the increasing globalisation of labour markets means that health professionals are moving to where they can get the best salaries, training opportunities and living conditions.[4] The UK is now so short of health professionals that some 44,443 of NHS staff are from non-EU countries (and an increasing number of EU nationals working in the NHS are likely to be from the new accession states).[5] We simply could not run the NHS without them!

What can be done? One option is for the developed nations to pay compensation for the costs of training the workers we recruit from developing nations.[6] However, we also need to look at how we support, train and care for our own staff here in the UK.[7] It is not just that people are not going into medicine or nursing, it is that they are leaving, especially from nursing, at an alarming rate. If we cannot retain UK nationals in the NHS, sooner or later we will not be retaining foreign nationals either.[11]

In the meantime, the global drives to reduce child mortality, improve maternal heath, curb the spread of HIV, TB and malaria, and the other health related Millennium Development Goals are in severe danger of being unfulfilled or even reversed, in large part because there are too few skilled practitioners in the countries that need them most.

The Psalmist reminds us that the Lord secures justice for the poor and upholds the needy.[8] This is an issue of justice that we as Christians seeking to serve the God of the poor need to address most seriously and urgently with our own government and the international community.

Steve Fouch is CMF Allied Professions Secretary

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Photo: PA

Peter May takes a critical look at the language used in public debate about sexuality

Is sexual orientation a myth?

The document, *Some Issues in Human Sexuality*,[1] recently debated in the General Synod, raises important questions about the significance of bisexuality, not least for our understanding of sexual orientation.[2] It claims, for instance, that Ancient Greek and Roman cultures did not have sexual orientation terminology in their language (p219). They viewed people as being simply 'sexual' and capable of expressing their sexuality in a variety of ways.

Sexual Behaviour in Britain, published in 1994, remains the most comprehensive study of national sexual attitudes and lifestyle.[3] The Thatcher government refused to finance this survey and it was rescued by the Wellcome Trust and a welcome report it was. Until then the best data available were found in the Kinsey reports of 1948 and 1953.[4,5] Kinsey claimed that 10% of the population were homosexual, a figure that never rang true in medical experience and the Wellcome report explained why.

Surveying nearly 20,000 randomly selected Britons, the researchers concluded that only 6.1 % of men and 3.4% of women had had *any* homosexual experience at *any* stage (p226). These statistics may be an underestimate, given people's reluctance to be honest in these matters, though great care was taken in the research method. It's possible the figures may also have changed in the past ten years, due to changing cultural mores, but presumably not from changes in biological or genetic causes.

The incidence of bisexuality reported by the Wellcome researchers was huge. They concluded that 90.3% of that 6.1% of men, who had had an homosexual experience, had also had a female sexual partner. This would leave 0.6% of men being exclusively homosexual. For women, 95.8% of that 3.4%, who had had an homosexual experience, claimed also to have had a male partner, leaving 0.14% of women being exclusively homosexual (p211). Barely 1% of men and less than 0.25% of women described their sexual experience as either *mostly* or *exclusively* homosexual (p183).

The report concluded that exclusively homosexual behaviour is rare (p227). It noted that for many, homosexual experience was youthful and transitory and unlikely to lead to a permanent behaviour pattern (p226), while the high prevalence of bisexual behaviour among homosexuals was well-documented (p211).

A recent article in *The Times*, written by a lesbian, said: 'Thousands of gay women have had relationships with men and some may not rule out the possibility of falling in love with a man in the future. But asking a gay woman to define herself as lesbian or bisexual is difficult. To opt for what may be the more honest answer of "bisexual" could be viewed as some kind of betrayal, a refusal to stand up and be counted.'

Genetic studies, for all their ambiguity, have ruled out the idea of a gay gene determining orientation.[6] The report before the synod did not mention the significance of twin studies. Identical twins are genetic 'clones' of one another, having an identical genetic make up. If sexual orientation was genetically determined, they would both exhibit the same orientation. But studies have shown that they do not. There may be a genetic or other biological disposition towards homosexual relationships in some people. We do not know for certain. But homosexuality is clearly not genetically determined. We may therefore be mistaken to speak of sexual orientations rather than sexual behaviours.

When we start talking about behaviour, we might then note that some sexual behaviours can be deeply habit forming. While some people seem to move from one type of sexual experience to another, others get addicted in a serious way. For some, use of pornography may come to dominate their lives. A preference for violent pornography may grip their imagination and drive the person to fulfil their desires. Promiscuity, sado-masochism, and the use of prostitutes can all become addictive behaviours.

The chemistry of falling in love is a sort of addiction. It needs to be constantly fuelled to be kept alive. Adultery is addictive. Few people embarking on an adulterous relationship find it is a 'take or leave' matter from which they can easily walk away. They are hooked and get an intense thrill from the encounter. Then there is that powerfully addictive and disturbing preference for sexual intimacy with children. Having engaged in sexual acts with children, paedophiles always remain vulnerable to repeating such behaviour.

We engage in addictive activities at our peril. The question remains: are these sexual obsessions different in kind from so-called 'orientations'? If so, wherein lies the distinction? The media talk about sexual orientation as though it is a natural feature of the individual, both innate and unchangeable, as much a part of the individual as racial origin and skin colour. The conclusion therefore is that it should be sacrosanct in human rights employment laws.[7]

But what if sexual orientation is no different in kind from other sexual fixations? The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* lists 23 different 'paraphilias' as sexual orientations.[8] These include heterosexuality, homosexuality, bisexuality, transsexuality, transvestitism, voyeurism, exhibitionism, paedophilia, and bestiality.

Edward Stein in his important book *The Mismeasure of Desire* states: 'One of the central claims of this book is that we do not have strong evidence to support the commonly held belief that sexual orientations are natural human kinds.'[9] The language of preference, of learned behaviour patterns and addiction makes much more sense of the known realities of sexual behaviour than talk about orientation. If that is true, it ought to change the whole nature of the public debate.

This is an extended version of an article that originally appeared in the Church of England Newspaper, printed here by kind permission of the editor.

Peter May is a GP from Southampton and member of General Synod

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Adrian Treloar on the strengths and weaknesses of the new bill

The Mental Capacity Bill
- gateway to euthanasia?

WE SHOULD BE VERY CONCERNED ABOUT THE CURRENT BILL. IT IS A LONG WAY FROM BEING BENIGN

The draft Mental Capacity Bill[1] was published this summer following a decade of discussion and negotiation. One of the remarkable things about the bill is how long it has taken to come to parliament. This is largely due to the considerable input from various faith-based and 'pro-life' organisations, including CMF, who have highlighted flaws and sought to improve the legislation. After years of discussion, we have another document to consider. While some sections are good others are, I believe, a step towards legalising euthanasia.

What is partly good?

The validity of **advance decisions** will be limited under the bill. They will have to be specific, relate to conditions that were anticipated, and the patient must not have done anything inconsistent with the decision since it was made. Furthermore, when the specified situation arises, if there are reasonable grounds to doubt that the patient did not anticipate circumstances that would have made him think differently, the decision can be questioned.

However, apart from these limitations, advance decisions will be given statutory power. This could lead to neglect of a patient if they have made decisions without understanding the consequences. Statutory power will make advance decisions therefore dangerous. Whilst welcomed as *advisory* by Christian doctors they are generally opposed if *binding* because of the damage that may occur to vulnerable patients.

A good aspect of the debate on advance decisions is that we have gained a much clearer description of the limits to their authority. Faced with an advance decision, the bill will give doctors considerable power to continue to cherish the life of the patient and provide appropriate care and comfort. There is a range of opportunities to question the validity of directives when they appear to harm the patient. This is a huge improvement on previous loose definitions. However, it is still not clear whether a suicide note would constitute a valid decision, requiring doctors to allow those who harm themselves to die.

Lasting powers of attorney (LPA) are partly good but also dangerous. They give another individual statutory authority to consent to treatment for those without capacity who refuse or cannot consent to care, including those who resist. This should improve care, as currently incapacitated patients who resist care may not be treated. Enduring powers of attorney already work well for money matters, and LPA may help medical care. However there are cases of fraud in money matters, and the likelihood of an appointed attorney not acting for the patient's best medical interests must concern us all. It is not clear how those who oppose good care for patients will be dealt with.

What is bad?

The bill states that **serious medical treatment** may be withdrawn for the **best interests** of the patient. It is very clear that this means the bill will allow the removal of food and fluids from patients in persistent vegetative state (PVS), as well as stroke patients and newborn disabled babies. It will also enable sterilisation of those with learning disabilities. The Government states that these matters will be subject to a code of practice and that recourse to the courts will continue for the time being in cases where this currently happens. However, codes change with time and the bill will therefore give statutory support to ending the lives of stroke patients by dehydration as well as allowing, without further legislation, the ending of life for PVS patients. Donees of an LPA will be able to *require* such ending of life by refusing serious medical treatment (including food and fluid by tube and possibly use of oral syringe feeding). Where the Court of Protection appoints a consultee, a government appointee will acquire the ability to stop

Mental Capacity Bill [2]

Key principles of the bill:

- An assumption of capacity
- Capacity is decision specific
- Participation of the patient as far as is possible in decision making
- Individuals retain the right to make eccentric or unwise decisions
- Decisions on behalf of incapacitated people must be in their best interests
- Decisions should be those which are least restrictive of basic rights and freedoms

The bill enshrines in law:

- Acts in connection with care and treatment of incapacitated patients
- Protection of carers from liability where they acted in the best interests of the patient
- Lasting powers of attorney (LPA) applying to welfare, healthcare and financial matters
- Court appointed deputies – able to take decisions on welfare, healthcare and financial matters
- Advance decisions – confirming the legal basis for people to make a decision to refuse treatment if they should lose capacity in the future
- Criminal offence of neglect or ill treatment of the incapacitated – liable to five years imprisonment
- New court of protection – to consider decisions about the needs of incapacitated patients (there are currently handled by the High Court).
- New public guardian – the registering authority for LPAs and deputies
- Code of Practice

History of the bill:

- 1989 - Law Commission begins initial investigation of the mental health laws
- 1995 - Law Commission issue their report: *Mental Incapacity*
- 1997 - Consultation on the Green Paper *Who Decides? Making Decisions on Behalf of Mentally Incapacitated Adults*
- 1999 - *Making Decisions* policy statement issued
- 2002 - Mental Incapacity Consultative Forum established to develop solutions to problems under the current law and explore proposals for new legislation
- 2002 - Views on a series of guidance booklets [3] sought through the consultation *Making Decisions: Helping People who have Difficulty Deciding for Themselves*. [4]
- 2003 - Draft *Mental Incapacity Bill* presented to a Joint Committee for scrutiny
- 2004 - Committee report published in February. The revised and renamed *Mental Capacity Bill* published in June

The MCB should not be confused with the draft Mental Health Bill issued by the Department of Health in 2002. Considerable opposition was raised against the controversial 2002 bill. A revised bill providing extra safeguards for mentally ill people was presented to a parliamentary scrutiny committee on 8 September 2004.

treatments in this way. So as well as consolidating the Bland judgement, [5] the bill will go a very long way beyond Bland to enable euthanasia by neglect of a wide group of individuals.

'**Best interests**' remains poorly defined. Indeed the bill is deeply flawed in its approach to best interests, which are described solely in terms of the patient's actual or hypothetical desires. The bill nowhere refers to life and health in listing the best interests of the patient. We all know, as doctors, that there really should be a consideration of good clinical care in 'best interests'. To omit this from the decision-making equation is unacceptable. Yet under proposed legislation it will not matter.

'**Serious medical treatment**' is not defined. It will certainly include simply administered food and fluid by tube, but may also include other oral nutrition (which we know is harder for many than tube feeding). Therefore the range of treatments that can be withheld or withdrawn is likely to be wide. The range of disabilities and illnesses will also be wide. This risks decisions being made on the basis of 'worth', 'personhood' or 'utility' of individual patients. Disabled and elderly patients are at deep risk in all such quality arguments.

We should be absolutely clear that this is not because we are'vitalist' (ie. that we seek to preserve life at all cost). It is absolutely right that we must limit medical care where it will not help or work. In my clinical practice, working with severely incapacitated individuals we do this frequently. However, this bill puts into statute the ability to require that serious medical treatment (including food and fluid administered by tube) be withheld, with the knowledge that life might soon end as a result. The ethics of this must be questioned. [6] If we are legally required to end life by such means we will, in my view, have fractured the vision we have of each one of our patients as uniquely deserving of respect, love and care. That is precisely what happened in Nazi Germany. The first victims were the disabled and elderly.

What is ambivalent?

Clause 58 was added at the request of Parliamentarians, Catholic Bishops and others. It provides that nothing in the bill will change the law on homicide or assisted suicide. This must be good, but it should be remembered that Bland and other judgements have already seriously weakened the law in these areas. The clause will not therefore prevent euthanasia by neglect and probably has very limited meaning as a result.

What does the future hold?

The Abortion Act 1967 resulted in a large proportion of Christian doctors being blocked from Obstetrics and Gynaecology, as those with a conscientious objection found it harder to ascend the career ladder. A few hung on, believing that doing some abortions enabled them to influence and save others. The same sort of thing will doubtless happen in the care of the sick and vulnerable if this bill is passed. Specialties such as Geriatric Medicine, Palliative Care, Old Age Psychiatry and General Practice currently occupy many Christian doctors. These may become 'no-go' areas; there must come a point where we simply say 'No, we cannot take part in euthanasia'. We should be very concerned about the current bill. It is a long way from being benign, and will probably turn out to have been the point at which euthanasia became legally established in this country.

Adrian Treloar is a Consultant and Senior Lecturer in Old Age Psychiatry in London

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Peter Armon asks 'when is the best time to go, from a trainee's perspective?'

Working Abroad

Photo: Wellcome

KEY POINTS

There is a desperate need for overseas healthcare workers. Opportunities for trainees abound. The CMO and DSS encourage doctors to spend time working abroad. Both the RCPCH and RCOG offer Fellowship schemes with VSO; one year 'out of programme experience' that may be retrospectively counted towards CCST. The RCS and RCGP are supportive of their members who wish to work abroad. The preferred time for trainees to go is perhaps after SHO training or during specialist registrar training. If Jesus is calling you to go, procrastination is disobedience. This article is aimed at trainees but the experience of established consultants and GPs is needed even more.

The poor will always be with us. The images on our TV screens remind us daily of desperate need and published facts confirm that need for healthcare workers overseas has never been greater.[1] So how can I, as a trainee, get involved and when is the best time to go? Opportunities abound with government and NGOs, secular and mission agencies. Every agency has long lists of vacancies. Many LDCs (less developed countries) are dependent on mission agencies and NGOs to provide healthcare in their rural areas.[2]

The CMO and the DSS say 'Go'

Despite the difficulties that some foresee and others are experiencing, the DSS is encouraging NHS doctors to consider short spells working abroad. *International Humanitarian and Health Work – a Toolkit to support good practice*[3] emphasises the benefits to the NHS and individual. It contains excellent advice on how to develop and sustain skills for international work, a chapter on resources and detailed appendices on projects, placements and agencies to approach. The DSS has also produced a *Compendium of the NHS's Contributions to Developing Nations*[4] which lists the involvement of Hospital and PCTs in overseas work, the countries they have links with, the nature of the work undertaken and contact details.

> 'The ultimate beneficiaries from UK professional health workers gaining international experience are NHS patients in the UK'
>
> *Liam Donaldson CMO*[3]

VSO and the Royal Colleges

VSO (Voluntary Service Overseas) have established links with RCPCH and RCOG, offering 12 month training fellowships in selected placements in LDCs.[5] Two CMF members are currently working in Malawi on a Fellowship with VSO and the RCPCH – they can be contacted via the CMF Office. RCOG/VSO Fellowship Scheme offers one year taken as 'out of programme experience' that can be retrospectively assessed by the RCOG STC and may count towards CCST. VSO source the placement and provide the training and RCOG source the in-country mentors.[6] There are currently RCOG trainers in Kenya and Indonesia. The RCOG also resources shorter trips abroad. Time out is taken partly as annual and partly as study leave. The RCOG has sourced a Charitable Trust that will pay airfares for 3-4 trainees per year. Writing recently in RCOG News, Matt Carty, Senior Vice President states: 'I hope more trainees can get the opportunity to broaden their clinical and life experience [overseas through these 2 schemes], a wonderful experience which hugely influenced the whole of my professional life.'[7]

The Association of Surgeons of Great Britain and Northern Ireland strongly encourage trainee and established surgeons to spend time overseas. They organise an annual day conference at the RCS entitled 'Surgery in the Tropics – making it happen'.[8] The RCGP is similarly positive: 'Working overseas is a rewarding and challenging experience. Our College recognises that the experience doctors gain overseas contributes significantly towards their professional development.'[9]

So when should I go?

There never is (and never has been) a 'right time' to go. The development of structured training programmes, together with a shortage of trainees in some specialties, has meant that Deans are reluctant to extend training periods. But if you don't go now, you may never. If Jesus is calling you to go, procrastination is disobedience. There is a balance to be struck between the 'now' and the 'not yet' of your going. This is not in the response you make but rather in the preparation that needs to follow your decision

to go. The time to go may depend on your specialty, training, family circumstances and the work you will be undertaking.

The time to go [10]

1. As an SHO: most overseas posts demand a wider range of experience
2. Taking a 'gap' year between SHO and specialist registrar training
3. As a specialist registrar (in a supervised post - see above)
4. As a research fellow
5. After accreditation, during your professional career, after retirement

It would be unwise for Pre-registration House Officers to go overseas before completing registration in the UK. Options 2 or 3 are perhaps preferred. Discuss the matter with your regional postgraduate Dean well in advance. It may be possible to reserve a Calman number while you are abroad. If your college or postgraduate Dean won't agree with your plans, a step of faith (obeying God rather than man) may be needed but it would be wise to discuss the matter with a senior Christian who has experience both overseas and within the NHS.

Jes and Jane Bates write from Malawi where Jes is working as an Orthopaedic Registrar and Jane is involved in community HIV/AIDS care

We went to South Africa after I passed FRCS part II. I wanted training in orthopaedics in an LDC, in a teaching environment. 'Thrown in at the deep end', I left with a lot of experience and confidence in dealing with a wide range of surgical emergencies. Taking a year's contract ensured it wasn't all take and no give. We then took a year out to go to Bible College. We had some worry about losing touch professionally but it wasn't a problem and we found it a very valuable time. We now work in a government teaching hospital, funded by UK churches, friends and family. We have many opportunities to talk and pray with patients, are involved with local CMDF, and developing a mentoring role with local medical students.

Best time to go?

Possibly at the end of basic training, before starting SpR post. With less training you are less useful and more likely to feel out of your depth. Colleagues have obtained SpR posts to go back to in the UK whilst working here.

Their message:

'God is faithful and if we act in obedience to him he will not abandon us. Be courageous, hold on to the vision God has given you.' Go to missionary conferences and find like-minded people to inspire you. Think early about church support and get them involved sooner rather than later.

'If you want to walk on the water, you've got to get out of the boat' [11] 'Do whatever he tells you' said Mary the mother of Jesus. [12] We can so plan and try to prepare for every eventuality that we give God very little say in the matter. Proverbs reminds us that 'There is a way which seems right to a man, but in the end it leads to death'. [13] The way to peace and fulfilment is to respond to God's call when he calls. That will often entail getting out of the security of the boat and stepping onto uncertain waters where he is holding out his hand to us. We read of Abraham that '(urged on) by faith, Abraham, when he was called, obeyed and went forth'. [14] Perhaps we should more readily seek to follow the immediacy of this response.

If going overseas is part of God's plan for your life, you can be assured that 'Those who honour me, I will honour' [15] and 'we know that in all things God works for the good of those who love him'. [16] That means your return to the UK and the finding of a future post back home are in his hands and he won't let you down. [17] Stepping out in faith can be scary but we know 'that underneath are the everlasting arms'. [18] You will be taking a risk but it's worth remembering that RISK is an alternative spelling of FAITH.

What next?

- Visit our overseas website *www.healthserve.org* and read the Medical Missions Handbook
- Contact the CMF Overseas Desk for further help and advice
- Attend some missionary prayer conferences
- Read and be inspired by biographies of past medical missionaries
- Talk and pray things through with a respected 'senior' who has 'been there'
- Consider what other 'missions' training might be useful [19]
- Attend CMF's *Developing Health Course*, 4-16 July 2005 [19]
- Talk things through with the appropriate authorities, College advisers and senior colleagues concerned with your future
- Keep up to date with revalidation issues
- If you are thinking of entering a hospital specialty, it is advisable to start specialist training before you reach the age of 30 and not to spend more than two years abroad before completing it.

This article is intended to stir trainees into action but there is no doubt that it is easier for established Consultants and GPs to get involved in overseas visits – even obtaining study leave to do so or utilising 'sabbatical periods' for such trips. Your experience and wisdom is needed even more!

Peter Armon is CMF Overseas Support Secretary

'If you want to walk on the water, you've got to get out of the boat'

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18. Deuteronomy 33:27
19. Look under Information and Courses and Bible Colleges on the Healthserve Pages *www.healthserve.org*

Mark Daly on the challenge to society and concerns for the individual

Photo: PA

Facing the OBESITY epidemic

KEY POINTS

The UK obesity epidemic adversely affects both morbidity and mortality and is fuelled primarily by high calorie foods and reduced physical activity. Obesity damages individuals, highlights global inequalities and reflects bad stewardship of resources. But conversely the promotion of a responsible lifestyle must not be confused with the worship of physical perfection. The morbidly obese patient often has marked psychological problems around food and body image. The situation calls for compassion and empathy teamed with good practical solutions both for the individual patient and for society at large.

Obesity is an increasing problem in the UK, with over 60% of the population overweight and 20% obese. This results in an increase in risk of morbidity and mortality from type 2 diabetes, ischaemic heart disease, hypertension, cancer and stroke, amongst others.[1] Obesity is not confined to the UK. The obese US population is approaching 30%. Many parts of urban Africa are experiencing an increase in levels of obesity and the incidence of type 2 diabetes following adoption of a western lifestyle.[2]

Body Mass Index (BMI) is measure of body fat based on height and weight that applies to both adult men and women. It is calculated by dividing a person's weight in kilograms by their height in metres squared (BMI=kg/m^2). The BMI categories indicate whether a person is over or under weight. There are limitations however, for example for those with a muscular build. Considering BMI with other factors such as waist circumference, levels of activity, and dietary intake will give a more complete picture of an individual's health. Racial factors should also be considered as patients of south-asian origin have a higher risk at a lower BMI.

BMI Categories:
Healthy weight = less than 25
Overweight = 25-29.9
Obesity = 30 or greater

In considering a response to obesity we have to reflect on its causes. It is clear that obesity must result from an excess of energy intake over expenditure. Despite a common belief that we all eat more than we used to, energy intake in comparison with 40-50 years ago has actually declined. Therefore activity must have declined to a greater extent. Additionally certain factors impair our ability sensibly to adjust calorie intake to our needs, such as the increased energy density of processed and 'fast' foods.[3]

As physicians we see the consequences of excess weight in our daily practice: the relentless increase compounded by the individual's incapacity to achieve a significant weight loss, their own failure further compromising their impaired self-esteem. Worse still, the poorer sections of society experience the brunt of this disease.

Christians believe that individuals have responsibility for themselves and others. Therefore obesity in a world where people still suffer from hunger and scarce resources is wrong from a range of perspectives:

- It damages the individual
- It reflects a waste of food and money that could be used to address global inequities
- The consumption of pre-processed food requires a higher level of energy consumption (production and transport) and implies neglect of our duty as stewards of the earth

We are not called to judge but to show compassion, yet we must also be as 'salt' to the world in which we live.[4] This is best considered in

WE NEED COMPASSION AND EMPATHY FOR OUR PATIENTS TEAMED WITH PRACTICAL SOLUTIONS

three ways – the challenge we offer to society as a whole, how we deal with people as individuals and how we behave ourselves.

A response to society and obesity

A prominent UK diabetologist remarked that type 2 diabetes targets the rich in poor countries and the poor in rich countries[5] – this largely reflects the pattern of obesity in our world. Therefore in the UK, obesity is another inequality suffered by poorer members of society. The reasons behind this are complex, but cost of healthy food and the high energy density of cheaper foods (high in refined carbohydrate and added fats) are likely to be major factors.[6] In addition, our society prizes material possessions to the extent that people are spending a lower proportion of their income on food. Furthermore, many are less prepared to spend responsibly with regard to health and other factors such as free-range farming, consumption of fresh fruit and vegetables, and trade justice issues.

Currently, there is some media interest in the role of the food industry in promoting unhealthy eating, especially to children. Whilst this is a controversial area, we should seek the following changes:

- Availability of healthy eating options at a similar cost to processed foods to all sectors of society
- Cessation of high-profile promotion of foods with high energy density but little nutritional value

We can all contribute to these changes. You might ask your child's school to restrict use of vending machines, or write to a local supermarket suggesting they change their policy of displaying sweets at the checkout.

Barriers to increased physical activity also need to be addressed. Public transport is unviable for many, and few roads are truly safe for cycling. However, most people could make daily use of alternative forms of transport. When I suggested to an obese patient with diabetes and his wife that they might sell one car and walk 1.5 miles to work each day, he was shocked and it was clear that such a solution would not have crossed his mind. Our challenge should therefore be:

- Safe non-car transport options
- Challenge society's view that a two car family is the norm
- Access to cheap/free leisure facilities for all

Knowledge is a further part. As a physician with an interest in obesity, I am involved in education of patients, members of the public and healthcare professionals on a regular basis. People do not know the scale of risk. The risk of type 2 diabetes starts before a person even reaches a BMI of 25 and translating this into real-life figures for height/weight shocks many. People need to know the facts that relate to them and their families. Focussing on extremes leaves too many with a false sense of security.

There is a catch to all this. The promotion of a responsible lifestyle must not be confused with the worship of physical perfection and the self-obsessed pursuit of beauty. We want to promote responsible living *without* excess consumption of precious resources and glaring inequalities across society. A more fundamental change could be to seek a radical approach to poverty.

Dealing with our patients

Too often I see the obese patient come to clinic desperate for a hormonal explanation for their body weight. They have convinced themselves it cannot be related to food consumption. Faced with a 180kg, 35 year old woman who reports a calorie intake 2,000 calories lower than her predicted resting metabolic expenditure, I know that this cannot be true whether recognised by the patient or not. I have to take away this crutch holding up an already poor self-esteem if she is to accept a treatment that involves less food, whether through diet, surgery or drugs.

The morbidly obese patient often has marked psychological problems around food and body image, which we must deal with in a compassionate way whilst maintaining a sense of individual responsibility. There are effective treatments for morbid obesity; lifestyle modification prior to surgery with mean weight losses in excess of 35kg is one of them. Surgery for the morbidly obese is not an easy answer to a greedy person, but often a lifesaver to a profoundly disturbed and unhappy individual.

Personal responsibility

To deal with obesity in our world is to address excess consumption on many fronts, whether food or a luxurious lifestyle that would shock all but our richest forebears. The subject provokes some hard questions for Christians:

- Are we guilty of excess in our lives or do we live simply without concern for what we eat and wear?[7]
- Have we taken too much interest in our bodies and the pursuit of physical beauty?
- Are we different from those around us?

Conclusions

Christ calls us to live to higher standards yet he gives us the means to achieve them. We must be salt for a society that needs to change from its rampant excesses. We need compassion and empathy for our patients teamed with practical solutions.

Mark Daly is a Consultant Clinical Endocrinologist in Exeter.

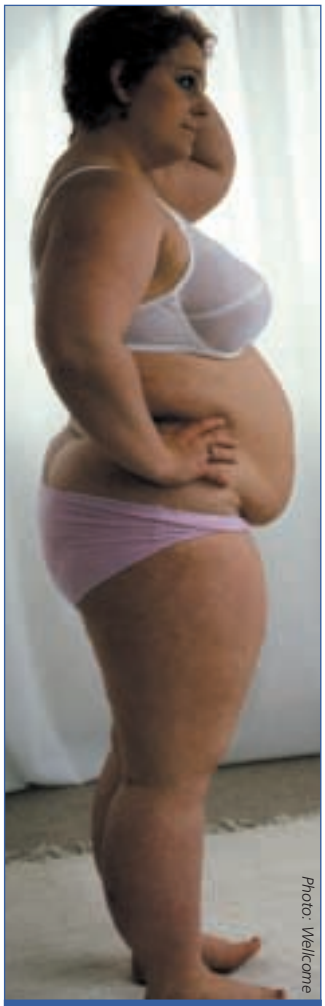

Photo: Welcome

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George Smith continues his series on complementary and alternative medicines

Photo: PA

Herbs in Medicine

KEY POINTS

Herbal medicines contain substances of plant origin and in general are available as over-the-counter products, not subject to close regulation. Whilst many valuable drugs have been identified, purified, evaluated for risk/benefit and eventually synthesised from plants, the effectiveness of most herbal medicines is still unproven and concerns about toxicity and drug interactions are real. In addition the history of the origins and present practices of the many varieties of herbal medicine indicate that they are rooted in and still associated with non-Christian belief systems. Christian doctors should be cautious about herbs both from a Christian and medical perspective.

Investigation into the use of herbs in medicine is a vast subject. Even the descriptions used - phytotherapy, herbal medicine, herbalism, traditional and natural medicines - are confusing, meaning different things to different people. Herbal reference books may add to this confusion by including natural products such as vitamins, minerals and diet supplements, which are essentially foods, but can be therapeutic in some cases of deficiencies and disease. Herbal medicines contain substances of plant origin where all or part of the plant is used to produce an infusion, medicine, tablet or application. Herbal pharmacopoeias may include hundreds of remedies, from aloe vera, through garlic, ginkgo biloba and ginseng to ziziphus jujuba.

A significant number of plants and herbs originally provided natural sources for extremely valuable drugs that have now been identified, purified, evaluated for risk/benefit and eventually synthesised. These include digitalis (foxglove), aspirin (willow bark), morphine (poppy), quinine (cinchona bark) and antibiotics such as penicillin.

Definitions

Herbal remedies can conveniently be described as over-the-counter products, not subject to close regulation and obtainable from pharmacies and health food stores without specific diagnosis or prescription from a health professional. Around five million people in the UK use these products regularly.

Herbalism (herbal medicine) as an alternative medical therapy is defined as the use of plants or substances derived from them, in treating disease, usually by medical herbalists without an orthodox medical qualification. Before the relatively recent application of scientific method into diagnosis and therapeutics, traditional medicines were mostly herbal. More than 1,500 herbalists practise in the UK at present.

Origins

From the earliest times, whether by accident, through inspiration or in desperation, plants have not only provided food, cosmetics and embalming ointments, but also a plethora of easily available remedies for the maladies of mankind. The use of treatments based on plants developed across the world, usually with strong religious associations.

Traditional Chinese Herbal Medicine is based on Taoism and the principle of balancing chi, the universal life force or energy; Ayurvedic Indian medicine has strong Hindu associations involving chakras (energy centres); North American Indian traditional medicine was practised by Shamans and linked to spiritism.[1] South American civilisations (the Mayas, Aztecs and Incas) had closely interrelated herbal medicine and religious traditions. English herbal medicine, certainly when practised by Culpeper, the modem pioneer of Western herbalism, had strong astrological connections.

Archaeological findings of medicinal plants have been found in ancient Iraqi burial sites but the first written pharmacopoeia occurs in the Egyptian *Ebers Papyrus* c 1500 BC. The Indian Vedas (poems also c 1500 BC) listed plants with medicinal actions.[2]

Although the early use of herbal preparations was often associated with the mystical and magical, Hippocrates (460-377 BC) appears to have attempted a more scientific approach. Galen (130-200 AD), physician to the Emperor Aurelius, recommended herbal preparations to balance the four humours of the body.

A *Doctrine of Signatures* evolved which suggested that the medicinal value of certain herbs was divinely signalled by their resemblance to the conditions or organs they treated. Pilewort was used because its knobbly tubers resembled haemorrhoids. Similarly, the spotted pattern of Pulmonaria was suggestive of lung tissue and so was used for respiratory problems.[3]

The popularity of herbalists and herbal medicines continued to wax and wane in conflict with orthodox medicine. Nicholas Culpeper (1616-1654), described as an astrologer/physician, rebelled against the horrific medical practices of his day such as purging and blood letting. He fought for the acceptance of natural herbal medicines but emphasised astrological influences that he believed controlled them.[4] Culpeper produced his first pharmacopoeia or *Herbal* in 1652. The National Institute of Medical Herbalists (NIMH) was formed in 1864, an attempt to regulate British herbalists and their medicines.

Over the next 150 years scientific research and development moved rapidly, leading to more exact knowledge of therapeutics and evidence based medicine. There are now university courses in phytotherapy, leading to a BSc in herbal medicine. Yet there is still a wide gap between herbalism and orthodox therapeutics.

Medical checklist

Does it work?

This is extremely difficult to assess. Whilst many active chemical constituents can be identified, standardisation of unrefined medicines from plants is complicated, making scientific evaluation and clinical trials difficult. Little reliable scientific information exists although reference books are available to advise on efficacy and safety. The powerful placebo effect must always be considered.

There have been attempts to perform scientific investigations into some popular herbal products. The *Desktop Guide to Complementary and Alternative Medicine* reviewed investigations into 44 such products but did not find any convincing evidence of efficacy. For example, the popular evening primrose oil '…has not been established as an efficacious treatment for any condition'.[5] There is little evidence of significant benefit from echinacea.[6] Another 60 medicinal herbs are listed where there is insufficient evidence to make useful assessments. Recent investigation by the National Cancer Institute showed no evidence to support the suggested beneficial effect of viscum alba (mistletoe) for cancer.[7]

Is it safe?

It is commonly believed that all herbal medicines and natural substances used as remedies must inherently be safe. Brief references, however, as to the toxicity of some plants (for example, Deadly Nightshade, certain fungi and berries) show this to be a fallacy. Interactions with other drugs can also be harmful: 78 herbal products may react with heart medication, 58 with anti-coagulants, 35 with diabetic medication and 9 with oral contraceptives. Some products interfere with the accuracy of diagnostic tests and 64 drugs and food supplements require therapeutic monitoring, generally unavailable to non-medically qualified herbalists.[8]

A recent article in the *British Journal of General Practice* emphasised these safety concerns, particularly in relation to reactions between anticoagulants and herbal preparations.[9] Whilst there is some evidence that St John's Wort (hypericum) is reasonably effective in mild to moderate depression, there are increasing concerns about its safety, particularly in UK, Japan and Canada. It has now been banned in France.[10]

The results of a five-year survey by the Medical Toxicology Unit at Guy's & St Thomas' Hospitals highlighted possible links between many herbal products and adverse reactions. Earlier this year the World Health Organisation issued a warning against the unregulated and often unsafe use of alternative medicines including herbal medicines and food supplements.[11]

Christian checklist

Can it be recommended with integrity?

So far, investigation into the vast majority of these products has produced little evidence for their efficacy but has raised many safety concerns.

What are its roots?

History of the origins and present practices of the many varieties of herbal medicine indicate that they are rooted in and still associated with non-Christian belief systems.

Are there spiritual dangers?

Belief in the healing properties of plants, part of God's creation, is naturally attractive to Christians but we must not ignore experience and reason. A scientifically evaluated active ingredient of a plant is surely safer than the unrefined original preparation.

Whilst plants in themselves have no specific spiritual influence, the religious beliefs of the practitioner (particularly Traditional Chinese Medicine, Ayurvedic Medicine and New Age therapists) can be spiritually harmful.

Biblical references to herbs and spices almost exclusively relate to their use in food preparation, anointing and embalming rather than their healing properties.

Conclusion

Although many herbal preparations contain therapeutically active ingredients, these are too variable to be used with confidence, and harmful side effects are well documented. From a medical standpoint, the use of herbal medicine does not, in general, reach the high standards of clinical excellence now required. From a Christian perspective, the roots of the therapy and the therapist's belief system also raise serious concerns.

George Smith is a Dermatologist and former GP in Berkshire

Photo: PA

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David Short continues his series on following Jesus in the workplace

Serving, not being served

Jesus summed up God's demands on mankind in two key commands: 'Love the Lord your God with all your heart and with all your soul and with all your mind' and 'Love your neighbour as yourself'.[1] Jesus fulfilled both perfectly in making it his supreme objective to do the will of his Father and by adopting an attitude of service towards other people.

We need to view ourselves not only as servants of God, but as servants of our patients

Jesus did not insist on his rights as the unique Son of God: 'For even the Son of Man did not come to be served, but to serve.'[2] He undertook the menial task of washing his disciples' feet,[3] he made time for children, and was angry when his disciples tried to prevent them coming to him.[4] He did not seek to boost his importance by surrounding himself with a protective wall of intermediaries. He didn't play 'hard to get'. Rather, he made himself available to the outcasts of society; he touched lepers and welcomed prostitutes.

Jesus accepted interruptions as an integral part of God's plan and direction for his life.[5] He was often surrounded by patients and their friends clamouring for his attention.[6,7] Yet he responded generously to demands on his time and advocated 'going the second mile'.[8] His attitude was non-judgmental, saying to the woman caught in adultery, 'Neither do I condemn you. Go now and leave your life of sin.'[9] He was totally non-racist, making a Samaritan – a race despised by his audience - the hero of one of his most famous stories.[10]

The word that inevitably comes to mind when we read about Jesus' contact with the sick and needy is *compassion*. Again and again, Jesus is described as being moved by compassion towards their suffering: 'Jesus had compassion on them (two blind men) and touched their eyes';[11] 'When Jesus landed and saw a large crowd, he had compassion on them and healed their sick';[12] 'When he saw the crowds, he had compassion on them, because they were harassed and helpless, like sheep without a shepherd.'[13] He was concerned for peoples' basic physical needs, such as hunger.[14]

The word 'compassion' is translated in different versions of the Gospels as 'filled with pity', 'felt sorry for' and 'deeply moved'. Jesus' compassion went beyond mere sympathy to empathy; he entered into the feelings of those who were suffering. His compassion led to action: he healed the sick, fed the hungry and comforted the bereaved, not merely with words but by removing the cause of their sorrow, even if it was death. One of the specific ways in which Jesus demonstrated his compassion was by *the act of touching* - particularly those with leprosy,[15] whom others would avoid. His touch conveyed healing, but it also said, 'I really care about you.'

Cultivating the servant attitude

Jesus said, 'Whoever wants to become great among you must be your servant, and whoever wants to be first must be slave of all.'[16] We have, for the most part, an irreducible amount of work to do, and we are constantly under pressure; so we cannot afford to have people wasting our time. But we should try more often to view ourselves not only as servants of God but as servants of our patients.[17] We need to ask ourselves, 'Am I significantly different from my non-Christian colleagues? Is being given due respect as a doctor, nurse or medical technician important to me, or is it an avenue of true ministry to others?' Our Lord's non-judgmental attitude carries a powerful challenge for us. Doctors see many patients toward whom it is difficult to be sympathetic; patients whose life-styles have contributed to their condition through alcoholic excess, drug abuse, smoking or sexual promiscuity. But they are people in need, and our attitude toward them should not be one of condemnation but of compassion.[18]

A servant attitude is the foundation of all effective witness. Dr William Emslie used to tell the story of a nurse who was sent by the ward sister to respond to a patient's bell. The old lady wanted a bedpan. The nurse attended to her needs and was just pulling back the curtains round the bed when the patient stopped her: 'Are you a Christian, nurse?' 'Yes' replied the surprised nurse, 'but how did you know?' 'I just thought it by the way you gave me that bed pan,' was the reply.

I often consider the words of an unknown author: 'I shall pass through this world but once. Any good, therefore, that I can do or any kindness that I can show to any human being, let me do it now. Let me not defer or neglect it, for I shall not pass this way again.' When we recall what the holy Son of God patiently endured, it makes us ashamed that we think so much of the petty injuries that we may have suffered.

'When I survey the wondrous Cross
On which the Prince of Glory died,
My richest gain I count but loss,
And pour contempt on all my pride.'

David Short is Emeritus Professor of Medicine in Aberdeen

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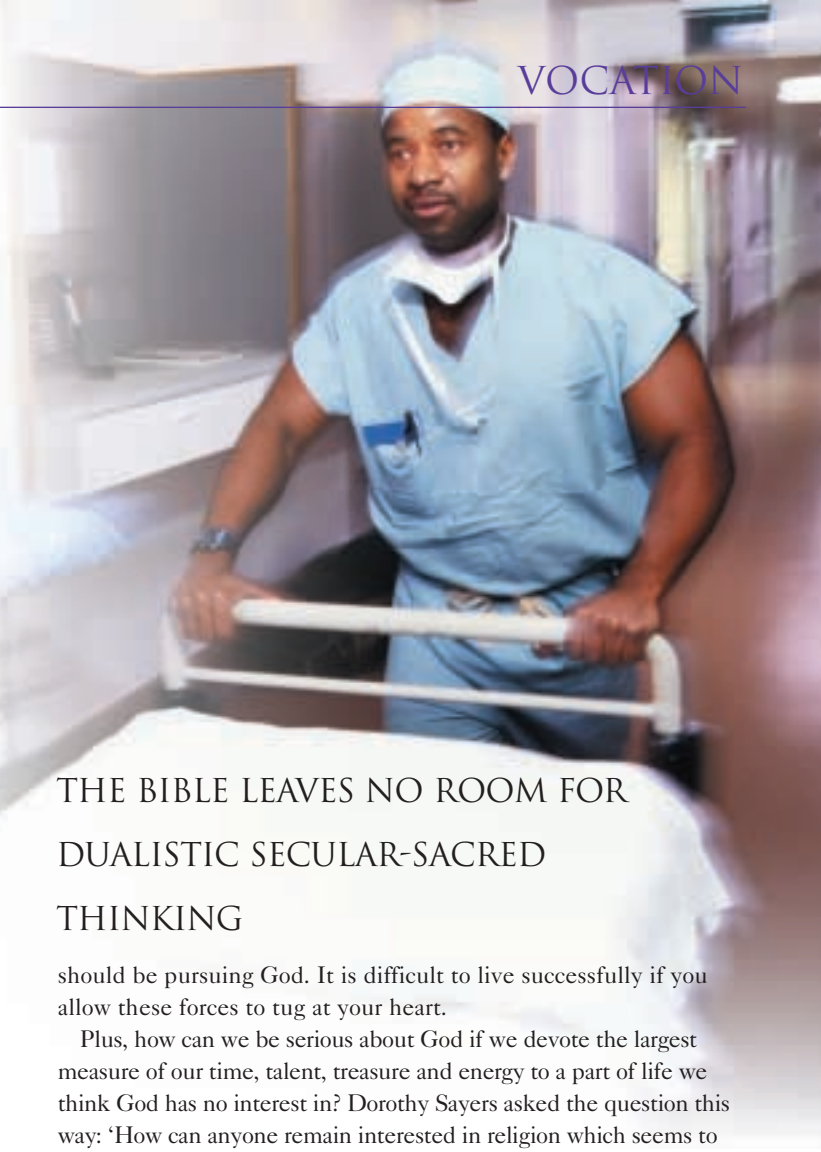
Walt Larimore gives a salutary warning

EMPLOYED BY GOD



As a young man, Tom started a business that grew into a successful enterprise. His competence and character meshed, resulting in an outstanding reputation in his community. Over several years, he saw employees and customers begin a personal relationship with God and grow in their faith. Tom didn't anticipate facing a decision familiar to some doctors.

One morning his pastor inquired, 'Tom, have you ever considered really giving your life to God - working full time for the Lord?' Tom felt confused. 'Pastor,' he explained, 'I feel that what I'm doing now is a form of full-time work for the Lord.' The pastor smiled. 'Tom, there's no doubt that God has used you in amazing ways; but the work you're in is secular. I think God is calling you to consider becoming involved in something higher.'

Eventually, Tom sold his business and accepted an administrative role in a mission organisation. He was in that role for two years when he became my patient and was displaying an array of physical problems. As I got to know Tom and studied the results of his medical tests, I became convinced that he was suffering from anxiety and depression.

One day I asked, 'Tom, do you think you're doing what God wants you to do?' His eyes filled with tears. 'I think God had me right where he wanted me - in my business in California.' He paused and continued, 'Do you think there's a difference between sacred work and secular work?'

Faulty thinking

The mistaken concept that some people do sacred work for God while the rest of humanity lives by doing secular work is an ancient one. In Western thought, this idea developed from Greek philosophy, which taught that any kind of menial work with physical materials was beneath the gods or men who had the means to choose how they spent their time. Slaves did the menial work, while those with means spent time in pursuits of the mind: religion or philosophy.

Confucius, the father of much of Eastern philosophy, taught virtually the same thing. This mistaken notion has plagued the church with the conclusion that 'worldly activities' are viewed as a major distraction to a person's spiritual development. Accepting the secular-sacred split invariably leads Christians in the workplace to feel caught between the demands of two worlds. On the one hand, you sense the need to be engaged in your work. On the other, a worldview tells you that you're wasting your time and

THE BIBLE LEAVES NO ROOM FOR DUALISTIC SECULAR-SACRED THINKING

should be pursuing God. It is difficult to live successfully if you allow these forces to tug at your heart.

Plus, how can we be serious about God if we devote the largest measure of our time, talent, treasure and energy to a part of life we think God has no interest in? Dorothy Sayers asked the question this way: 'How can anyone remain interested in religion which seems to have no concern with nine-tenths of his life?'

What the Bible teaches

The biblical worldview leaves no room for secular-sacred, dualistic thinking. Unlike the aloof gods of ancient thought, the God of the Bible is actively involved in his world. He engaged in creation. Note that the biblical words used to describe God's work of creation are physical and earthy: 'When the Lord God made the earth and the heavens ... the Lord God formed man and breathed into his nostrils the breath of life, and the man became a living being. Now the Lord God had planted a garden in the east, in Eden; and there he put the man he had formed'. (Genesis 2:4-8)

The apostle Paul reiterates God's claim over the workplace. In Paul's day, slaves comprised the bulk of the workforce. Rather than using the terms employee and employer, as we use today, he addressed slaves and masters. 'Slaves, obey your earthly masters in everything; and do it, not only when their eye is on you and to win their favour, but with sincerity of heart and reverence for the Lord. Whatever you do, work at it with all your heart, as working for the Lord, not for men, since you know that you will receive an inheritance from the Lord as a reward. It is the Lord Christ you are serving'. (Colossians 3:22-24)

If you are living with a divided secular-sacred worldview, then you'll tend to make one of two choices: you will separate yourself as much as possible from 'worldly' things; or you will forget God and devote yourself to the pursuit of success as the world defines it. Trying to live in both worlds can be crippling. No matter what your job may be, God can and will use you when you do it with honour and integrity.

Walt Larimore is a former family physician and author of the Saline Solution

Michael Harper offers practical advice to doctors who know their limits

Building a SPIRITUAL TEAM

It would be so much easier to care for our patients if we were omnipotent. Omnipresence would be useful too! We are all too constrained by the limitations of our giftedness and time.

Most of us are too busy. We face multitudes of demands, usually all at once, and they are all-encompassing. We are tempted to put a little notice on our surgery door 'Only come in if you are worse than me'. Nonetheless we often feel that we are failing. We are not getting to the root of problems and all too often our patients' needs are not being met. Indeed, we feel that half of what we do is akin to a confidence trick.

Think of a situation: a difficult patient, who causes you untold heartache and is profoundly opposed to your faith, needs a biopsy. Today he turns up in your surgery for the result. You are running late. He arrives early. You still have three patients left to see when he comes in for his 11am appointment – at 12.15. But he's a different man and when you gently tell him that it's bad news, tears fill his eyes and he tells you he feared as much. He doesn't think he's much good, he says, and then comes the shocker; he says he 'thinks he'll need God for this one', and asks if you can help. What are your options?

There are times to gather a situation and ensure that support is made available. This is one such situation. So five minutes must be his. It helps to affirm his perspective: 'Yes, Jim, I rather think you will. Many people find that in these circumstances.' Make it clear that you're there for him. But are you the person to take things forward? Do you have time? Or this a job for a team?

'Look, Jim, we have a chaplain who works with us, and I'd like you to see him – but I want to keep in touch with how things are going both with the consultant and with him. What do you say? You'll see him. Good. I think it will really help. Can I touch base with you in a fortnight? And, Jim, I'll need to tell the chaplain a bit about what's happened, and he may wish to talk with me; is it OK for us to hold this in confidence within the team? OK. I'll give you a form to sign to that end – perhaps you could leave it with the receptionist. Would you like me to say a brief prayer with you now? No? Sure, of course. But I'll keep praying for you anyway.'

Have you got a team? How can you gather one? Identify what the needs of the patients are. They are diverse, but many of us can see what is missing, what problems we're not dealing with properly. But where does one start?

Knowing the needs of the patients will help. Then one needs to be clear on the care required to reach the need. And finally one needs to take a long, hard look at one's own skills, abilities and resources. Where is the shortfall greatest? So a working plan develops.

Have you got a team? How can you gather one?

Ideally the team will have within it a Christian counsellor, a chaplain with pastoral and evangelism gifting, doctor, nurse, possibly social worker, possibly someone able to lead creative therapy – but the leader must be (you think I'm going to say the doctor) Jesus. There are things to decide; will the team be volunteer, or paid? If the latter, where will the money come from? Will the PCT support it? Will they be contracted (probably wise), and how will you relate with the local churches? Other questions will arise but the team can be built.

Unprofessional and incompetent do-gooders, no matter how enthusiastic, need to be kept off the team.

Having a team doesn't mean losing involvement. 'Look, I really want to keep a handle on how things go' we might say to our patient 'so I'd like to see you again in a couple of weeks'. Your team is doing so much of the work; you're leading it.

Team members need to know what to do if they are getting out of their depth; so there needs to be an emergency protocol. It brings safety, and makes people feel covered and cared for. It also reassures you – you don't want to have to pick up the pieces of a disaster that you never knew was going on.

There will be times when you can't use the team. Something crops up and it's inappropriate to ask a patient to go and make an appointment with someone else. Like in A&E, there is a need to assess the emergency and react appropriately. But emergencies are much less common than the routine.

Finally, there are different ways of using a team. One friend of mine in General Practice invites patients who the Lord points out to him to consider applying to be seen by the whole-person team; those patients see counsellor, doctor and chaplain for extended appointments, and a whole of life diagnosis and treatment plan is worked out with the patient. Time consuming?

Yes. But it's only for those who are seen to have particular hunger for real change, and exciting things can happen … we know.

Michael Harper is CEO of Burrswood Christian Hospital and Place of Healing, near Tunbridge Wells (www.burrswood.org)

how i'd handle it!

Helen Johnson and **Rachael Pickering** resuscitate a stressed on call junior

Tired and stressed

Alex's night is not going well. Whilst clerking down in A&E, a ward he's only just left calls him, wanting an opioid prescription. He runs back up. Bleep: the lab have thrown away a sample he spent an hour extracting from a violent, demented lady, all because he mis-spelt her name! Bleep, bleep: someone else wants to self-discharge! Bleep, bleep, bleep: when will he be returning to A&E?! Tired, stressed and hungry, he loses his temper and snaps down the phone at the A&E nurse. He shouldn't be behaving like this but…

Pit stop!

We both remember nights like this all too well! Alex is over-worked and under-rested but his bleep is firing on all cylinders! Every racing driver needs regular pit stops. Both car and driver benefit in the long-run. In the race that is a medical on call, a brief time-out can improve a doctor's performance, so benefiting everyone.[1] Even the Great Healer took his team away to eat and rest when things got too hectic.[2] So, Alex could lock himself in the toilet for five minutes! NHS loos are well-recognised safety valves: bang your head on the door, count slowly to ten or even have a good cry. Bleeps can usually go unanswered for five minutes.

Resuscitation

Even the prophet Elijah snapped! Tired, stressed and hungry, he wanted to die. God provided food, time out and rest…before sending him on to his next assignment.[3] Once Alex has regained emotional control, he should attend to his physical and spiritual survival. What about some of the following?.. Shoot arrow prayers: 'Lord God help me!'[4] Read a pocket Bible or *Doctor's Life Support* to regain perspective.[5] Recall a timely verse: '…neither height nor depth, nor anything else in all creation, will be able to separate us from the love of God…'[6] A quick wash and drink are excellent pick-me-ups. Alex's next destination should probably be the nearest vending machine.

A cunning plan

Munching on a Mars Bar (if there's nothing healthier on offer), Alex could make a cunning plan.

1. Damage limitation is the smart option. No-one likes being snapped at but most nurses are amazingly forgiving. A&E nurses are particularly flexible and helpful. A sincere telephoned apology could do wonders for the rest of Alex's night in A&E! He could even ask her to apologise on his behalf to his waiting patient.

2. Prioritisation is worth learning. Try listing bleeped requests as 'urgent', 'this shift' or 'next shift'. Let people know where they stand, for example: 'Thanks for letting me know about this. I'll get onto it by the end of the shift'. There is nothing non-Christian about reminding others that you only have one pair of hands and legs! If people argue with your prioritising, turn to…

3. Negotiation, the art of making everyone happy. Alex could have given that ward nurse three options: accept a non-opioid verbal, do nothing until he could leave his higher-priority patient, or send an HCA down with the drug chart. This last option would have satisfied him, the nurse and the patient!

4. Delegation is wonderful…in theory at least. Alex's team should be brought in to help, and jobs reallocated where possible. Be clear about which team member you're asking to do what and that (s)he is proficient in the necessary skills.

'But I'm a Christian…'

Irritable sleep-deprived Christian medics often feel guilty.[7] Yet our bodies are not meant to function without sleep or nourishment. An irritable remark certainly isn't a positive witness, but a sincere apology from a tired medic is a rare thing and people do sit up and notice. If you're usually irritable when sleep-deprived, it may be worth apologising in advance.

Spare time?

Alex should look at his time off. Sleep, sensible meals and time with God are absolute musts.[8] A plethora of Christian meetings (however worthy) is unlikely to refresh, but a relationship with God should take priority. This does not necessarily mean a regular quiet time or weekly church attendance.[9] Regular chats with a 'soul friend' may be better than dozing through Bible study groups![10] Calling into the hospital chapel can be helpful. CMF have a mentoring system and regional juniors groups.[11]

Looking to the future

The memory of 1:2 on calls without protected sleep may be dimming for most of us but the NHS still works its on call doctors hard! The Hospital at Night policy, rolling out across the NHS, should help further.[12] Alex may find such awful nights becoming rarer as he gains experience. Still, even seasoned juniors have the occasional nightmare shift. If his problems continue, Alex should confide in his tutor. He could also contact the *Doctors' Support Network*, and see his GP;[13] he may be at risk of burnout and depression.

Be thou my vision, oh Lord of my heart… be Thou my best thought in the day and the night, both waking and sleeping, Thy presence my light. (Ancient Irish Hymn)

Helen Johnson is a part-time GP locum in the Scottish Borders and Rachael Pickering is a GP registrar in London

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What would you have done? Is there an issue you'd like to discuss? Email: rachael.pickering@cmf.org.uk

EUTYCHUS

Abortion debate extends to the pill

A growing number of doctors and pharmacists in the US are refusing to dispense the oral contraceptive pill on the grounds that it sometimes allows fertilisation but not implantation, and is thereby potentially abortifacient. The state of Wisconsin passed a bill to allow pharmacists to refuse to dispense drugs on moral grounds, but the governor vetoed the bill. One pharmacist has already lost his job after refusing to dispense an oral contraceptive. (*BBC News Website* 2003; 13 September)

Dutch paediatricians and euthanasia

The Dutch Paediatric Society is urging that decisions to hasten the death of babies with severe multiple handicaps should not be reported directly to the coroner's office, as currently required under Dutch law. Rather they suggest committees of doctors and lawyers should receive the reports, as this approach would be less threatening and would encourage more frequent reporting of cases, achieving greater transparency of what is a largely secretive practice. The Dutch law permitting 'voluntary' euthanasia does not cover mercy killing of any patient unable to express their wishes and yet research indicates that in about 100 cases each year paediatricians make decisions that result in the death of severely disabled babies. (*British Medical Journal* 2004; 329:591)

Abu-Ghraib inmates tortured by doctors

A damning report in the *Lancet* has added fuel to the scandal about Abu-Ghraib prison in Iraq, uncovering evidence that US medical personnel complied with demands for prisoners to be tortured. Professor Steven Miles of the University of Minnesota cites reports about inmates being subject to burns, shocks, asphyxiation and other physical methods of interrogation. Medical care of detainees was insufficient in many cases and failure to report injuries or deaths properly or abetting abusive guards by doctors also occurred. The Bush administration maintains that its armed forces will uphold the principles of the Geneva Convention wherever possible. In a separate editorial in the same issue of the *Lancet*, the journal urges any doctors who have been involved in such incidents to come clean, and to give a complete account of events at military compounds where terrorist prisoners are being held. (*Lancet* 2004; 364:9435, *BBC News Website* 2004; 20 August)

Prevention is better than cure

The proportion of babies born with neural tube anomalies in Newfoundland dropped by 78% after the Canadian government introduced a policy of having folic acid added to flour, cornmeal and pasta (*BMC Pregnancy and Childbirth;* 2004, 4:20) The UK is yet to implement a policy to reduce the incidence of spina bifida by fortifying foodstuffs: instead the majority of babies with spina bifida are aborted.

Abstinence pledges work

A study released by the National Longitudinal Study of Adolescent Health in the US claims that teenagers who make abstinence pledges are less likely to be sexually active whilst at school or to engage in risky sexual activity. They are also less than half as likely to experience pregnancy as those who do not make a pledge and have half the number of sexual partners on average. Differences in behaviour were found to be similar even when race, socio-economic background and religion were factored in. (*The Heritage Foundation*, 21 September quoted in *SPUC Digest*)

IPPF and UNFPA push for more abortion

International Planned Parenthood Federation (IPPF) has released a 10-year plan to establish a worldwide right to abortion on demand. IPPF's Strategic Framework 2005-2015 lists a number of strategies to achieve its goal of 'a universal recognition of a woman's right to choose and have access to safe abortion'. It also aims to 'analyse opposition messages and tactics and formulate messages and strategies that anticipate, respond and counteract them'. In a similar vein, the UN Population Fund has released its annual State of the World Population report which claims that access to abortion and contraception is 'an essential condition for meeting the UN's Millennium Development Goals to reduce global poverty by 2015'. (*www.unfpa.org* 2004; 15 September, *www.ippf.org* 2004; 10 September)

Most Britons would help others die

A poll conducted by NOP World on behalf of the Voluntary Euthanasia Society (VES) indicates that 47% of Britons would help a loved one die if they were suffering unbearably. Of the 790 adults asked 82% supported a change in the law, and 51% would want 'help to die' if they were terminally ill and suffering unbearably. Deborah Annetts, chief executive of the VES said, 'By saying they would be prepared to break the law if a terminally ill loved one asked them to, the public are sending a clear message to our law-makers that the law needs reform'. (*The Guardian* 2004; 9 September)

Communion conundrums for US Catholics

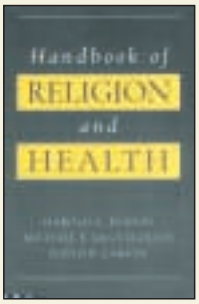
US presidential candidate John Kerry has been outspoken about his pro-choice position, which stands in stark contrast to that of George W Bush. Many US Catholics argue that a 'true' Catholic cannot vote pro-abortion, whilst others believe their voting decision can rest upon more than just pro-life issues. A private memo by Cardinal Joseph Ratzinger is causing some confusion. He has concluded that a politician must be denied communion if, after consistent teaching by the bishop, he persists in supporting abortion. However, he also stated that although any vote for a pro-abortion politician is cooperation in 'evil', such voters may still receive communion if there are 'proportionate' reasons for their votes. The debate about what such 'proportionate' reasons may be continues. (*C-FAM bulletins* 2004)

Furore over Italian fertility laws

Italy's *Medically Assisted Reproduction Law*, which came into effect in March, may prove unworkable. The new law aims to give the embryo and the mother equal rights. Only stable, heterosexual couples of childbearing age can seek infertility treatment and can create only three embryos in one cycle of treatment, none of which can be genetically tested, and all of which must be implanted at once. Under the law one woman had to have three IVF embryos transferred to her womb at once, and later undergo selective termination because her life was at risk. Italians are travelling to neighbouring countries for infertility treatment and the tiny republic of San Marino is opening a private clinic just across the border in order to cash in on this development. Reproductive medicine specialists and women's rights groups in Europe have criticised the legislation, which is supported by the Catholic Church. A parliamentary committee is currently reviewing the law. By contrast, the HFEA's UK guidelines stipulate that only two embryos should be placed in the womb at any one time because of the risk of multiple pregnancy (*British Medical Journal* 2004; 329:71, *Independent* 2004; 15 September)

BOOKS

Handbook of religion and health



Koenig, McCullough and Larson
Oxford University Press
2001
£52.50 Hb 700 pp
ISBN 0195118669

Is religious belief bad for your health? Many *Triple Helix* readers may be interested in the answer to this question, and happily it is a question that can be answered from the results of a large volume of good research. The evidence for the effects of religious belief, or spirituality, upon health and disease is collected in this book. At over 700 pages and weighing 1.5kg, this volume will probably prove to be a classic.

The *Handbook of Religion and Health* is a superb example of American thoroughness and completeness. In presenting the evidence for the effect of religion on health, disease and recovery from illness, it reviews and discusses research that has examined the relationships between the patient's religious beliefs and a variety of mental and physical health conditions. It covers the whole of medicine and is based on 1,200 research studies and 400 reviews. These papers from the world literature are collected, summarised and assessed according to their scientific reliability and validity. The two biggest sections of the book, each ten chapters long, are *Research on Religion and Mental Health* and *Research on Religion and Physical Disorders*.

Does the patient's religious belief have any relevance for their health, prognosis and response to treatment? Is this true for both physical and mental illnesses? These are questions, amongst others, to which the *Handbook of Religion and Health* seeks to give answers. Psychiatry and mental health receive comprehensive cover and the authors have been fair-minded, including all relevant studies whether the result are positive or negative.

Under *Research and Mental Health* are discussed: religion and well-being, depression, suicide, anxiety disorders, schizophrenia and other psychoses, alcohol and drug use, delinquency, marital instability, personality, and a summarising chapter on understanding religion's effects upon mental health. The authors are extremely cautious in drawing conclusions but the results are overwhelming. If the factor being studied were something less emotive than faith and religion, the media would have taken these findings up as front-page news. To quote: 'In the majority of studies, religious involvement is correlated with:

- Well-being, happiness and life satisfaction
- Hope and optimism
- Purpose and meaning in life
- Higher self-esteem
- Adaptation to bereavement
- Greater social support and less loneliness
- Lower rates of depression and faster recovery from depression
- Lower rates of suicide and fewer positive attitudes towards suicide
- Less anxiety
- Less psychosis and fewer psychotic tendencies
- Lower rates of alcohol and drug use and abuse
- Less delinquency and criminal activity
- Greater marital stability and satisfaction…

We concluded that, for the vast majority of people, the apparent benefit of devout religious belief and practice probably outweigh the risks'.

Correlations between religious belief and greater well-being 'typically equal or exceed correlations between well-being and other psychosocial variables, such as social support'. That is a massive assertion, comprehensively attested to by a large volume of evidence. In George Brown's studies on the social origins of depression,[1] various types of social support were the most powerful protective factors against depression.

The factors that correlate with religious belief and practice and tend towards better health outcome are all measured and assessed epidemiologically. To give some examples from those listed above, 80% or more of the studies reported an association between 'religiousness' and greater hope or optimism about the future. 15 out of 16 studies reported a statistically significant association between 'greater religious involvement' and a greater sense of purpose or meaning in life. 19 out of 20 studies reported at least one statistically significant relationship between a religious variable and greater social support. Of 93 cross-sectional or prospective studies of the relationship between religious involvement and depression, 60 (65%) reported a significant positive relationship between a measure of religious involvement and lower rates of depression; 13 studies reported no association; 4 reported greater depression among the more religious; and 16 studies gave mixed findings. And so on, with all the 13 factors, religious belief proved beneficial in more than 80% of studies. This is despite very few of these studies having been initially designed to examine the effect of religious involvement on health.

The authors develop a model for how and why religious belief and practice might influence mental health. There are direct beneficial effects upon mental health, such as better cognitive appraisal and coping behaviour in response to stressful life experiences. There are also indirect effects, such as developmental factors and even genetic and biological factors.

Most of the studies were carried out in the USA and are based upon Christian or Jewish belief. There is some work from other countries and other religions, and the results are the same. In this review I have only commented upon the mental health studies; the findings for physical illness point just as clearly to the benefits of religion for patients. It is a great pity that this important book is not better known and noticed but I suppose our secular and largely anti-Christian press has a vested interest in not acknowledging it. Emphatically, religious belief is not bad but very good for your mental and physical health.

Andrew Sims is Emeritus Professor of Psychiatry in Leeds

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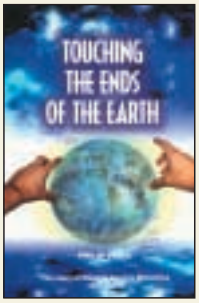
Touching the ends of the Earth

The story of Medical Service Ministries 1903 – 2003



Phillip Price
MSM 2003
£9.99 Pb 168 pp
ISBN 0 95090 973 4

Founded in 1903 as the Missionary School of Medicine, this book gives a history of the

BOOKS

work of the organisation over the past 100 years. Its title comes from words spoken by one of its early Presidents to students each year, as they were commissioned.

The school was established to provide a basic medical training for missionaries from a non medical background. Students were required to agree never to assume or accept the title of doctor or to practise in the UK. The threefold aims of the school were: to enable missionaries to look after their own health; to enable them to nurse and treat one another on the mission field when ill and far from medical aid; and to enable them to start dispensaries for the local people, so as to open a door for the Gospel.

Over the years, many hundreds of missionaries attended their courses. The early courses lasted nine months and were residential. Linked to the Royal Homeopathic Hospital and always including a grounding in Homeopathic Medicine, the school came in for some criticism from evangelical circles. It would seem that many of its students went on to do much more than just 'dispensary' work with some involved in cataract and other operative surgery. This is a testament, perhaps, to the practical nature of the teaching that was given and the boldness of pioneers when no alternative medical help was available.

Following the Second World War and the School's 50th Jubilee, expectations were high but student numbers began to decline. Shorter courses were introduced and in the 1970s, students were allowed to attend on a part time basis. A change of name and direction followed, and a Scholarship Fund was launched in 1993. The school finally closed its doors in 1996. MSM functions today as a continuing resource to Medical Mission. Grants are offered to Christian workers and accredited missionaries seeking further training in the area of personal health and community care.

The book is full of stories and personal anecdotes from past students and staff, in addition to details of the milestones in the organisation's history. It provides a fitting testament to those who pioneered and carried through a much needed and appreciated work in preparing missionaries for overseas assignments in the days when many were going to isolated areas where there was no doctor or other medical help available.

Peter Armon is CMF Overseas Support Secretary

When life hurts

Philip Yancey
Hodder 2004
£5.99 Hb 59pp
ISBN 0 340 8629 0

This little book, which takes less than an hour to read, is designed to help those who are distressed by questions about suffering and are in need of comfort. Yancey, well-known for his popular book *What's so Amazing about Grace?*, looks at questions like 'Why does God allow the innocent to suffer?' and 'How can I be sure God cares for me personally?' Drawing particularly from the Psalms, Job and the Gospel accounts of Jesus' suffering, and using illustrations from his personal experience, the author gently opens a way back to God for the questioning sufferer.

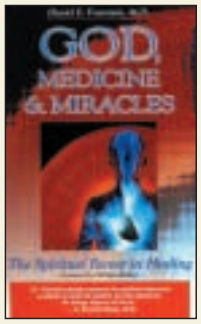
In the final chapter, we are inspired and challenged by the true story of a doubting twenty-six year old woman who suffered terribly from a fatal illness, but finally encountered the love of Christ through the remarkable caring of Christian neighbours in her last few weeks.

It may well be worthwhile getting a copy and keeping it on your bookshelf to lend to anyone you know personally for whom wrestling with suffering becomes an issue. It could be particularly useful as something to leave in the hands of someone with whom you have already had a conversation. I think the style of this book makes it more suitable for someone with a Christian background who is in a place of struggle, or someone who wants to know what the Bible says, rather than for the complete outsider.

Kevin Vaughan is CMF Associate General Secretary

God, medicine and miracles

The spiritual factor in healing



Daniel E Fountain MD
Shaw Books 2000
£7.25 Pb 272 pp
ISBN 0 87788 321 1

Dan Fountain is a member of the ICMDA and a long-term missionary medic who worked in the Democratic Republic of Congo. He has received numerous awards for his contribution to Community Health and is a firm advocate of whole person healthcare.

This is not a book about 'faith healing' but about how Christian faith contributes to human wholeness. Early on, he distinguishes between disease, which he defines as 'a particular condition that upsets a person's well-functioning equilibrium', and illness which 'has to do with the person and the uncomfortable disturbing things that happen to and within that person when a disease is present'. He goes on to draw a line between cure, which relates to disease, and healing which relates to illness.

These distinctions are not just those of a pedantic physician but essential to our

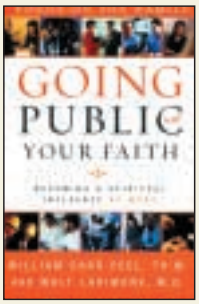
understanding of patients' needs and our response to their situation. Much emphasis is placed on the role of the Christian counsellor as a member of the healing team, the need to listen (really listen) to our patients and the place of a spiritual understanding of what is going on in the patient's life.

He deals with questions of sin, the chemistry of emotions and their effects on the immune system and our response to disease. Consideration is given to the nature of addiction, sexuality and depression. He illustrates the power of forgiveness and confession both from personal experience and from scripture. Finally, he explores the resources that Christians have at their disposal as they face up to the challenge of ill health. Do we see disease as a tragedy or a challenge? Our perspective will influence the outcome. In his final chapter, he looks squarely at issues of death and considers ways of finding hope in dark places. There is a useful appendix on a team approach to healing. This is a challenging and provocative yet helpful book. It is well worth reading.

Peter Armon is CMF Overseas Support Secretary

Going public with your faith

Becoming a spiritual influence at work



William Carr Peel THM and Walt Larimore MD
Zondervan 2003
£9.99 Pb 215
ISBN 0 310 24609 1

I have heard it said that there is one thing that Christians and non-Christians have in common: they both hate evangelism. At first it might seem a strange thing to say, but on reflection many of us will agree with this. Have *you* ever felt uncomfortable about how to witness, or felt that people are trying to get you involved in evangelistic efforts that make you cringe inwardly, but you daren't say anything for fear of being considered a second class Christian? If so, there is hope for you in this book.

From a biblical perspective and illustrated with many stories from their own and others' experience, Bill Peel (pastor and theologian) and Walt Larimore (a doctor now working with 'Focus on the Family') demonstrate that evangelism is a process, not an event. They go on to show that not only can we get involved without feeling like a square peg in a round hole, but that there is an essential role for each one of us. The church's goal should not only be to get the community into church but to get the church into the community and that's where the ordinary working day comes in.

Taking a farming illustration that Jesus used, they help us to see that a prolonged but essential period of cultivating and then sowing may be needed, before the season for harvesting comes in a person's life. Little by little as we get to know people in our daily work and as we pray for them, we can see what God is doing in their lives and be able to help them to take the next step towards a relationship with God.

This book is readable, full of biblical teaching, and will encourage you to believe that God can use you. Much of its practical application for Christian doctors and healthcare workers is found in the *Saline Solution* conferences that CMF is taking around Britain, but *Going Public with your Faith* is for all Christians in every walk of life and I plan to give several copies away as presents this year.

Kevin Vaughan is CMF Associate General Secretary

War against the weak

Eugenics and America's campaign to create a master race

Edwin Black
Four Walls Eight Windows: New York/London 2003
£10.99 Pb 552pp
ISBN 1 56858 321 4

Edwin Black painstakingly traces the development of eugenic ideology, from its early days in British academia to the take over by well-funded American institutions, and its later disgrace in Hitler's Third Reich. Eugenic ideals about the superior white 'Nordic' race were so unquestioningly accepted in governmental and 'society' circles, that I was frequently astounded. The strong relationship forged between American and German eugenicists, and the jealous respect held for Nazi scientists as they enacted eugenic policies also appals.

At some 550 pages of dense text this does not make easy reading, but Black's journalistic talent and eye for a good angle have resulted in a very engaging book. The content is expansive, with 'More than fifty researchers in fifteen countries at more than one hundred institutions, some 50,000 documents, together with hundreds of pages of translation', making an impressive case against eugenics, but also causing some repetition. This is partly due to the book's construction, which is not purely chronological. Rather, the author traces eugenic trends through the pre-war years from a variety of perspectives. While this makes the book more accessible, allowing a personal angle and character development, it may not appeal to those who prefer a clear time-line of events.

For those who like modern history and investigations of the human condition, it's a must-read. It makes an interesting addition to other explorations of the development and decline of Nazi Germany. There are also lessons: the thinking behind the concentration camps didn't solely come from the mind of one dictator. Rather, a philosophy under discussion between academics and physicians in Europe and America was played out to extreme ends in one country. Perhaps we should be more careful about what we are prepared to discuss within the confines of academic walls.

Current proponents of genetic developments or euthanasia are keen to distance themselves from the old eugenics movement. In the final chapters Black looks to the future of 'newgenics' - the explosion of genetic science that enables us to pursue certain eugenic goals under a more sanitised banner. Whilst supporting the health benefits on offer, he warns that we need to guard against discrimination if we are to avoid the same trap that the first eugenicists fell into.

Jacky Engel is CMF Publications and Research Assistant

OPPORTUNITIES ABROAD

For those looking for a change or a challenge or with a call to use their skills overseas in the short or longer term. Many other opportunities are listed on the vacancies page at www.healthserve.org - these lists are regularly updated. Agencies offering short term 'experience' trips can also be found on the Healthserve Pages on the site. The 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.

Cameroon

Action Partners is looking for a **General Duties Medical Officer** (able to provide simple surgical cover and to cope with administration as required) and an **Ophthalmologist**, to be based at **Meskine Hospital**, both on a two year contract. Both would be involved in training local staff. A **General Surgeon** is also needed for a three months (preferably longer). Self funding but accommodation provided. Proficiency in French preferable.

Contact: Personnel Dept, Action Partners, Bawtry Hall, Bawtry, Doncaster DN10 6JH
Email: *info@actionpartners.org.uk*
Web: *www.actionpartners.org.uk*

China

Jian Hua Foundation requires a **Director of Medical Services**. The role will need leadership and organisational skills together with experience in business and people management. A sound working knowledge of public health and current challenges facing the Chinese medical system is preferred together with a sufficient experience to command respect in academic circles both within and outside China. Fluency in English and Mandarin is required and a commitment to a minimum of five years with the possibility of an extension to ten years.

Contact: Martin Thorman, Director of Personnel and Administration, The Jian Hua Foundation, PO Box 71675, Kowloon CPO, Hong Kong
Tel: +852 2336 5312 Fax: +852 2337 2965
Email: *martin.thorman@jhf-hk.org*
Web: *www.jhf-hk.org*

India

BMS World Mission is sending a multidisciplinary medical team to the Christian Hospital at Chandraghona in Bangladesh from 12-27 February 2005 (possibly another in Autumn 2005). **General Surgeons, Anaesthetists, Orthopaedic, Ophthalmic & Plastic Surgeons, Obstetricians, Gynaecologists** are needed. Self funding. Cost is likely to be approximately £1,000 per person

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

Malawi

Beit Trust Cure International Hospital requires an **Orthopaedic Surgeon** with a vision for mission, and a commitment to training, to join a team of one FT and 2 PT surgeons. Possible option of trauma commitment in a local government hospital. Experience in paediatric orthopaedics and a willingness to undertake private work to generate income preferred. Ideally long term but short term considered

Contact: Mr Peter Kyalo
Email: *kyalo@malawi.n*

Nepal

International Nepal Fellowship (INF) requires a **Plastic and Orthopaedic Surgeon**. A broad range of mostly severe and late cases will be seen. The work will include training staff in new techniques and upgrading their knowledge together with involvement in audit and research activities. Self funding.

Contact: Emily Platt, Recruitment Officer, INF, PO Box 5, Pokhara, Nepal Tel: +977 (0)61 520111 (ext 117) Fax: +977 (0)61 520430
Email: *recruit@inf.org.np* Web: *www.inf.org*

Team Nepal needs doctors, in specialty training grades or fully trained, to work in three rural hospitals (20-50 beds). These posts provide a much needed service to poor rural communities and offer excellent training opportunities for those specialising in **O&G, General Surgery, Medicine or Paediatrics**. Contracts of varying length are available from between 1 - 12 months or even longer.

Contact: Dr Ted MacKinney at *mackinney@bigfoot.com*

Nigeria

Action Partners require doctors at Vom Hospital, to be involved in assisting the upgrading and restructuring of the Hospital with a new focus on **Paediatrics, Obs & Gynae and Surgery**. The work will involve training and encouraging Nigerian doctors. Two year contracts are preferred, but shorter periods are possible Self financing. Accommodation provided.

Contact: Personnel Dept, Action Partners, Bawtry Hall, Bawtry, Doncaster DN10 6JH
Email: *info@actionpartners.org.uk*
Web: *www.actionpartners.org.uk*

Papua New Guinea

The Evangelical Church of Papua New Guinea along with Pioneers/ UFM needs doctors to join the Medical Team at **Rumginae hospital**, a 60-bed, two + doctor rural hospital providing a broad range of basic services, serving at the hub of a network of smaller Health Centres and Aid Posts scattered among the remote needy communities of the Western Province of Papua New Guinea. Rumginae is also the base for training Community Health Workers. Short or long term opportunities available

Experience or additional qualification in **General Practice, Paediatrics, Anaesthetics or Surgery** is desirable with at least two years' post registration experience in hospital medicine. Bible School training is preferable but not essential.

Contact: David Brown, Personnel Secretary, UFM Worldwide, 47a Fleet Street, Swindon, Wilts SN1 1RE, UK
Email: *davidbrown@ufm.org.uk*
Web: *www.ufm.org.uk*

Rwanda

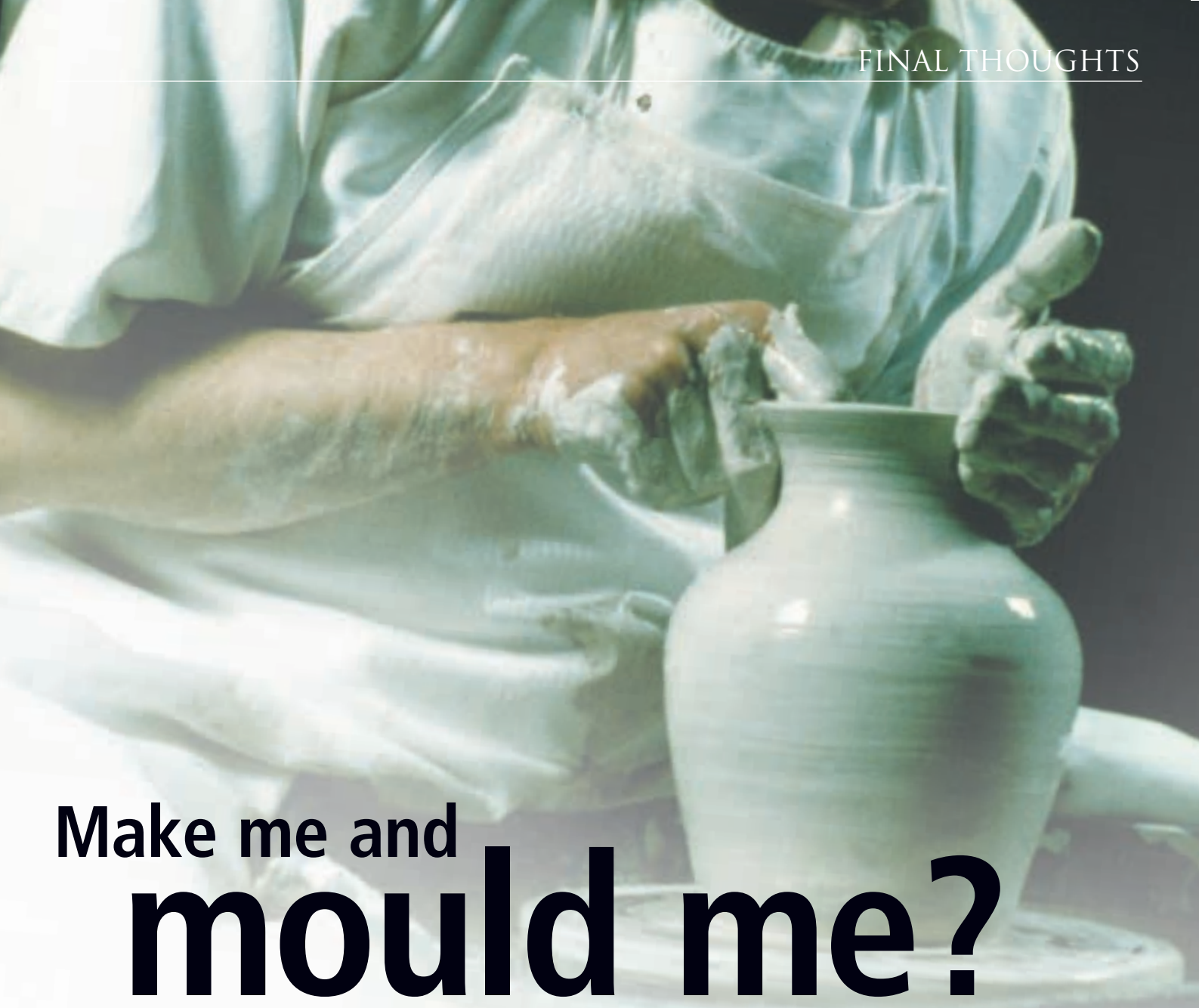
Both **Generalist and Specialist doctors** are needed at **Kibogora Hospital**, a 200 bedded facility functioning as a District Hospital in SW Rwanda. Provision of Surgical cover is a priority from January 2005. Specialist Short term visits of at least one month, preferably longer, would be welcomed to mentor, support and teach local Medical Staff. French is spoken by most of the staff but English translation is available.

Contact: Sheila Ethrington.
Email: *sae@uuplus.com* Mobile: 00250 0854 1206

Southern Africa

AIM is aware of a considerable number of openings for doctors, mainly in rural government medical institutions. Two year contracts are offered. Assignments will depend on the qualifications, experience and interests of each candidate. Local salary and housing is provided and automatic registration for UK trained doctors.

Contact: Associate Overseas Personnel Director, AIM International, Halifax Place, Nottingham NG1 1QN. Tel: 0115 983 8120
Email: *personnel.support@aimeurope.net*
Web: *www.aimeurope.net*



Make me and mould me?

ALL THE TIME THE SENSITIVE HANDS OF OUR MASTER POTTER ARE SHAPING US

The arrival of overseas guests inspired a visit to our local pottery where we were given a running commentary as the potter demonstrated his skill. First, he took an unattractive lump of grey clay and threw it with some force onto his wheel. As the wheel span round, he kneaded the clay well, then moulded it into a lovely shape before flattening it and starting all over again.

'You must have very sensitive fingers', said my companion, 'Are you feeling some impurities in the clay'? 'Yes', replied the potter, 'Some clay resists more than others. Its basic nature affects how much it has to be worked on before it's ready to be shaped into what I have in mind.'

After much patient refashioning he finally produced an elegant container, hollowed out by hand and carefully smoothed both inside and out to his satisfaction. Of course it was still soft, so he gently manoeuvred it off the wheel to await the next stage. Before it could keep its shape it would have to go through the intense heat of an oven, finally emerging firm, strong and attractively coloured instead of the original dull grey. We heard how the innate property of the clay and the temperature of the fumace govern the final outcome.

'Another thing', he said, 'if you go upstairs to the factory you'll see them turning out a lot of look-alikes, but with my work each piece is unique. That's what I love about it. From each lump of clay I start with I plan to make something new and different. Then, when I'm satisfied, I mark it with my initials and it goes on display. You won't find it in the general store'. He spoke without arrogance and it was with loving satisfaction that he showed us some of his creations, each identifiable as his because they bore his mark.

I could no longer keep silent. Had he deliberately been speaking in parables? I asked if he knew the verse, 'we are the clay, you are the potter' (Isaiah 64:8). He nodded and gave a little smile. We agreed that there are times in life when we can feel like protesting clay, but all the time the sensitive (and pierced) hands of our master potter are shaping us into something uniquely to his glory - unless we keep up our resistance.

Janet Goodall is an emeritus Consultant Paediatrician in Stoke-on-Trent

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