Autumn 2005

for today's Christian doctor

triple helix

transforming communities

criminalising christian behaviour, euthanasia, making poverty history, hfea, abortion, medical unemployment, prayer, leslie burke, religious hatred law, working with cmf

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contents

Criminalising Christian behaviour

Legally enforced political correctness

Our obedience to God takes precedence if the law of the land requires us to disobey him.

This edition of *Triple Helix* highlights three possible changes in British Law that could lead to Christians receiving criminal convictions.

The first involves Lord Joffe's *Assisted Dying for the Terminally Ill Bill* (p4), which requires doctors who are not willing to authorise euthanasia to refer to other doctors who are; a move most Christian doctors would view as complicity in intentional killing.

The second involves the *Racial and Religious Hatred Bill* currently traversing the House of Lords, which some fear could put Christians behind bars for seven years, simply for preaching the Gospel (p15).

The third relates to a proposed revision of the General Medical Council's guidance for doctors, *Good Medical Practice*, which could well be interpreted by the courts as giving doctors a legal obligation to refer abortion requests to 'sympathetic' colleagues. This comes together with calls for doctors to report to the GMC colleagues claiming the protection of the conscientious objection clause in the 1967 *Abortion Act* (p7).

Given the biblical teaching that God institutes human authorities[1] and expects us to obey them,[2] how ought we to respond?

Part of being a good citizen involves exercising our democratic right to ensure that unjust laws are kept off the statute books. The absence of a conscientious objection clause in Lord Joffe's draft euthanasia bill has already been widely criticised and as a result is expected to be rectified when the revised bill appears in late October/early November. The GMC's proposed revision of *Good Medical Practice* is still out for consultation[3] and I would encourage Christian doctors to make submissions by the closing date of 30 November. The *Racial and Religious Hatred Bill* has still to be passed by the House of Lords; and as I write this there is still time for protest and amendment.

But if laws that discriminate against Christians are passed, and obeying such laws involves disobeying God, then Scripture is clear that there is a place for civil disobedience. When the King of Egypt ordered the Hebrew midwives to kill all male Hebrew children they refused to do so and God commended and rewarded them.[4] Rahab the harlot similarly refused to co-operate with the king of Jericho in handing over the innocent Israelite spies and was later praised for her faith.[5] The prospect of death did not stop Shadrach, Meshach and Abednego refusing to bow down to the image of the king or Daniel persisting with public prayer.[6] When Peter and John were commanded by the Jewish authorities not to preach the Gospel they replied, 'We must obey God rather than men'.[7] So whilst recognising that we have an obligation to obey the governing authorities God has instituted, nonetheless our obedience to him takes precedence if the law of the land requires us to disobey him. It is striking that these biblical examples include refusals to participate in shedding innocent blood or to refrain from preaching.

Daniel and his three friends were rescued miraculously from their respective predicaments; but there is of course no guarantee that God will turn things in our favour if we are in a situation of having to disobey the law. The long list of heroes of faith in Hebrews 11 contains those who were delivered from the consequences of civil disobedience but also those who paid the price. And paying the price through facing discipline, job-loss, a fine or imprisonment may be what God requires us to do.

I expect that in coming days we will increasingly be calling on Christian colleagues to support us, and Christian lawyers to advise and protect us in such circumstances. We will no doubt win some battles and lose others – but regardless we have the confidence that we follow in the footsteps of a Saviour who in facing everything the greatest Empire on earth could throw at him, willingly carried the cross and emerged ultimately victorious.

'Blessed are those who are persecuted because of righteousness, for theirs is the kingdom of heaven. Blessed are you when people insult you, persecute you and falsely say all kinds of evil against you because of me. Rejoice and be glad, because great is your reward in heaven, for in the same way they persecuted the prophets who were before you.' (Matthew 5:10-12)

***Peter Saunders** is CMF General Secretary*

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news reviews

Doctors' opinions on euthanasia

Leaders with extreme views have hijacked the voice of the profession

Review by **Peter Saunders**
CMF General Secretary

Britain is teetering on the brink of legalising physician-assisted suicide (PAS) and possibly also euthanasia as the result of a powerful campaign by pro-euthanasia factions to change the opinion of the public, media, politicians and (perhaps most significantly) doctors.

Following the House of Lords debate on 10 October on the Select Committee report on Lord Joffe's *Assisted Dying for the Terminally Ill Bill*, Lord Joffe is expected to introduce a revised bill into the House of Lords along the lines of the Oregon model (PAS but not euthanasia).

We have already reported in this journal how the Royal College of Physicians (RCP) took a neutral position in giving evidence to the Select committee on behalf of the Academy of Royal Colleges last autumn,[1] apparently without consulting either those colleges or its own members. In like manner the British Medical Association (BMA) adopted a neutral position at its June Annual Representative meeting after doctors' leaders employed what one commentator has called 'Stalinist tactics'[2] to manipulate procedure in securing a neutral motion by an 11 vote majority at a barely quorate meeting in the closing hour of conference.

In stark contrast both the Association for Palliative Medicine and the Royal College of General Practitioners made strenuous efforts to establish their members' views. The APM survey found that over 90% of palliative medicine consultants opposed a change in the law[3] and in like manner RCGP members and faculties gave overwhelming support to a statement on assisted dying for the terminally ill opposing any change in legislation.[4]

When the 24 September edition of the *British Medical Journal* published five articles in its education and debate section on euthanasia, with four out of five plus a covering editorial (titled 'A time to die') being strongly pro-assisted dying, over one hundred letters from doctors were posted on the *BMJ* website in the following ten days. Of these over 95% were against any change in the law.[5]

The majority of doctors at the clinical coalface still oppose euthanasia, as indicated in recent major polls,[6,7] but it seems that some of our leaders, and especially those in positions of power in ethics committees of the Royal Colleges and BMA, support a more liberal view.

It is time for frontline doctors to rise up and reclaim the high ground from those leaders with extreme opinions who have spoken on our behalf without making any attempt to find out what we think.

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Making poverty history

Was anything really achieved in 2005?

Review by **Steve Fouch**
CMF Allied Professions Secretary

At the start of the year, who would have believed that a meeting of world leaders at a Scottish golf resort would inspire the largest popular music event the world has yet seen, or that Africa would be big news in the media? UN summits, meetings of the World Bank and IMF, and even the World Trade Organisation have all hit the headlines as never before, and the main theme has been the eradication of poverty.

We were told back in January that this was the year to Make Poverty History. The message was that decisions made this year would save lives. But did they? Was it all just so much hype and obfuscation, or was something concrete achieved?

The bitter irony that the famine in Niger only broke into the world news agenda after it had been going on (and ignored) for some months (and just as the G8 Summit and Live8 came to an end) cannot go unremarked upon, because the reality is that quick fixes for poverty do not exist. It will take generations even to see some nations climb out of poverty. For all the lip service and posturing of the media stars, thousands were dying unnoticed in an all too preventable famine.

While arguments abound as to whether it is aid or trade, entrepreneurship or non-governmental organisations, privatised or pubic utilities that will end poverty, and while the academics and governments bicker at the UN, G8 and WTO, the poor carry on dying. Jesus' striking words to the Pharisees come to mind, 'You strain out a gnat only to swallow a camel!'[1]

But some things were achieved at the G8 – some major steps in debt relief, a few hesitant steps on aid. Less happened at the UN Summit. The whole issue of fairer trade was shelved until the WTO meeting in December 2005, where it may stay on the shelf even longer. Small steps then, not major changes. Some lives may be saved in the short to medium term, but nothing major will change for the millions living in grinding poverty. Not this year, or next.

The reality is that it will take time to end extreme poverty effectively. As we have said before in *Triple Helix*,[2] part of the mission that Christ calls us to is to help those in need and speak up on their behalf.[3]

It would be easy to be discouraged and think nothing has happened, but the illusion that crept into the popular consciousness through such well-meaning events as Live8 was that the changes would all happen this year in one go. The reality is that it will be incremental steps that lead to change. Persistence, being in it for the long haul, that is what we are called to, not quick fixes.[4]

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The Millennium Development Goals

Attempted hijack by pro-abortion groups

Review by **Steve Fouch**
CMF Allied Professions Secretary

Too many observers the Millennium Summit at the United Nations this September was a farcical waste of time in terms of fighting global poverty and seeing the Millennium Development Goals (MDGs) properly supported.[1] Governments and NGOs, all fighting their own corner, effectively hamstrung efforts to fight poverty. One of these destructive lobbies was the pro-choice movement.

The fifth MDG resolves to reduce maternal mortality by three quarters by 2015,[2] and is closely related to the third and fourth goals, which seek respectively to eliminate gender disparity in primary and secondary education and reduce by two thirds the mortality rate among children under five. The shocking levels of maternal and infant mortality around the world are actually getting worse, not better, and so the fourth and fifth MDGs look some of the least likely to be met.[3]

Yet in the midst of lobbying for increased access to good quality obstetric services for the poor, better education for girls, access to and teaching about contraception and challenging social attitudes that disempower women and girls, another argument has crept into the debate, almost under the radar. Several groups including the International Planned Parenthood Federation (IPPF) have argued that increased access to reproductive health includes access to abortion services.

While no one could reasonably argue against a woman's right to be free from abuse, fear of death and injury from the preventable complications of childbirth and pregnancy, there must be questions raised about the imposition of dubious Euro-American values towards sexuality and attitudes to the unborn that lie behind this Western pro-choice agenda. Furthermore, the resources put into developing abortion services could easily detract from those other, more directly effective measures in tackling maternal and child health.

At the same time, The UN has made it clear that the term 'reproductive health' does *not* include abortion services.[4] The IPPF and others are fighting a battle, which is at best irrelevant, and at worst a hindrance to the wider task of fighting global poverty and health inequality.

In fighting for the poor and disempowered as Christians[5] we should be promoting 'a culture of life rather than death' (as Pope John Paul II coined it). We should be standing up for the weak and disempowered, rather than letting a new form of neo-colonialism threaten the very lives we seek to save.

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More clever things with embryos?

Parthenogenesis and the HFEA review

Review by **Peter Saunders**
CMF General Secretary

The tabloid headline 'Virgin conception first for UK'[1] entered the public consciousness in early September; but the newest 'HFEA-approved' development in embryo research described was simply the next logical step following on from recommendations made by the Warnock Committee in 1984 and subsequently given statutory force in the 1990 Human Fertilisation and Embryology Act.

Warnock laid the framework for an Act, which although giving lip service to some status for the human embryo, nonetheless allowed embryos to be frozen, experimented on and destroyed. In recent years the boundaries have been pushed further to allow so called 'therapeutic cloning', pre-implantation diagnosis, saviour siblings and now parthenogenesis (virgin conception).

Space here does not allow a consideration of the significance of the 'virgin conception'[2] but it seems extremely unlikely that stem cells derived from such defective embryos (as opposed to normal adult stem cells[3]) could ever be of any therapeutic value. It is ironic that this new 'development' has come so swiftly on the heels of Lord Winston's recent presidential address to the British Association's Festival of Science in Dublin, where he deplored the extremist hype coming from sections of the scientific community about the therapeutic properties of embryonic stem cells.[4]

The Department of Health is now holding a public consultation leading to a review of the Human Fertilisation and Embryology Act.[5] The consultation document seeks views on 'whether and how the Act might be updated given the rise of new technologies, changes in societal attitudes, international developments, and the need to ensure effective regulation'. The consultation, which closes on 25 November, will take 'full account of the House of Commons Science and Technology Committee's recent review of human reproductive technologies and the law', which controversially called for the abolition of the Human Fertilisation and Embryology Authority (HFEA) itself and the deregulation of designer babies, social sex selection, animal-human hybrids and human reproductive cloning. In fact the proposals of the committee were so radical that half of its members refused to back its conclusions and instead filed a minority report.[6]

CMF has been openly critical of the HFEA for the way this un-elected and unaccountable quango has repeatedly gone beyond its remit to make on the hoof amendments to the Act for new developments that were not foreseen by those who originally framed the law. But this long-awaited review might, paradoxically, make matters even worse. If the Science and Technology Committee have their way, we may see scientists 'playing around' even more in days to come.

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Helen Barratt outlines recent developments

Late abortion
A window of opportunity?

The launch of the *Alive and Kicking* campaign [1] at the Labour Party Conference in Brighton on 26 September brought together a growing alliance of human rights groups formed in response to mounting evidence of growing public support for changes in UK abortion legislation. In a public poll carried out for *The Daily Telegraph* earlier this year, only 27% of those questioned believed that the current 24 week legal limit for abortion should be retained. 58% of those questioned by *YouGov* said abortions should not be carried out after the 20th week of pregnancy, with women more likely than men to favour tighter controls. One in three women favoured a limit on terminations of 12 weeks or under. [2]

Terminations were originally allowed up to 28 weeks of pregnancy when abortion was first legalised in 1967 and, although the limit was reduced to 24 weeks in 1990, there are now calls to reduce this further. Although the vast majority of the 180,000 abortions that took place in England and Wales in 2004 took place before 13 weeks, 124 were carried out in the 24th week. In addition, the *Human Fertilisation and Embryology Act* 1990 permits abortion at any stage of pregnancy where there is a 'substantial risk' of 'serious handicap' and over 100 such procedures take place each year after this limit.

Senior politicians, including Michael Howard, have called for an overhaul in abortion legislation. [3] Indeed, in light of the *YouGov* poll, Liberal Democrat MP Evan Harris called for the House of Commons Science and Technology Committee and its equivalent in the House of Lords to hold a joint investigation into the case for cutting the 24-week limit. [4] However, although Prime Minister Tony Blair has previously hinted that he might consider re-examining limits for late-term abortions, Downing Street later stressed that he was not signaling any government law plan. [5]

Calls for a reduction in the abortion limit have been driven at least in part by new technology such as 3D ultrasound, which provides detailed colour images of the unborn child. The new scanners, developed by Professor Stuart Campbell and colleagues at London's *Create Health Clinic* have demonstrated fetuses at twelve weeks stretching, kicking and making complex movements. At 14-15 weeks they were seen sucking their thumbs and yawning. By 18 weeks they were opening and shutting their eyes and by 26 weeks they were scratching their noses, smiling and frowning. [6] Conventional ultrasound produces only 2D images of the developing fetus.

As well as being the upper limit for abortions, the 24th week of pregnancy is traditionally regarded as the point of viability, the time in the pregnancy after which the unborn baby could theoretically live outside its mother's womb if it was born early. However, some argue that this is more a measure of the sophistication of our neonatal care, and over the past 20 years the success of this specialty has increased dramatically. [7] In many centres it is almost routine for babies born pre-term at 24 weeks' gestation - four months early - to survive with good clinical input. An electronic paper published in the journal *Pediatrics* last year reported that 66% and 81% of those infants born at 23 and 24 weeks of gestation respectively survived to be discharged home. [8]

Whilst a reduction in the abortion limit appears unlikely to happen in the immediate future, it is perhaps ironic that one of those leading calls for the limit to be reduced to 22 weeks is Lord Steel, the architect of Britain's original abortion laws. [9]

However, it is worth noting the significant burden of lasting neurodevelopmental difficulties in this group. Many thousands of pounds are invested in the intensive care of each of these children, as well as their clinical follow-up, and often their need for special education. Yet at the same time, late abortions are taking place in the UK and occasionally result in live births; these children receive no care or investment of any kind at present and are simply left to die. In July 2004, the British Medical Association's (BMA) annual representative meeting (ARM) called on the NHS, the General Medical Council and other professional bodies to work together to ensure that babies born alive as a result of a termination receive the same full neonatal care as that available to other babies. [10]

In view of this, it seems paradoxical that the same meeting in 2005 overwhelmingly rejected a call to reduce the legal time limit for abortion. As reported in the summer edition of *Triple Helix*, members voted by three to one to maintain the present limits, not only flying – so it would seem – in the face of public opinion, but also denying the evidence of countless neonatal studies: senior doctors at the conference reportedly told delegates that there had been no change in neonatal survival rates in recent years. [11]

The abortion debate is one of the oldest in bioethics, and dialogue has traditionally proved difficult with both parties seeming to come from irreconcilable positions. Whilst it's easy to get bogged down by academic arguments about when life begins, the essential nature of the fetus does not change at viability (or the current abortion limit), and the results of the *Telegraph* poll suggest that the public realise this. If this is the case, we have a rare opportunity to influence this difficult area. The question is, what will we do about it?

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Charles Foster explains the current law

Conscientious objection to abortion

Ethics, polemic and law

The pro-abortion lobby has announced the latest phase in its offensive. *Marie Stopes International* wants to force GP surgeries to display lists indicating which doctors in the practice will refer women for abortion, and the pressure group *Doctors for a Woman's Choice on Abortion* is encouraging patients to report to the GMC doctors who refuse to play any part in abortion.[1]

There is widespread confusion about the extent of the conscientious objection clause in the *Abortion Act* 1967. Section 4(1) reads:

'*Subject to subsection (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorized by this Act to which he has a conscientious objection….*'

Subsection (2) relates to treatment '*necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant women.*'

What is covered by 'participate in any treatment'? The House of Lords in *R v Salford AHA ex parte Janaway* considered this point.[2] Mrs Janaway was a secretary at a health centre. She was a Roman Catholic and believed that abortion was wrong. She was asked by a doctor to type a letter relating to the referral of a patient to a consultant with a view to abortion. She refused, and further refused to type any other letters concerned with abortion. Apart from s4(1) this refusal would have been a breach of her contract of employment. She relied on s4(1), but the case was nonetheless dismissed. Did s4(1) apply to typing letters that were a part of the referral process? No, said the House of Lords. 'Participate', said Lord Keith, should have '*its ordinary and natural meaning*' and '*referred to actually taking part in treatment administered in a hospital or other approved place….. for the purpose of terminating a pregnancy.*'

This citation has been repeatedly quoted as authority for the proposition that anything that occurs outside the operating theatre falls outside the ambit of s4(1). But it not clear that this is the case. First, and obviously, *ex p Janaway* was not to do with a doctor. Is there really no distinction between a secretary typing a letter and a doctor referring? To assert that there is not downgrades the professional act of referral into a merely administrative business. Is not the initiation of the professional process that leads to the 'treatment' necessarily part of the 'treatment'? For all other purposes the doctor at the point of referral owes to the patient the duty of a doctor, not that of a secretary. This point was never argued in *ex p Janaway*.

Second, in *ex p Janaway* itself there was discussion of the Abortion Regulations 1968, which deal with the 'green form' (now blue!) to be signed by the two registered medical practitioners pursuant to s1 of the Act. While noting that, '*The Regulations do not appear to contemplate that the signing of the certificate would form part of the treatment for the termination of pregnancy...*', Lord Keith went on to say: '*It does not appear whether or not there are any circumstances under which a doctor might be under any legal duty to sign a green form, so as to place in difficulties one who had a conscientious objection to doing so…So I do not think it appropriate to express any opinion on the matter.*' While of course the signing of a green form is much nearer the actual act of termination than the act of referral is, the general question of whether the medical steps preliminary to the act of termination are covered by s. 4 must be regarded as still open to argument.

Third, *ex p Janaway* was decided long before the European Convention on Human Rights was grafted into English law. Article 9 of the Convention provides that, '*Everyone has the right to freedom of thought, conscience and religion; this right includes… freedom …to manifest his religion or belief in worship, teaching, practice and observance.*'

The Human Rights Act 1998 requires judges to interpret UK legislation, if it is at all possible to do so, in accordance with the Convention rights. If a UK law is incompatible with those rights, a 'declaration of incompatibility' can be granted – effectively an authoritative direction to the government to make the legislation concordant with the Convention. It can be argued strongly that Article 9 should require the conscientious objection clause to encompass a refusal to refer. The arguments are technical and outside the scope of this article.[3]

The BMA has given detailed guidance. It appears to assume that *ex p Janaway* applies to referral. It asserts: '*Doctors with a conscientious objection to abortion should make their views known to the patient and enable the patient to see another doctor without delay if that is the patient's wish.*'[4]

The GMC, in the current edition of *Good Medical Practice* states: '*If you feel that your beliefs might affect the advice or treatment you provide, you must explain this to patients and tell them of their right to see another doctor.*'[5] The new draft of *Good Medical Practice*, currently out for consultation, goes further. It says: '*If carrying out a particular procedure, or giving advice about it, conflicts with your beliefs, you must explain this to patients and tell them of their right to see another doctor. Where it is not practicable for a patient to make such arrangements themselves, you must ensure that arrangements are made for another suitably qualified colleague to take over your role so that the patient's care does not suffer.*'[6]

The new draft would impose a much more onerous duty on a conscientiously objecting doctor. It could itself be attacked under Article 9. There are some interesting times ahead.

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Kiran Martin presents a world-leading best-practice model.

Rendle Short Lecture 2005

Transforming communities

key points

The Asha project is a world-leading best-practice model for transforming slum communities. Since Dr Kiran Martin was originally called to the work it has grown to involve 70 staff caring for a population of 200,000 in Delhi's slums. Successful healthcare delivery in slums must be in partnership with communities, and Asha's strategy is based on three tiers of involvement through community health volunteers arising from women's associations, community health centres staffed by doctors and a polyclinic providing facilities for investigations and specialist care. All levels of the community including children play a part in improving healthcare, overcoming discrimination and planting churches. Jesus' Nazareth manifesto in Luke 4:16-19 of good news, physical healing and justice provides the model.

The Hindu religion has about six hundred and forty million gods. I come from a Hindu family and as a child my grandmother took me to the temple every day. I would have to bow my head before many of those gods painted all over the walls. Yet I knew there was no real truth here. I was very empty in my spirit.

The way the Lord Jesus revealed himself to me is an amazing story. I had never ever read the Bible; I had never gone to Sunday School. Somehow I just knew a little bit about Jesus but little did I know that he had such a radical, transforming power.

I went on to study medicine and paediatrics and while I was studying I felt that the Lord was saying to me, 'I really want you to go among those who are the poorest people in the city. That is where I would have been found if I was in Delhi.'

The Invisible Poor

If you visit Delhi you see slums everywhere. You see them next to five star hotels. You see them by very big posh bungalows. You see them next to Embassies and High Commissions. They are hardly out of sight but they are off society's radar screens.

The Lord spoke to me, 'You know I have come to bring good news to the poor. I have come to bring good news to those who lack food, to those who lack shelter, safety, security. I'm going to do it through you.'

Twelve million people live in Delhi, out of which three million live in shanty colonies. In fact half of the world's population today live in urban areas and in any town or city in India about one third of people live in shanty colonies.

In the slums there can be as few as one public toilet for 125 people. Most of the time it's not used for obvious reasons. Not surprisingly out of every 1,000 under fives, 20 die due to diarrhoea. Some 80 per cent of children under five in the Delhi slums are malnourished.

I suspect that few UK doctors will have even seen Vitamin A deficiency. In India it's very common and the major cause of blindness in children under five. There is a national programme for vitamin A prophylaxis, but the coverage is only 27%.

Polio and other preventable diseases are found in abundance in the slums. Some 55,000 children died of neonatal tetanus last year. The immunisation coverage in Delhi slums is only 30%, an average for all the vaccines is approximately 20%.

This is just to give you an idea of the kind of causes of deaths under five that you find in India. The infant mortality rate that you find in the slums of Delhi is 100 for every 1,000 live births, which is one of the highest in the world. Under five mortality rate is 146 for every 1,000 live births and

Photo: Asha

child survival rate is 86% so out of every 100 children born only 86 of them live to the age of five.

Tuberculosis is of course very common. Out of eight million cases of TB in the whole world, 3.5 million of them live in India and a large proportion of those live in the slums. Tuberculosis in an impoverished slum family leads it into destitution.

Only half of the children would ever go to a primary school and out of that about half of them drop out by class five. The largest number of child labourers in the world exists in India and they contribute 20 per cent of India's GNP working 12 hours a day.

Principles of transformation

It was very clear to us that any kind of healthcare delivery in the slums must be in partnership with communities. In Isaiah 61 it says that those places that are waste, that are completely devastated, are those the Lord will use to bring about revival and to bring about restoration.

I started helping the women from all the different slum areas together to form women's associations. The whole healthcare programme of Asha is basically in partnership with them. Asha trains these community health volunteers and empowers them actually to deliver primary health care and treat common ailments.

The community members actually decide priorities. Do they want immunisations first, or would they rather have a water tap? Do they want a proper TB controlled programme or help with shelter? It's their decision. Asha trains all the traditional birth attendants. There was very high maternal mortality and newborn infant mortality.

A second tier is community health centres in different slum areas staffed by Asha doctors and other staff. In such cases where there's no land available our mobile vans work along with the community to improve health. A third tier is the Asha polyclinic which provides facilities for investigations and specialist care.

The under-five child health programme is exactly like that: same tier one, tier two, tier three and most of the work gets done at the level of tier one. I would give full credit to the community members who have been so actively involved. Child survival rate is a very good indicator of a good child health programme so 95 out of 100 children are living till age five.

At first we did not initiate a reproductive health programme because it was not a priority for the community. The average family size now has gone down to three. In Delhi the sex ratio is actually 800 females per 1,000 males, quite an alarming figure. So we have many interventions to ensure the happy birth of a girl child.

It's amazing to see how much they have developed such a wonderful Gospel model of the way in which they live. They won't even hesitate to wake up in the middle of the night to take a neighbour to the hospital. Or they will collect money to help somebody with no money for a delivery. They have self-help groups that function as informal banks for savings and loans. They make greeting cards and scarves sold at a fair price.

Children's associations have emerged, for the age groups of 7 –14. Each has a president, secretary and treasurer. All the children have a street they are responsible for. They promote breast-feeding, they discourage bottle-feeding, they know the symptoms of tuberculosis and they are really actively involved in promoting good health.

They have discussions about social injustices that go on in the slum, especially gender discrimination against girls. They have special support groups for handicapped children, and even the children collect money for those who are much poorer than they are. We have resource centres where children come and do their homework, play games and read books.

Women have been at the centre of planting churches. Early on the women started saying, 'We can't even read the Bible, how will we be able to preach.' I said, 'The Lord will give you wisdom.' It's amazing to see how these women have actually been able to stand up and expound Scripture that somebody else reads out to them through the revelation of the Holy Spirit.

Isaiah 61 says, 'The Spirit of the Lord God is upon me because the Lord has anointed me to preach good news to the poor. He sent me to bind up the broken hearted, to proclaim liberty to the captives and the opening of the prison to them that are bound.'

This is a word for those who are crushed with grief in the slums, those who are greatly depressed in their spirit, which is what I found when I first went to Delhi. This passage was Jesus' manifesto (Luke 4: 16-19).

Today he says, 'I have come to bring really good news to them. I have come to make them whole. I have come to set them free from loan sharks, to set them free from cycles of violence. I have come to set you free from the bottle, from dependency on drugs. Then he says that he has come to comfort all who mourn, those who are grieving and sorrowful.

I'm so grateful to God that he has chosen me and my team to have a small part to play in his wonderful plans for the poor.

Dr Kiran Martin *is director of Asha, a team of 70 healthcare professionals that in a decade has helped transform the lives of 200,000 of Delhi's slum dwellers.*

This article is abridged from the 2005 Rendle Short Lecture delivered at the CMF National Conference on 22-24 April 2005. The full text is available on the CMF Website at www.cmf.org.uk

Photo: Asha

Asha

I have come to comfort and heal, set them free from loan sharks, free from cycles of violence

John Rennie asks how Christians should respond to the crisis

Medical unemployment and the BRAIN DRAIN

key points

The unemployment crisis amongst juniors has been exacerbated by the influx of international medical graduates (IMGs) lured here from disadvantaged countries only to face long soul-destroying periods without work. A Christian response must involve striving for justice for IMGs and being prepared to withstand the moral resentment of those who feel that these doctors have no innate right to employment in our country. A key to reducing the brain drain from poor countries is on-going education and fulfilment in their own country through links mechanisms, short courses, mentoring and electronic links. Christians should be in the vanguard of such projects, willing to go at our own expense and with no thought of reward.

The issues surrounding medical unemployment have been rehearsed endlessly in the Christian and secular medical press.[1,2] Our UK graduates have become articulate as they contemplate unemployment at the start of the two year Foundation Programme. Meanwhile the UK, with one of the highest dependencies on overseas graduates compared to other European countries (30% compared with France at 5%),[3] continues to accept International Medical Graduates (IMGs) who today are faced with long and depressing periods of unemployment. Having passed their PLAB examinations they have to join long queues of well-qualified doctors hoping to be offered even the lowliest post (see box).

We must ask ourselves,'Is there a distinctive Christian attitude to medical unemployment in the UK today?'Whilst supporting doctors who have come to the UK, can we aid those who stay in their home countries to gain education and fulfilment?

Professional and Linguistic Assessments Board (PLAB) test part 2

- Administered by the General Medical Council
- Enables IMGs to gain limited registration
- 79% of candidates passed in 2003
- 93% of these doctors obtained employment within 12 months (but figures have now worsened considerably)
- Those who undertake a clinical attachment find a post more quickly
- Competition for posts is greatest in Wales

Source: *www.gmc-uk.org/register*

International Medical Graduates (IMGs)

- There are 210,000 doctors in the UK of whom 80,000 are in hospital practice
- Each year 13,000 register for the first time with the GMC
- Of these 40% are from UK medical schools, 15% are from the European Economic area (EEA) and 45% are non-EEA doctors from overseas (IMGs)
- IMGs make up 40% of the UK workforce and 25-30% join the UK workforce permanently
- BMA figures estimate about 3,000 unemployed juniors in the UK at present

Figures from *bmjcareers.com*

You may think our main concern should be for the futures of those who today are passing through our medical schools and who are now contemplating periods of unemployment during their early years as junior doctors. If the government has got its calculations horribly wrong, and we are simply training too many doctors, is this just a fact of medical life that we have to get used to? The next few years are crucial but few of us are in a position to influence government policy.

A sense of injustice

You may think the scandal of overseas doctors being lured to this country when their own countries can scarcely afford to lose their expertise, should be of

May 2004 – May 2005 average number of applicants per post across SHO, PRHO and Foundation posts:

Medicine	154
Surgery	143
All specialties	130

Figures from *bmjcareers.com*

equal concern. We have a distinguished history in the UK of welcoming trainees from abroad and particularly from developing countries for periods of appropriate training and acquisition of skills before their return home. Many of these trainees will chose to stay in the UK. But for the present how can we assist those doctors who, having 'burnt their boats' in their home country, have made the UK their destination?

We as Christians must have a conscience about this unfolding dilemma affecting as it does so many like-minded and hitherto disadvantaged colleagues. Firstly we should feel a sense of injustice that these doctors have been lured to the UK from countries that are already at such a disadvantage; and having allowed them to come and to qualify for practice in the UK that they should face such long and soul-destroying periods of unemployment before they can begin to train.

Justice is the highest moral ideal from the perspective of society. We as Christians in society must strive for justice for these doctors even if we are forced to use self assertion, coercion or resistance,[4] and we must be prepared to withstand the moral resentment of those who feel that these doctors have no innate right to employment in our country.

How do we marry that sense of injustice for the sending countries and for the individual doctors who find themselves facing long periods of unemployment in the UK, with the individual needs of those doctors and our desire to share the good news of God's kingdom with them? Do we see any opportunity in the dilemma that has unfolded? Do we see any opportunity for the gospel in the plight of these hundreds of doctors in terms of hospitality and encouragement?

On the one hand we have to campaign to make it possible for these doctors to remain in their countries and to feel that their gifts are recognised and their futures secure. On the other hand if they have come to the UK we have the opportunity to be hospitable, to welcome them into our general practices and hospital firms. Often the time span may have to be stretched to support them through the debilitating and depressing period of unemployment.

Stemming the flow

One of the keys to reducing the brain drain from poor countries has to be on-going education and fulfilment in their own country. If these numerous doctors can be encouraged to stay in their own countries and can be promised continuing education and mentoring then appropriate skills could be taught and learnt in the home country and links established that can be maintained over web sites, email and teleconferencing. What is it that makes these links so special? It is the recognition and affirmation that comes by offering something to them freely, that is acquired in the privileged country and generously offered to those in less privileged countries.

Many university and trusts around the UK have established 'Links mechanisms', and they offer teaching and training in a wide range of specialties.[5] Short courses are well-received, short term exchanges are established, and repeat visits offer continuity and friendship in an unparalleled manner. Christians should be in the vanguard of such projects, relying upon the rich medical heritage we have benefited from and willing to go at our own expense and with no thought of reward. Offering this educational input and affirmation would begin to address the disparities between the West and poor countries. At present there are many and varied projects spread thinly, but to make a difference the input needs to be multiplied on a grand scale.

A vital aspect of renewing educational efforts needs to be a new emphasis on enabling the disadvantaged to make full use of their potential. Provisions must be made to help these doctors and nurses support themselves not in the spirit of benevolent remedial activity but in an attempt to share resources, insights and gifts.[6]

By our labour of education we will be affirming the integrity of those we seek to educate. Affirmation is vital for nurses and doctors working in remote areas of the developing world. Teaching opportunities abound to pass on something of the rich heritage we have in medical education in the West. By passing any knowledge on to someone who has a low salary and many dependents, that in itself becomes a powerful tool in the ability of that person to be appreciated, to improve their status with their work colleagues and to give them incentives to return to acquire new knowledge. The Continuing Medical Education programme in the UK has become an important tool in the on-going assessment of doctors. This programme has been rolled out and become invaluable for affirming doctors in many African countries who have willingly participated in similar programmes which are culturally and sensitively appropriate. There is a great need to roll out such programmes in nursing and the allied professions where low salaries and poor status predominate, and where on-going education, on site, has been shown to improve clinical standards and affirm and retain staff.

Post PLAB 2 Conference for International Medical Graduates

This is a day conference to be held by CMF on Saturday 21 January 2006 in London.

Topics to be covered include writing a CV, interview skills, NHS orientation, finding jobs, transcultural medicine. Further details, when finalised, will be posted on the website.

John Rennie *is a Consultant Surgeon, Kings College Hospital, London*

We as Christians in society must strive for justice for these doctors even if we are forced to use self assertion, coercion or resistance

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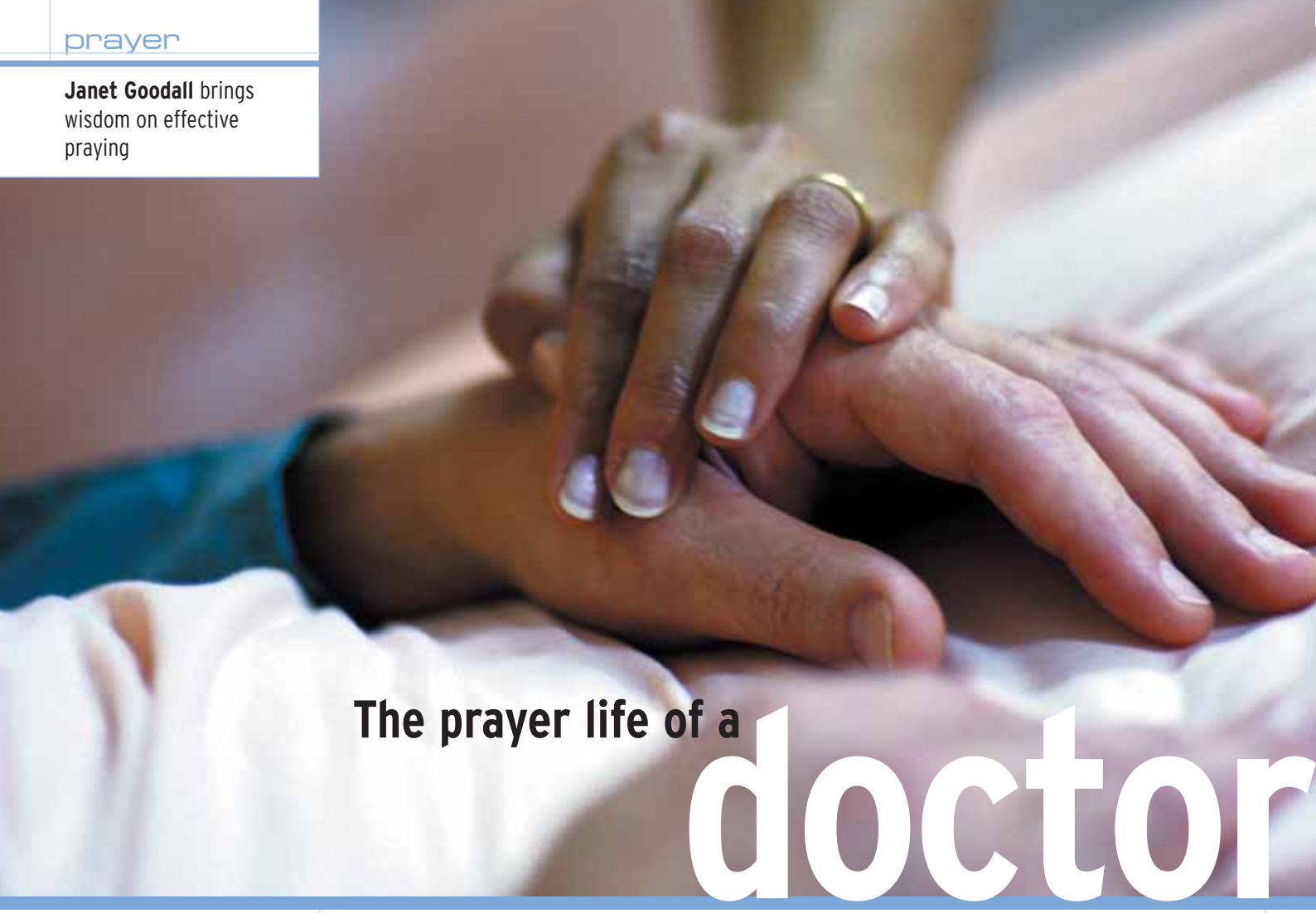
Janet Goodall brings wisdom on effective praying



The prayer life of a doctor

key points

Prayer is an immense privilege and like Jesus, busy doctors need both to establish patterns of prayer that work and also to exercise perseverance and patience in their praying.

Prayer like respiration should be a constant activity and both the 'breathing' model and Scripture give help and guidance to overcome the problems in praying that we all experience.

Habitual sin, swift decision-making, idleness and times of great struggle can adversely affect our praying but prayer offered in helplessness commits the problem to the power of God, who is then able to do immeasurably more than we ask or imagine.

Doctors are not alone in leading busy lives. Jesus was busy but still took time to draw close to the Father in prayer, responsive to his word. We must do the same.

Prayer has been described as the breath of the soul .We breathe in (are inspired) by the Spirit, God's pneuma (Genesis 2:7, John 20:22) and breathe out our prayers in the name of the Lord Jesus (John 15:16). Through prayer we support each other (2 Corinthians 1:8-11) and join in the battle against spiritual wickedness (Ephesians 6:12-18.) It is an immense privilege to carry everything to God in prayer.

The practice of prayer

Just as respiration keeps us alive, so we should daily stay alive to the unseen presence of God, often saying 'thank you' as well as 'help'. We can instinctively pray for those in the blaring ambulance, or for careworn patients and passers by. Yet relationships do not thrive on monosyllables. How then should we pray?

Some expand on the Lord's prayer (Matthew 6:9-13) whilst others use the 'ACTS' sequence: approaching God with Awe and adoration, prompting Confession of unworthiness and specific sins. Thankfulness follows, for mercy and grace (Hebrews 4:15,16) and answered prayer. Supplication, so often put first, comes last.

Prayer requests mount up. No one else might be praying for colleagues and heartsink patients. So our lists grow and will occasionally need pruning. Whilst personality influences prayer life, listening and responsive hearts are essential. Like Jesus' first disciples, we are called to perseverance in prayer (Luke 18:1).

30 years after faithfully committing herself to pray for a Cambodian Christian college under threat of extinction, an elderly lady heard how 100 churches had since been born from that ministry.

Problems in prayer

Wandering thoughts. No doubt we all know these, especially when harrassed. As well as praying about the preoccupation itself, a notepad is useful for things needing attention later.

I don't feel as though I'm getting through. Assurance of God's attention is based on facts, not feelings. He has promised never to leave us (Hebrews 13:5) and is always ready to hear our prayers (2 Chronicles 7:12-22). The Spirit of Jesus intervenes for us when we don't know how to pray (Romans 8:26-27). Praying through a psalm, finding a prayer partner or prayer meeting can all help. Doubts should not become excuses for neglecting Christian fellowship (Hebrews 10:25). It can warm our hearts again.

I've prayed and prayed about this but God doesn't answer. Prayer must be in line with God's will (John 15:7.) Whereas he can and does say both 'Yes' and 'No' he frequently says 'Wait'. Over time

he may change our hearts' desires (Psalm 37:3-4) whilst hindsight often explains his delays. He frequently gives more than we expected (John 11:4). Even so, prayers for physical healing are not always answered as had been hoped. Sometimes God's answer is to heal tension and anxiety rather than to eradicate the disease.

I get jumpy if I go without food. Should I fast to pray properly? Prayer and fasting often go together in Scripture, as at times of special temptation (Matthew 4:1-11) or decision-making (Acts 13:2) or to free the mind for a time of concentrated prayer (Luke 2:36-37; Acts 14:25). Fasting should be voluntary and is not necessarily abstinence from food, but could include avoiding unnecessarily long conversations, too many meetings, novels or other distractions - whatever is our particular weakness. The point of a fast is to focus on God and to seek his will.

Some people pray in tongues but I don't. Am I not spiritual enough? Those who have this gift find it helpful when other words fail, when feeling dry, or when longing for worthier worship. Paul speaks of it in 1 Corinthians 12 and 14, but in chapter 13 he focuses down on the greater importance of love, the first fruit of the Spirit. Gifts are gifts, and Paul indicates that not all are given to all (1 Corinthians 12:11). He warns against (unloving) conceit and envy, but encourages keeping in step with the Spirit (Galatians 5:22-26).

Powerless prayer

As with literal respiration and physical dyspnoea, the vital flow of pneuma, the Spirit, can be impeded in comparable ways.

A blocked airway. Airway obstruction can kill. Similarly, harboured sin blocks off the free flow of the Spirit, but repentance and confession let in the oxygen of the forgiving grace of God.

Intermittent bronchospasm. The body's reaction to inhaled toxins reminds us how readily our souls risk pollution in a godless society. To cherish sin in our hearts is to stop the Lord's ears (Psalm 66:18). Instead, his Spirit will help us to identify and avoid harmful agents.

Running too fast makes us breathless. Habits of swift decision and prompt action can habituate us to approaching God hastily too. Early morning quiet is thwarted by nights on call or affectionate small children. It takes determination and imagination, perhaps to try a prayer walk, jog or swim. An appointment with a prayer partner can become a shared appointment with the Lord - but we might just need a good sleep! Lack of exercise, physical and spiritual, predisposes to dyspnoea. To drop altogether the discipline of spiritual exercise leaves us unfit for the race set before us. Nehemiah met his (often dangerous) tasks strengthened by times of earnest prayer, but his SOS prayers were effective, too.

An unbalanced diet impairs exercise tolerance by producing either obesity or malnutrition. Souls, too, become inert on junk food. 'Relaxing' for too long with TV or magazines can produce spiritual anorexia, as will certain videos in conference hotel rooms. We can, of course, 'pray the world news' and also need to unwind, but to stay spiritually fit we need also to spend time with God's word. The mind reflects what it feeds on, so if our goal is to develop the mind of Christ (1 Corinthians 2:16) we must guard the input.

Carrying a heavy load, or an uphill struggle can both have us panting and ready to stop. When Moses felt this, he was urged to share his workload and give others a chance to grow (Exodus 18:17-23). At times, though, on top of all else come family problems, difficult relationships, or sickness of body, mind or emotions - all ours to shoulder and made so much heavier when working in isolation. 'Helplessness is the real secret and the impelling power of prayer,' said Hallesby. Yet at such times, periods of concentrated prayer can be nigh impossible. *The Doctor's Life Support 2* will provide iron rations, but we should ask others to pray for us, knowing, too, that the Lord's own sustaining care never ends (1 Peter 5:7).

Prayer changes things

In our medical lives, we regularly meet with overwhelming difficulties. By trusting them to the love of God we can prayerfully, often wordlessly, channel God's love to others.

A very young baby faced major surgery and radiotherapy. The doctor, moved by the child's state and the prospect of major disabilities, told her mother, 'I'll pray for Emma'. Years later the mother reported how she, and eventually Emma herself, had come to know the God of all comfort.

When he developed acute leukaemia, Prof David Short wrote, 'I am prepared for storms ahead. Isaiah 43:1-2 comes to me with great comfort at this time: Fear not, for I have redeemed you; ... you are mine. When you pass through the waters, I will be with you; and when you pass through the rivers they will not sweep over you.' After commenting on the lack of bridges or ferries over the approaching river, he added, 'Whatever happens, he will be with us. I am asking my friends to pray that I may be enabled to run the last lap well and that Joan (his wife) may have special help from the Lord.' These prayers were abundantly answered.

Prayer offered in helplessness commits the problem to the power of God. He is then able to do immeasurably more than we ask or imagine (Ephesians 3:20).

Taken from a talk given at a CMF breakfast in Birmingham, March 2005.

***Janet Goodall** is Emeritus Consultant Paediatrician in Stoke-on-Trent*

Prayer offered in helplessness commits the problem to the power of God. He is then able to do immeasurably more than we ask or imagine

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Charles Foster reflects on a long-running legal saga

photo: Empics

The Leslie Burke debacle

Fixing what ain't bust

Litigation is a terribly dangerous business. The Leslie Burke debacle[1] is a sad illustration. It has provided some splendid headlines for the pro-euthanasia lobby and ripped away one of the main legal safeguards against irresponsible end-of-life decision-making by doctors.

Leslie Burke has cerebellar ataxia. He will ultimately need artificial nutrition and hydration (ANH). When he does, he will be legally competent. He was concerned that the General Medical Council's (GMC) guidelines[2] did not make it sufficiently clear that his clinicians had an obligation to give him this basic care if he wanted it. He was worried that he might be deprived of ANH. He brought judicial review proceedings, contending that the GMC's guidelines did not represent the law.

This was wholly unnecessary litigation. Both Munby J, the High Court judge who first heard the case, and also later the Court of Appeal, noted that it was old and trite law that once a patient is accepted into a hospital the medical staff come under a positive duty at common law to care for the patient. A fundamental and unsurprising part of that duty is a duty to take reasonable steps to keep the patient alive. It is true that the GMC's guidelines are not models of elegant drafting, but no sane doctor has ever or could ever have read them as questioning this basic principle. Of course there are difficulties in deciding the ambit of a doctor's duty where the patient is incompetent: then the whole question arises of where the 'best interests' of the patient lie. But in Leslie Burke's case there was no such difficulty. The Court of Appeal made it clear that doctors must already honour the wishes of competent patients who wish to be kept alive:

'*no authority lends the slightest countenance to the suggestion that the duty on the doctors to take reasonable steps to keep the patient alive….may not persist. Indeed it seems to us that for a doctor deliberately to interrupt life-prolonging treatment in the face of a competent patient's expressed wish to be kept alive, with the intention of thereby terminating the patient's life, would leave the doctor with no answer to a charge of murder.*'

So it is rather odd that Leslie Burke went to the law in the first place. It is even more strange that he went, as he did, brandishing his autonomy rights. For autonomy, crucial though it is in its place, has a way of metastasising nastily from where it is helpful to where it is deadly. At first instance the predictable happened – Munby J sang an eloquent hymn to autonomy:

'*…The personal autonomy which is protected by Article 8 embraces such matters as how one chooses to pass the closing days and moments of one's life and how one manages one's death…. The dignity interests protected by the Convention include, under Article 8, the preservation of mental stability and, under Article 3, the right to die with dignity and the right to be protected from treatment, or from a lack of treatment, which will result in one dying in avoidably distressing circumstances…. Important as the sanctity of life is, it has to take second place to personal autonomy; and it may have to take second place to human dignity….*'

The passage duly appeared in lights on the website of the Voluntary Euthanasia Society (VES). It was the biggest forensic coup in their history.

The GMC appealed. The Court of Appeal allowed the appeal, criticising Munby J most bitterly for conducting a general and rather inaccurate survey of the law relating to the broad area of withdrawal of treatment rather than focussing on the narrow and very easy issue raised by the proceedings.

The most significant part of the Court of Appeal's judgment was its effective abolition of the test of intolerability. This test had a long and distinguished lineage. What it meant was this: in deciding whether treatment should be withdrawn in cases where there has been no specific request for life-sustaining treatment, there is a strong presumption in favour of the continuation of life. This is really an operation of the 'best interests' principle. You can have no interests at all if you are dead. The presumption can be displaced, but only if it can be demonstrated that continued life would be intolerable. That is obviously a difficult thing to demonstrate. But the Court of Appeal in *Burke*, going counter to all the authorities, frowned on this test. 'The test of whether it is in the best interests of the patient to provide or continue ANH must depend on the particular circumstances.' That is a much more elastic test than intolerability. Much more medical skulduggery can be squeezed within it. It is a much more difficult test to police.

The Court of Appeal dealt in a workmanlike way with the wholly impractical suggestion that, outside the realm of life-sustaining treatment, patients were entitled to demand specific treatment that the clinician did not think was clinically indicated. Most clinicians will welcome that guidance. But again there was nothing remotely new in what was said: that is what the law has been saying and what doctors have been doing for a long time.

The net result of *Burke* is that the lawyers are richer, the VES is happier, Leslie Burke is as safe as he always was, and many other vulnerable patients are less safe. Jesus gave good legal advice in Matthew 5:25-26 – stay out of court if you can.

Charles Foster *is a Barrister in London and legal advisor to the CMF Medical Study Group*

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Mark Mullins reviews the proposed new legislation

RELIGIOUS HATRED LAW

Photo: Empics

For the third time since coming to power the Government is seeking to pass a law against stirring up religious hatred. It is, in my view, a blasphemy law for all religions in all but name and, as a result, risks seriously limiting the freedom of Christians to criticise the claims of other religions and proclaim the uniqueness of Christ.

The *Racial and Religious Hatred Bill* will amend Section 18 of the *Public Order Act* 1986 so that it will read:

A person who uses threatening, abusive or insulting words or behaviour, or displays any written material which is threatening, abusive or insulting, is guilty of an offence if-

he intends thereby to stir up racial or religious hatred, or

having regard to all the circumstances the words, behaviour or material are (or is) likely to be heard or seen by any person in whom they are (or it is) likely to stir up religious or racial hatred.

The Government has claimed that this offence is only aimed at curbing extreme words or behaviour, hence the requirement that the words used be 'threatening, abusive or insulting'. However this is the same requirement used in Section 5 of the Public Order Act under which Harry Hammond, a 67-year-old street preacher, was tried and found guilty for holding a placard displaying the words 'Stop Immorality, Stop Homosexuality, Stop Lesbianism' (Harry Hammond v DPP [2004] EWHC 69). Clearly the threshold for what is considered to be 'threatening, abusive or insulting' is disturbingly low when one considers the variety of religious sentiments which would be in a similar category to Mr Hammond's sign.

The wording of the second limb is of equal concern. As the legislation is framed in the alternative ('he intends to stir up racial or religious hatred OR…') no intention is required on behalf of the speaker nor is it required that hatred was actually stirred up. It need only be shown that there was likely to be present a person in whom religious hatred was *likely* to be stirred up.

Proponents of this law argue that there are significant safeguards placed within the proposed legislation – including the fact that the Attorney General must provide his consent before a prosecution is brought. However, even if this supposed safeguard does mean that not many individuals are actually prosecuted each year, it will not stop suspects having to go through the stress of lengthy investigations before the Attorney General makes his decision and is therefore bound to have a chilling effect on people's willingness to engage in controversial religious debate for fear of the process itself, if not the outcome. For those who are in fact found guilty of the offence, the penalty is up to seven years imprisonment, an amount that is two years more than that given for causing actual grievous bodily harm!

A similar piece of legislation has been passed in Australia with worrying consequences. Two pastors were tried and found guilty of 'vilifying Muslims' under the *Racial and Religious Tolerance Act* which was passed in the State of Victoria in 2001. Daniel Scot, a Christian pastor from Pakistan living in Australia, held a seminar on 9 March 2002 in which he, an expert on Islam, sought to teach members of his congregation about what the Qur'an says and what some Muslims believe. Muslims had infiltrated the group and reported Daniel Scot to the authorities under the *Racial and Religious Tolerance Act*. Pastor Nalliah was similarly reported for his involvement in writing articles published in a 'Catch the Fire' newsletter and on the internet. It is now being reported that, in response to this case, Muslims are now having their meetings infiltrated by Christians. Far from helping to soothe tensions between 'extremist groups' (the expressed wish of the government), I believe that this Bill will only serve to increase tensions, as it will encourage religious groups to use this new legislation as a stick to beat their opponents with.

I mentioned at the beginning that this is, in reality, a blasphemy law for all religions. There is further difficulty, however, as 'religion' is not defined in the legislation and is therefore open to subjective interpretation. Under the current open-ended wording, Christians could find actions brought against them by witches and Satanists.

Furthermore, the only way a blasphemy law for all religions can operate is if there is no defence of truth and indeed there is no such defence here. The only defence that can be raised where comments are made in public is that a person did not intend **and** was not aware that his words or behaviour might be threatening, abusive or insulting. The gospel, by its nature, is an offence to the unsaved so it is unlikely to help Christians.

As the Prophet Isaiah said in Isaiah 59: 14

So justice is driven, and righteousness stands at a distance; truth has stumbled in the streets, honesty cannot enter.

***Mark Mullins** is co-chairman of the Public Policy Sub-Committee of the Lawyers' Christian Fellowship*

BE INFORMED and help inform your churches.
For details of what happens next with the Bill,
see *www.lawcf.org* and *www.religioushatredlaw.info*
LOBBY peers and MPs by writing to them and visiting them.
PRAY that the hearts and minds of MPs and Peers will change

Time for **change**

Are you fed up with balancing seemingly endless daily tasks – getting through the patient work load, talking to relatives, ordering tests, chasing results, teaching the odd medical student and running off to clinic? Do you crave a bit of variety and the time to think a bit, and maybe do things differently? Then why not consider going part-time to become a CMF staffworker?

Working with CMF

Dr Rachael Pickering looks at how some doctors are using flexible working patterns to work with CMF

CMF's student ministry is vitally supported by an able and willing team of staffworkers and relay workers. Each staffworker covers a few medical schools in one geographical region, and supports local students and juniors' groups. Typical tasks include giving student talks, helping student leaders plan programmes, organising juniors' open house groups, and discipling key students one-to-one.

Usually staffworkers are part-time, working also in clinical medicine, and are paid for their CMF work on the same pay scale as primary school teachers. Relay workers are voluntary posts (unpaid) and form part of the UCCF training programme. They are usually full time but for six months or a year. They work only in one medical school, are supervised by a staffworker; and are usually immediately post-housejobs.

Origins

Although CMF has had travelling secretaries serving students in the past, the latest incarnation of CMF staffworkers started in 1996 when Dr Jim Paul arrived to assist Peter Saunders, who was then Student Secretary. Jim worked part-time in medicine and part-time for CMF for over two years. It didn't do his career any harm as he has since completed specialist training in palliative care, along with the Cornhill theological training course and an MA in Bioethics!

Expansion and growth

Currently we have four staffworkers and one relay worker dotted around the country. The most we've had on the go at any one time was seven. Altogether, about 20 doctors have worked as

How to juggle

Dr Mark Pickering, CMF Student Secretary, has worked part-time for most of his medical training

During my school days I found fame (but not fortune) in a talent competition, juggling whilst eating a tangerine, an apple and a hard-boiled egg - shell and all! Pretty impressive, you might say, if not a little weird. More than a decade on, my childhood hobby is now an integral part of my life. But I've swapped the fruit and veg for more challenging juggling equipment: two part-time jobs (GP registrar and CMF Student Secretary); marriage to an equally busy doctor; keeping up with our young daughter Zoe; and the usual postgraduate exam struggles.

How it all started

I got involved with CMF as a first year medical student on the students' coordinating committee (SCC), then joined the *Nucleus* editorial committee, ending up as student editor. After house jobs in London I applied for a GP vocational training scheme, but didn't get on. Though disappointed, I stopped to think and took the opportunity to work for CMF as a London staffworker full time for six months. After this I went back and did an A&E SHO job, during which time our daughter was born. After my wife Rachael's maternity leave I had some fun as a house-husband for six months alongside, you've guessed it, squeezing in a bit more work for CMF. It wasn't unknown for me to give a student talk with Zoe slung round my shoulders in a papoose.

In for the long haul

During that time I applied to be CMF Student Secretary. It was a big decision as I knew it would mean committing to CMF for a substantial period of time, which would affect all of us. We decided that I should remain part-time in medicine, largely as I had not worked long enough as a doctor at that point to keep my 'street cred' with medical students and junior doctors for very long should I decide not to continue. Both Rachael and I applied for flexible training (me because of CMF, Rachael because of childcare) and in the Lord's providence this was during a fairly brief period when the London Deanery flexible training

staffworkers, for between six months and three years. Most have been juniors, combining part-time medical training - usually as official NHS flexible trainees - with one or two days a week for CMF. One pair of London-based staffworkers even held down a medical SHO rotation as a two-year job share. Others are already fully trained doctors, working part-time in hospice medicine or general practice, often as flexible career scheme GPs.

Confessions of a staffworker

Becky Payne (nee Brain) worked as our South West staffworker for two and a half years until February 2005:

Being a staffworker was great. I grew loads spiritually and it was wonderful to see God at work in people's lives. At times it could be frustrating – my CMF supervisors seemed so busy and sometimes I felt guilty about ringing them! But, having said that, they always listened to my queries and gave me good advice.

Looking back I wouldn't change anything really. I'm glad I did it. Certainly it's given me a more holistic attitude towards medicine, and my presentation skills are so much better! As well as that, working for CMF during my GP training gave me more opportunities to think through the practical application of ethical issues we face as Christian doctors.

Since I finished as a staffworker, I've been busy getting married and am now about to become a mum! My only slight regret is that I'll still have half a year's further training to complete after my maternity leave; whereas, if I hadn't worked for CMF, I'd have been an established GP by now. On the other hand, working for CMF led to me meeting my husband Gareth, so I've a lot to thank the fellowship for!

Want to be more flexible?

Flexible training - for foundation years, SHO and SpR training, working at least 50% of full-time *www.bma.org.uk/ap.nsf/Content/flexibletraining*

Flexible Career Scheme – for fully trained GPs and hospital doctors who wish to annualise their hours, working up to five sessions a week on average *www.nhsprofessionals.nhs.uk/doctors/services/flexible-careers-scheme*

Interested?

If you're interested in becoming a CMF staffworker, feel free to contact Peter Saunders, General Secretary, at *peter.saunders@cmf.org.uk*. We can also arrange for you to talk to one of our current staffworkers so you'll get an honest insider's opinion of what it's really like!

***Rachael Pickering** is CMF editorial assistant*

budget was flush with cash. We were each accepted and before long I was starting as CMF Student Secretary, whilst continuing to build up SHO experience suitable for general practice.

I have now been working in this arrangement for three and a half years and although looking for a successor as Student Secretary, I have no plans to stop the current medical/CMF juggling act and aim to move to a different role within CMF.

Pros and cons

There have been many positive sides to my chronically split personality. For a start, working in the NHS has kept my feet firmly on the ground. I have gained valuable practical insight and experience with the ethical issues that I speak or write about for CMF. Conversely, my CMF work has had a positive effect on my medicine. I have been constantly challenged to maintain high standards, practically and ethically, as well as take opportunities to share my faith, as I have no desire to be a hypocrite after urging others to do the same with my CMF hat on!

I have been forced to focus more and be disciplined about how my time is spent. There are so many things I would like to do in both sides of my work, but this is impossible, so I regularly have to decide which of many good things should be prioritised and which can be delegated or left.

There have been tensions also. I often feel torn between my two lives and can end up thinking that I am doing neither of them sufficient justice, as either job could very easily satisfy more than a full-time commitment. An over-full diary has led to many weeks when either I ran out of ends at which to burn the proverbial candle, or else forgot to notify someone (usually my wife) of some impending important event.

Overall I think that maintaining a life outside of medicine has been a sanity booster, and it has certainly kept me from becoming jaded with the NHS rat race, a fact that has been noted by more than one of my consultants.

Just say 'no'

So what can be done when two big parts of your life are in regular collision? Be realistic with your goals and plan ahead. Regularly reassess your priorities and delegate areas of responsibility to others. Learn to say 'no' without feeling guilty - in a busy life with little slack, saying 'yes' to one thing automatically implies saying 'no' to others.

Colourful career path

Looking back there aren't many things I'd change. Of course I have learnt lessons and made mistakes, but I love combining my work for CMF with my medical training. It's given me a colourful career path and lots of valuable experiences, as well as the joy of seeing students grow in their knowledge of God and their ability to apply his commands to their daily lives and future career decisions. I'm still learning, but the journey is an exciting one.

***Mark Pickering** is CMF Student Secretary*

news from abroad

Is Medical Mission a thing of the past?

Writing under this heading in the Magazine of the Central African Missions (August 2005), Gordon McKillop wonders '*how folks would respond to the NHS if they really understood how 95% of the world's population have to face sickness or injury*'.

He goes on to describe a number of situations he has faced recently including one of an elderly lady with a fractured femur. She was sitting bolt upright on a wickerwork frame expertly tied together with twine onto the luggage carrier of a rickety old bicycle. It had taken 15 hours, travelling overnight, over potholed dirt paths. Not for her the 999 call and an ambulance with flashing lights with the highly trained paramedics offering instant pain relief, carrying her to the well equipped local A&E Department. The thought of the intense pain this old lady had suffered and the expression of heartfelt gratitude as the health centre nurse gently helped her into the poorly equipped health centre, left Gordon feeling humbled and overawed.

He writes: '*When we see the harsh reality of life here – sickness and injury all around with death all too frequent and premature, I can't believe that the day of the medical missionary is over….*'

Responding to the health workforce crisis

Coming from a slightly different perspective, the August Edition of the id21 *Insights* magazine, explores some of the issues related to the shortage of healthcare workers in developing countries – '*an issue which is firmly on the international policy agenda*'. Various aspects of the problem are reviewed and some working examples of solutions considered. Not all the suggested solutions work equally well but those that do have usually been tailored to an understanding of individual situations, some only relevant to specific professions. Solutions must be found if the continuing drain of healthcare professionals from the developing world to the West or from the countryside to the cities, is to be reversed. Visit their website: *www.id21.org/insights*

Some comments from members working abroad

With 1 Timothy 6:17-19 in mind, a member writes: '*Since moving here I have been struck by the massive emphasis in the Bible on God's heart for the poor, the weak, the marginalised, the abused and the oppressed. I wonder how I didn't see it before. I can only think that I skipped over all those verses because I didn't quite know what to do about it. Or maybe I was scared that facing those passages head on would have involved sacrificing a lot of the luxuries that I'd come to view as necessities… laying down my life.*'

Another member, working in an Islamic country writes: '*One rather well off man who travels over an hour from a nearby town to come to our hospital was asked why he travelled so far when there were other hospitals nearby? He replied, "If you say I need an operation, I need an operation and not that you want to make money. If you don't know what is wrong with me you say so. You tell the truth and I trust you".*' Jesus said: '*Let your light so shine before men….*'

A member, recently returned from Bangladesh writes: '*Christians in England need to know that every day life-style decisions directly affect the poor overseas. We MUST choose to care for the environment, to choose fair trade, to shop and invest ethically, to live as simply as possible and pray, pray, pray.*'

Thinking of getting away from it all; of taking a break from medicine?

A German ex colleague working with World Horizons in Spain writes: '*We are so aware of the need for a French-speaking church in this area*' (yes that wasn't a slip of the pen) '*and once again we cry, Lord please send workers into the Muslim harvest files of Almeria*'. French (and Arabic) speaking workers with a call to the Muslim world are greatly needed in Spain. Visit their website: *www.worldhorizons.org*

For those who want to get involved or find out more

Our website at *www.healthserve.org* has recently been updated. If you haven't visited the new site, do have a look. Some of the areas have been renamed and we hope you will find it even more user-friendly. The site contains masses of useful information for those thinking of working overseas, short or long-term and for students planning an elective.

Current needs and vacancies are listed on the drop down menu under 'Opportunities'. Other short-term opportunities can be found by clicking on the Opportunities icon itself and going to 'Mission Exposure Teams'. The *Healthcare Missions Resources Directory* contains lists of useful contact addresses for a whole variety of healthcare mission related issues. Details of articles, conferences and courses on overseas mission related issues and other mission related materials can be found elsewhere on the site.

And finally - It's good to be family

One member newly-arrived on foreign soil with her family of four wrote to express her joy at the welcome she received from the only other CMF member working there, with whom we had put her in touch. She asks for our continued prayers for her family as they settle in, learn the language, find a home, schooling and transport, though she comments that '*not having a car is actually rather nice, we are seeing Maputo in a much more natural way*'.

Another member, recently returned to the UK, gives thanks for support and prayer and the gift of a large family car.

Don't forget to pray regularly for those of our members working overseas. In particular, for those mentioned in *CMF News* who have recently moved abroad and for those who have just returned.

***Peter Armon** is CMF Overseas Support Secretary*

eutychus

Sperm surgery

Intracytoplasmic sperm injection (ICSI) could become a more successful fertility treatment with the introduction of a new technique. The present procedure gives men with low sperm counts the chance of fatherhood, but there are concerns that the introduction of the acrosome (which covers the head of the sperm) into the egg may damage the embryo. A study using mice at the University of Hawaii, reported in *Proceedings of the National Academy of Sciences*, found that acrosomal enzymes reduce the rate of embryo development. During natural fertilisation these enzymes help the sperm penetrate the egg but without introducing the acrosome into the egg. The study found that removal of the acrosome before injection prevented embryo damage and it is hoped the 'take-home baby rate' will increase if this technique is used. (*Daily Telegraph 2005*; 26 September)

Dutch slippery slopes

New guidelines are expected to go before the Dutch parliament in October, formally permitting doctors to perform euthanasia on infants deemed to be terminally ill. Opponents of infant euthanasia have warned that the practice could be extended to mentally incapacitated patients who are also unable to give their consent. The Netherlands passed euthanasia legislation 10 years ago. (*The Guardian 2005;* 30 September; quoted in *SPUC Digest*)

Euthanasia test for Supreme Court

The US Supreme Court's first case under new Chief Justice John Roberts concerns assisted suicide. The federal government argues that a law in the state of Oregon allowing terminally ill patients to end their own lives should be overturned. The court's ruling will have implications across the US but a report is not expected until June. (*http://news.bbc.co.uk/1/hi/world/americas/4312672.stm*)

Red Cross supplanted by Red 'Crystal'

The International Committee of the Red Cross intends to allow national first aid societies to use a red 'crystal' in the place of a cross or a crescent if they object to these symbols. Israel's first aid and ambulance organisation has been campaigning for a change and would be able to join the movement if the red crystal is approved in Geneva later this year. The International Committee said the new emblem would be 'free of any perception of religious, political, or other connotation'. It would 'enable national societies that have not been able to use the existing emblems to become full members'. (*BMJ 2005; 331:654*) Eutychus wonders if some people might interpret the crystal as a 'New Age' symbol.

Euthanasia doctor is struck off

A doctor who tried to 'help' a terminally ill friend die has been struck off the medical register by the General Medical Council. 'Right-to-die' campaigner and former VES Chairman Dr Michael Irwin, from Surrey, admitted obtaining benzodiazepine sleeping pills to help his friend die, but denied the misconduct charge. The 74-year-old has already received a police caution for his actions. A GMC panel said his actions were irresponsible, and found him guilty of serious professional misconduct. (*http://news.bbc.co.uk/1/hi/health/4286470.stm*)

New German euthanasia programme

The Swiss assisted-suicide organisation *Dignitas* has opened an office in Germany. Since it was founded in 1998, some 453 people have been helped by *Dignitas* to end their lives, approximately half of them from Germany. The opening of the office in Hanover has sparked strong criticism from the Bishop of Hanover and the Justice Minister of Lower Saxony. Ludwig A Minelli, who founded *Dignitas*, said that the new office would push the assisted suicide debate in Germany, where the practice is currently illegal. (*Deutsche Welle* 2005; 29 September; quoted in *SPUC Digest*)

Condom promotion in Uganda not reducing HIV risk

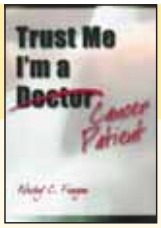
A study of condom distribution and promotion in Uganda has failed to support the view of some commentators that the dramatic fall in the incidence and prevalence of HIV/AIDS in the country was due to condoms rather than abstinence. The authors note that whilst the uptake of condoms was much higher among the intervention group, proving that the intervention had overcome barriers to access, this improvement in uptake actually appeared to be associated with an increase in behaviour that may paradoxically increase the rate of HIV transmission in sexual networks with high levels of partner change. (*J Acq Immune Defic Syndr* 2005;40(1):77-82) Paradoxical rises in the incidence of STDs with condoms has previously been described as 'the seat-belt phenomenon'. People wearing seatbelts feel safer, so end up driving more dangerously (*Lancet* 2000; 355:400-3)

Sculpture gives pause for thought

Alison Lapper Pregnant is a giant, white Italian marble statue of a pregnant disabled woman that now occupies the fourth plinth in Trafalgar Square. The work by Marc Quinn has been praised for highlighting the great inner strength of the model who has fought to gain acceptance in a world dominated by the able-bodied. But a *BMJ* article suggests that it may engender a feeling of guilt in doctors because of the association of phocomelia with thalidomide, even though the drug was not relevant in Alison's case. (*BMJ* 2005; 331:849, 8 October) Eutychus wonders if it might spark some self-examination over the medical profession's involvement in abortion for handicap, which was initially fuelled by the thalidomide disaster of the early 1960s.

Draft guidance on sexually active children criticised

Draft guidelines for people working with sexually active children suggest all those sexually active under 13 years of age should be reported to the police. When a doctor knows someone under 16 is sexually active they are advised to check with the police in case the sexual partner is known to them. The London Child Protection Committee has issued the draft guidance but has been criticised by the BMA, who are warning that young people's trust in health services will be destroyed if the guidelines are followed. The BMA also fears that doctors may be prevented from acting in the 'best interest' of the child. The guidance arose from the Bichard Inquiry into the Soham murders. (*BMA News 2005; 1 October 2005*)



Trust me - I'm a cancer patient

Wesley Finegan

- Radcliff Publishing 2004
- £14.95
- Pb 192 pp
- ISBN: 1 85775 877 3

I found this book by Wesley Finegan, a Christian doctor and a cancer patient, immensely helpful. At the end of a busy clinical day I sat down with the book and reflected on the different situations I had encountered, what I had hoped to impart in information, support and advice and how the patients and their carers had responded. I then turned to the relevant chapters of this book to consider the questions the author suggests the patients ask and the actions he recommends to them. Time and again I found the chapters accurate, positive and empowering for the patient. It is a 'self-help' book of the best kind and very much in tune with the current thinking of helping patients and their families to help themselves.

This is not a book to sit down and read from cover to cover. It is too full of information for that. Far better to dip into the relevant chapter for you, should you or the one you are alongside be on the cancer journey in some way. After reading '*What do I need to know about my pain?*' I would be well placed to describe my situation to the clinician in an informed and constructive way. I would have thought about the different aspects of my pain or pains and what aggravates them. I would know about a TENS machine and be able to ask whether this might help; I would be reminded to ask if I could keep on driving despite new medication.

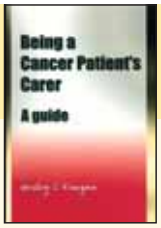
Beautifully woven into the text is the author's Christian faith and its meaning for him in his own experiences of cancer. This comes over very naturally without pushing the reader into a corner or preaching at a time of great vulnerability.

Beautifully woven into the text is the author's Christian faith and its meaning for him in his own experiences of cancer.

I was then phoned by a close friend who had gone to hospital for a hernia repair and come home with a diagnosis of inoperable cancer. Before visiting I pondered on whether I could I take a copy of the book to her? How would she receive it? My conclusion was that she would very much appreciate the book but not on my first visit. Perhaps I needed to feel comfortable listening to her hopes and fears at this time, rather than producing a book that includes a chapter '*I'm going into the hospice*'. In a few weeks, once chemotherapy is under way, I will definitely recommend it to her. Now there's a good test! This must be a good book to recommend rather than to lend. The reader will want to return to it so often that they will need a copy of their own.

Thank you, Dr Finegan for this excellent text.

***Gareth Tuckwell** is Medical Director, Hospice in the Weald*



Being a cancer patient's carer – a guide

Wesley Finegan

- Radcliff Publishing 2005
- £14.95
- Pb 200 pp
- ISBN: 1 85775 638 X

Winner of the 'First Edition Medical Books for the General Reader' category at 'The Society of Authors and The Royal Society of Medicine Books Award 2005'

This book is written by a Christian doctor for the benefit of those who find themselves caring for someone who is suffering from cancer, and throughout its pages there is the stamp of authenticity from one who has been both a patient and a carer. Wesley Finegan combines his specialist knowledge of palliative care with his own experience of being a cancer patient, and more recently of being a family carer himself, to produce a practical guide that will prove invaluable to anyone taking on the daunting task.

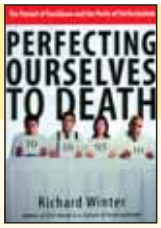
The book deals with a range of physical and psychological problems, issues around communication, cancer treatments, dying and bereavement. It is split into short topically based chapters, and can be read cover-to-cover or dipped into as relevant issues arise. The style and format make it easy to read, and he makes every effort to get beyond the jargon to make the information accessible. It is packed with practical advice, and it provides answers to many of the questions that are often asked. It also encourages the carer to work together with the patient and health professionals to achieve realistic and mutually agreed outcomes.

While this book is primarily for carers, I believe any professional who may be involved in the care of a patient with cancer would do well to read it. I was struck by the depth of insight into the carer's perspective that it conveys, and I think I have come away with a better understanding that will inform my own practice. If I were a lay person caring for a friend or relative with cancer I would want to have this book to help me. Yet many carers may never know that such a book exists – unless we have read it and are prepared to point them in the direction of the help and advice that is available.

Wesley Finegan writes from the perspective of one who has specialist knowledge but who has also experienced the 'subject' first-hand. He also writes as a Christian. While he makes specific mention of his own faith in one or two places, I sensed that in some intangible way his witness permeates every page of this book. Perhaps it is the quiet compassion and humility of one who has experienced suffering, and who has not been diminished by it. What is certain is that in some way this book is further testament to the grace of God who can work all things together for good to those who love him (Romans 8:28).

If I were a layperson caring for a friend or relative with cancer I would want to have this book to help me.

***Jeffrey Stephenson** is a Consultant in Palliative Medicine in Plymouth*



Perfecting ourselves to death

The pursuit of excellence and the perils of perfectionism
Richard Winter

- IVP 2005
- US$16.00
- 205 pages pb
- ISBN: 0-8308-3259-9

Richard Winter is a psychiatrist and theologian who says one of the reasons why people are unsatisfied with life is because society is preoccupied with air-brushed and computer enhanced features, perfect bodies, perfect homes, designer babies.

He says that people can be grouped into 1) non-perfectionists 2) healthy perfectionists and 3) dysfunctional perfectionists. Healthy perfectionists are realistic about their strengths and weaknesses. They are driven by a positive motivation to achieve. They pursue excellence. Unhealthy perfectionists are never good enough; their self-worth depends on performance; they are over-concerned with mistakes. Non-perfectionists are laid back and fun to be with but can be irritatingly lazy and unreliable. Some people are perfectionists in some areas of life only. Interpersonal perfectionists are frightened of their flaws; they fear rejection, because of what others may think of them. This can be associated with relationship problems, anxiety, burnout, eating disorders and depression. Perfectionists who have excessive standards for those around them have a tendency to be arrogant, impatient, blaming and distant. Because standards are not reached anger is generated and if directed inwards, depression can occur; if directed outwards rage with others may occur.

Winter encourages the reader to keep a journal and to use cognitive therapeutic techniques – identify habitual thoughts, learn to question them and begin to experiment with new and more reasonable thoughts:

'November 12. I go to put the dishes in the dishwasher. My husband has put the dishes on the wrong rack...

Emotions: frustration and anger.

Perfectionist thoughts: Why can't he do it the right way? The bowls should go in the wider spaces. Why can't he be systematic? Why is he so stubborn? Why doesn't he respect my opinions?

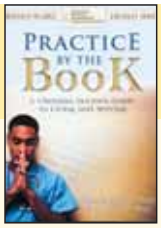
Alternative thoughts: I believe my way is better, but there are other ways to load the dishwasher. A few crumbs won't make much difference. I shouldn't let a small thing ruin all the good in our relationship. He is not stubborn about most things.

Conclusions: This is a small matter. I don't need to get so angry about it. Perhaps if I stop nagging him, he will be more likely to change. He listens to me and respects my opinion in most things...'

Winter writes as a Christian but states, 'I am aware that my readers will not necessarily share my Christian worldview.' He addresses the issue of perfectionism theologically: 'Not only can you not make yourself perfect, but you also do not have to be perfect to be accepted by God.' 'True perfection is found in developing a Christ-like character.' He quotes C.S. Lewis: 'those who put themselves in His hands will become perfect, as He is perfect.'

This is a helpful book and unlikely to offend those who are not Christians. It is well written and referenced, useful for those who have a problem with perfectionism or are trying to help those who have.

Dominic Beer *is a Consultant Psychiatrist in London*



Practice by the book

A Christian doctor's guide to living and serving
Gene Rudd and Al Weir

- CMDA (Christian Medical and Dental Association) 2005
- US$16.99
- Pb 260 pp
- ISBN: 0 970 66314 5

Does being a Christian make a difference to our medical practice? Probably most of us would like to answer 'yes', but if we take an honest look at ourselves and the other doctors around us, we may have some doubts. We may feel caught up in something bigger than ourselves, where we have little room for manoeuvre.

Gene Rudd and Al Weir, two doctors from CMDA (our sister organisation in the USA) have learned from experience that being a Christian can radically affect the way we practise medicine, but it is not an automatic process. 'When Christ changed our lives to make us Christians, he also changed the kind of doctors that we should become. We as Christian doctors must learn to weave together our science and the Spirit of God.'

It will take careful thought and deliberate effort, if our practice of medicine is going to count for Christ; but the benefits are great and we neglect them at our peril. If we feel that the pressures of professional life are robbing us of the abundant life that Jesus promised (John 10:10), and we would like the whole of our lives to count more for Jesus, this book can help us.

The writers take us through such topics as the foundations of our daily relationship with Christ and what influences our lifestyle and career choices. We are invited to consider how Jesus' bias to the poor and needy affects our priorities, how competence and Christ-like character need to be developed, how we tackle ethical issues, how we can best use our resources of time and money, how we cope with pain in our own lives, how we protect and enhance our relationships in marriage and with colleagues, and how God can use our personal testimony.

Each chapter is freely illustrated with personal stories and contains biblical guidelines and practical suggestions. Many of the stories come with refreshing honesty and humility, and lessons learned from failure are readily admitted. Although written from the US context and sometimes in a rather American style, the material of the book is relevant and readily applicable to any doctor and will help all of us who want to rediscover our joy in Christ and be more effective for him in our professional lives.

This book is relevant and readily applicable to any doctor who wants to rediscover joy in Christ and be more effective in professional life

Kevin Vaughan *is CMF Associate General Secretary*

obituaries

Gwen Barton (q Royal Free 1940; d 29 June 2005)

Gwen's early career was in the pathology laboratory at the Royal Free Hospital, which was evacuated to Arlesey, Beds, during the Blitz. Here she met her future husband Major (later Lieut-Col) Cecil Barton, and they were married in 1943. The couple moved to Carmarthenshire, where their three children were born. Gwen worked as a GP in Wales, later returning to pathology. Research into cholinesterases led to her gaining her MD in 1957, and she was made a consultant pathologist a few years later. A respected specialist in chemical pathology, Gwen was a founder Fellow of the Royal College of Pathologists.

After retiring in 1976 she continued to work in general practice, occupational health at Odstock Hospital and, most notably, as the first medical director of the Salisbury Hospice. Her final retirement did not come until her 80th birthday. Gwen played an active role in her village of West Grimstead. Particularly good with children, she ran clubs and organised events in the community. She was church organist and choir mistress for over 30 years. She was greatly loved by colleagues, friends and her large family. Particularly touching were letters received after her death from young people who had attended the Sunday club she ran. Here she not only taught them about Jesus and their responsibility to others but ensured they had fun at the same time.

(Rex Barton)

Robin Burkitt (q Dublin 1938; d 19 April 2005)

Robin Burkitt considered the most rewarding part of his professional career was from 1954 to 1963 when he was senior registrar at Upton Hospital, Slough. During this time he was proud to have played a major role in transforming the reputation of the hospital.

Robin was born in Enniskillen, Northern Ireland. At Trinity College, Dublin he studied modern languages then changed to medicine. His brother Denis carried out pioneering research into cancer (Burkitt's lymphoma) for which he achieved worldwide recognition.

After qualifying Robin took a post in the Royal Cornwall Infirmary where he met his future wife, Violet. They were married shortly after war broke out. Robin joined the Army and was sent to France until the German advance forced a retreat in haste. He was later posted to West Africa where he worked in the Gambia and Nigeria. He returned to England in 1944 to train as a surgeon.

Subsequently he joined Ashford Hospital, Middlesex, as a surgical registrar and gained his FRCS. He joined a medical practice in Nairobi, Kenya. However, the time in Kenya was not a great success and after three years the family returned to UK. In 1963 Robin took up a consultant post at Ashford Hospital. He was highly regarded, not only because of professional skills as a surgeon, but also for his great gifts of communication. He worked tirelessly for the Slough Branch of the Multiple Sclerosis Society.

Right to the end he visited local people offering sympathetic advice and comfort drawing from his great knowledge and experience. Robin had a very strong faith. He worshipped at the United Reform Church in Beaconsfield for many years. His wife died in 1997, having suffered poor health since the early 1970s. He will be greatly missed by his three children and their families as well as the many people who had enjoyed his friendship.

(Robin Burkitt - son)

Ruth Crookes (q Queen's, Belfast 1992; d 5 July 2004)

Ruth did junior and senior house officer jobs at the Ulster Hospital, Dundonald and then went into general practice. She became a partner at Kerrsland Surgery, Belfast, in 1999. Ruth was very involved in the life of her local church and had a vibrant faith. She was a witness to God's faithfulness during her short, final illness. She leaves a husband, Jim.

(Taken from obituary in BMJ)

George Smith (q St George's, 1950; d 1 August 2005)

Dr George Smith died after a short illness aged 79. After more than 30 years as a Buckinghamshire GP, he was still working as a dermatologist when he became ill. His ready smile and gentle personality endeared him to many. He was also a man of strong belief, dogged determination, wisdom and perseverance. George's first wife, Sylvia, died in1981; for the last 16 years he has been married to Helen, the other half of the inseparable George and Helen duo.

George was a Christian first and foremost who loved Jesus above all else and saw medicine as a place where God had called him as his primary ministry. As well as being a CMF member, George was involved from the early 1980s in *Caring Professions Concern*, and for many years was part of the *Christians in Caring Professions* (CiCP) leadership team.

George was always concerned for truth, that people should not be misled by things which seemed good but could ultimately lead to error and a weakening of faith. For this reason, in later life he started exploring the world of alternative therapies, especially their spiritual roots and the influences they could bring to bear. He was fearless in the talks and writing he did for CiCP and CMF. In particular, CMF is thankful for the hundreds of hours both he and Helen dedicated over the last three years, researching and writing the recently completed series in *Triple Helix* on alternative therapies.

George's greatest gift to others was simply who he was. He loved the Lord and he cared for others, both in this country and abroad. At his funeral celebration – it could not simply by called a funeral – Rev Jim Graham referred to three words that, for him, summed up George: integrity, perseverance and graciousness.

(Derek Munday & Rachael Pickering)

This is a new column in *Triple Helix*. We have previously carried brief obituary notes in *CMF News* but here are able to give more details. We try to commission obituaries but are limited by the information we have to hand, which explains the variable length of reports. We welcome 200 word submissions in the above format and particularly value personal reflections.

John Martin asks how well we understand Jesus' message

Physician heal yourself

'The Spirit of the Lord is upon me because he has anointed me to bring good news to the poor…' (Isaiah 61:1)

There's nothing like the buzz when someone who grew up in a village comes back to home to preach. I remember such an experience over 30 years ago and it still gives me cold shivers.

I was a second year student and my highly enthusiastic brother not only put leaflets all over the place but brought a singing group including electric guitars (unheard of) to replace the church's wheezy reed organ.

There was a huge turnout: people who'd known me since I was in short trousers, known my father, my grandfather and grandmother, the first couple married in the church. Some could tell tales of my great-grandfather, one of the pioneers of the district.

Like many a student I delivered something akin to a PhD thesis. Eyes glazed over. Then the old minister got up. 'Well, it's nice to hear from this young man. I'm sure that as he reads a bit more theology he'll see that what he's said today doesn't stand up!'

To tell the truth I didn't mind. Intuitively I sensed he was right, but the locals were livid. They may not have made sense of what I had to say, but a know-all incomer who hardly knew anyone had no right to publicly criticise a local lad.

No doubt there was a buzz when Jesus returned to his hometown Nazareth. Word had come about what he'd done in nearby Capernaum. Maybe he would settle down now. His wonderworking would surely attract crowds and boost the local economy. No one was nodding off in the synagogue this Sabbath.

Jesus quickly runs into a wall of unbelief and scepticism. How can a local lad claim that the rule of God has come right here and now - through his agency? We know his family. They're not that special. So young man, if you are what you claim, show us a sign. It's said you performed miracles in Capernaum. Maybe the reports are over-egged.

We know two things about the people who rejected Christ that day. First, they were the present-day heirs of a people who had enjoyed God's special care for generations. They were part of the Israel of God, people who knew God's works and his ways. Second, they were people who in human terms knew all there was to know about Jesus. They had all the advantages but tragically they failed to enter the inheritance that God had planned for them.

It's a warning to us. We are people who have been favoured with knowledge of God. He has showered blessings unnumbered on us. Even so it's possible for our eyes and ears to be blocked. Do we properly hear the manifesto Jesus unveiled in that day Nazareth? Jesus announced a new deal for the poor. Is the faith we claim to possess Good News for the poor in practical and real ways?

Are we, like Jesus kinsfolk and neighbours, people who on surface level know practically all there is to know about Christ, but tragically fail to grasp the full import of his message?

***John Martin** is Associate Editor of Triple Helix and Head of Communication for the Church Mission Society*

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