Autumn 2006

for today's Christian doctor

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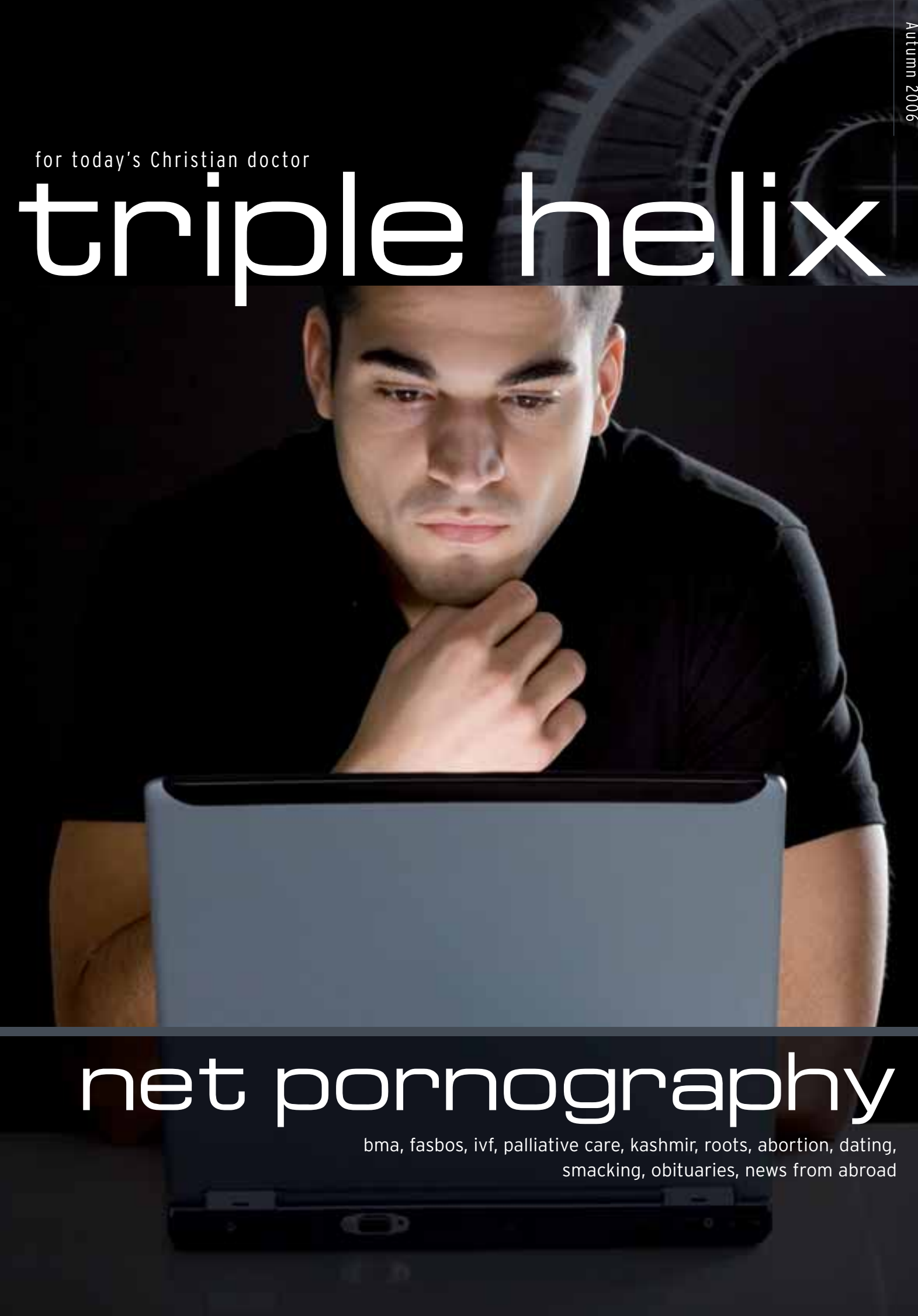

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contents

Elijah or Obadiah?

The role of Christian doctors

Whether you see yourself as an Obadiah or Elijah, or someone called to play another role entirely, I pray that this edition of *Triple Helix* will equip, inform and inspire you on that journey

The Old Testament prophet Elijah's confrontation with the prophets of Baal in 1 Kings 18 is one of the best-known stories of the Old Testament. One man has the courage to stand up to Israel's apostate king Ahab and his evil wife Jezebel and wins a great victory on Mt Carmel. God himself intervenes in the contest both to vindicate Elijah and to demonstrate his own majesty and power. It is a reminder that even during the darkest times of human history God remains in control.

The story of Elijah's withdrawal into the desert when later overcome by fear and exhaustion is one beloved by all who have ever found themselves 'honourably wounded' in the Lord's service. God's provision of food, drink, rest and a fresh refilling with his Spirit is a prescription we all need to draw on frequently if we are to retain our sanity and spiritual health in a world increasingly hostile to Christian living and Christian values.

But the story that I would like to draw your attention to is that which immediately precedes the battle on Mt Carmel – the meeting that takes place between Elijah and Obadiah. Obadiah is a lesser-known Bible character – but he was in charge of King Ahab's palace and clearly, like Joseph, Daniel, Nehemiah and Mordecai in other Bible stories, had risen to a position of great influence and responsibility in government. We are also told that he was a 'devout believer in the Lord' and that while Jezebel was killing off the Lord's prophets, Obadiah had 'taken a hundred of the Lord's prophets and hidden them in two caves… and supplied them with food and water'. Like a former day Schindler, he was prepared to take risks to do the right thing.

Ahab, egged on by his wife, intended to kill Elijah, who had three years earlier prophesied to him that God was sending a drought as judgement on Israel's idolatry and apostasy. The meeting between Elijah and Obadiah took place as the latter was combing the land at Ahab's command to find grass to feed Ahab's starving animals.

Elijah tells Obadiah to go to Ahab and announce his arrival but Obadiah is reticent to do so afraid that if Ahab cannot then find Elijah, his own life will be in danger. He is reassured when Elijah agrees to meet Ahab himself later that day. As they say the rest is history.

It can be uncomfortable to be an Elijah in today's world. But some of us are to called to do just that – to stand up for justice and truth publicly in a hostile environment, delivering messages that the powers that be might not want to hear, being prepared to confront injustice and corruption, speaking out in order to be a 'voice for the voiceless' through letters, articles, submissions, personal visits and on the media.

The responsibility of Elijahs is to speak the truth without compromise; but the danger of playing such a prophetic role is that one can come across as bigoted, simplistic and strident - throwing judgements like grenades from a distance whilst shrinking from the face-to-face encounters with those in authority that really bring results. Elijah did not shrink from seeing the job through and risking all to do it – and he was also prepared to face the risk of meeting Ahab and not leave Obadiah to face him alone.

It can be equally unsettling to be an Obadiah – occupying a position of responsibility in our society's corridors of power. Obadiahs have responsibilities too – to use the position of power and influence God has given them to protect the vulnerable and innocent and to be willing to face up to unjust authority when it is called for. The danger of playing this 'incarnational' servant role is that one can be tempted to become compromised, timid and anxious about one's reputation. Obadiah was afraid about what Ahab might do – but despite his fear he was willing to pass on Elijah's message to the king, even though it put his own life at risk.

God needs Christian doctors in these days who are willing to be prophets like Elijah, people who are prepared to speak unpalatable truth, who are willing to put their heads above the parapet to expose corruption and injustice, and challenge flawed policy, regardless of the personal cost. And God also needs Obadiahs who will accept responsibility within our society's flawed institutions – in NHS Trusts, Royal Colleges, Hospitals, BMA, GMC and government – in order to be salt and light; to safeguard the services for the most vulnerable and to care with compassion for the most needy. And most importantly God needs the Elijahs and Obadiahs to work together, respecting, enabling and encouraging one another, for the extension of his kingdom and for his glory.

Whether you see yourself as an Obadiah or Elijah, or someone called to play another role entirely, I pray that this edition of *Triple Helix* will equip, inform and inspire you on that journey.

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

news reviews

Sanity prevails at the BMA

Overwhelming vote to reject change in law on assisted dying

Review by **Peter Saunders**
CMF General Secretary

The British Medical Association voted overwhelmingly to reject any change in the law on euthanasia and physician-assisted suicide at its annual representative meeting on 29 June 2006.[1] The vote followed the body's controversial move to a neutral position in 2005 and similar decisions to oppose assisted dying by both the Royal College of General Practitioners (RCGP) in September 2005 and the Royal College of Physicians (RCP) in May 2006. Lord Joffe's Assisted Dying for the Terminally Ill Bill was defeated by a 148-100 majority in the House of Lords on 12 May.[2]

The BMA motions read as follows: that this Meeting:

- believes that the ongoing improvement in palliative care allows patients to die with dignity; 84% for, 16% against
- insists that physician-assisted suicide should not be made legal in the UK; 65% for, 35% against
- insists that voluntary euthanasia should not be made legal in the UK; 65% for, 35% against
- insists that non-voluntary euthanasia should not be made legal in the UK; 94% for, 6% against
- insists that if euthanasia were legalised there should be a clear demarcation between those doctors who would be involved in it and those who would not; 82% for, 18% against

The BMA decision brought it into line with the World Medical Association, the Royal College of Nursing, the Royal College of Psychiatrists and the Association for Palliative Medicine, all of which have always opposed assisted dying.

Following the vote claims were made by Liberal Democrat MP Evan Harris that CMF had 'packed' the BMA meeting to unduly influence the vote, and that religious lobby groups were 'dictating policy'. But in fact, although Christian doctors had played a role in putting forward some of the 23 motions from local BMA divisions calling the BMA to oppose assisted dying, only 13 CMF members had attended the BMA ARM – 2.5% of the total 520 appointed delegates, and 5% of the doctors voting at the debate. Not one of these 13 were amongst the eight speakers who spoke in the debate.[3]

This claim of Christian influence followed similarly wild allegations that the campaign group Care Not Killing, in which CMF plays an active role, had spent over £11.8 million opposing Lord Joffe's Bill when in fact the true figure was just over £30,000.[4]

Christians should not feel intimidated by accusations of 'imposing our morality'. To the contrary, in a free society we have both a right and a responsibility to contribute to the democratic process in order to ensure that laws we consider both unnecessary and dangerous to vulnerable people do not enter the statute books.

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FASBOs (fetal anti-social behaviour orders)

Christians should support properly resourced and evaluated policies

Review by **Dominic Beer**
Consultant Psychiatrist in London

The UK Prime Minister Tony Blair recently stated, 'If we are not prepared to predict and intervene far more early, children are going to grow up in families that we know perfectly well are completely dysfunctional. The kids a few years down the line are going to be a menace to society and actually a threat to themselves'.[1]

Should Christians support these initiatives or should we be critical of the 'Big Brother approach'?[2]

The following are known risk factors for anti-social behaviour: impulsivity, low intelligence, poor parental supervision and adverse parenting, parental criminality, memberships of the delinquent peer group, large family size and low family income, opportunities for crime.[3] When both genetic and environmental factors are present, the risk of adult criminality is 40%. This risk can be substantially reduced by good parenting: adoption studies show that children reared apart from antisocial biological parents have only a 12% risk of adult criminality.[4]

Fetal and infant brains are very vulnerable, as in the case of fetal alcohol syndrome. Infants severely neglected in Romanian orphanages are at higher risk of attention deficit disorder.[5] The impulsivity of this illness is predictive for adult antisocial personality disorder.[6]

An eminent forensic psychiatrist emphasises prevention of antisocial behaviour by: targeting those at high risk of developing adult antisocial personality disorder and prevention of passing on antisocial behaviour by targeting high risk families by intervening in pregnancy, infancy and pre-school.[7]

The UK Government provided parenting support via its Sure Start programme[8] but those most at risk may well have slipped through the net. Clare Tickell, National Children's Homes Chief Executive, says: 'It is right that the Government is focusing on early intervention… this approach can positively change the lives of some of the most vulnerable children, young people and their families'.[9]

We as Christians should support properly resourced and evaluated policies that help vulnerable children and which may also prevent future criminal behaviour.

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Obesity and IVF

National guidelines should be fair, evidence-based and in children's best interests

Review by **Rachael Pickering**
Triple Helix Associate Editor

The media recently reported that moves were afoot to stop obese women receiving in-vitro fertility (IVF) on the National Health Service (NHS).[1] The broadsheets were less hysterical but many larger women received the message that the NHS was not going to help them fall pregnant.[2]

Behind the headlines was a report by the British Fertility Society (BFS), recommending that women with a BMI of more than 36 should not receive IVF.[3] Their 2005 survey revealed that, despite NICE recommendations less than ten percent of 37 centres were funding three IVF cycles. Furthermore, individual PCTs had varying social exclusion criteria - including smoking, obesity and existing children. According to lead author Mr Richard Kennedy, the report was an attempt to reduce disparity: 'Having PCTs come up with their own criteria is creating a postcode lottery that is, frankly, unacceptable'.[4]

Other experts have crossed swords with the BFS: Dr Taranissi, holding the UK's highest IVF success rate, took issue with using BMI alone as an exclusion criterion: 'These recommendations do not have a medical basis. They are financially driven'.[5] Ironically though, by deciding on a BMI of 36 as the cut off, these guidelines may actually increase the numbers of larger women obtaining assisted fertility.

Obesity is rapidly increasing and its causes run deeper than a couch potato lifestyle. It's been suggested that maternal obesity preconditions fetal eating preferences, and research is underway.[6] Meanwhile though, of what about the report's recommendations that smokers, lesbians and women with existing children be given the IVF go ahead? Why is the BFS not concerned with the effects of smoking on fetuses and children? Where is the report's review of evidence pointing towards the need for father figures in children's lives? And what about justice for the childless woman with severe polycystic ovarium syndrome, watching her slim second-marriage neighbour going off for IVF?

We take our cue from the Great Physician in being concerned for each individual we come across. Jesus did not discriminate against people because they lived in a poor area or had socially stigmatising health conditions.[7] On the other hand, he was not afraid to give individuals advice that, although in their best interests, was perhaps unwelcome at the time. National IVF guidelines should be fair, evidence-based and in the best interests of the potential children.

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Global poverty marches on

Time for Christians to blow the whistle

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

In the last few years we have seen the Millennium Development Goals, the UN declarations on AIDS, Blair's Africa Commission and the Gleneagles G8 Declaration. But despite all these good words and agreements, the evidence suggests that most governments are not delivering on aid, debt relief or opening up global trade in the ways that they agreed.[1]

12,000 people will still die today from preventable illnesses, including 8,000 children who will lose their lives to immunisable infectious disease such as measles and TB. Still nearly 1.5 billion people will live on less than 1 US dollar a day. This is not news, but despite all the high level rhetoric, there is still not the collective will to bring about real change.

It is bitterly ironic that Warren Buffet and Bill Gates, two arch capitalists, will do more in 2000 and in the years to come to fight the diseases of poverty than many governments.[2,3] The UN reckons that its eight ambitious Millennium Development Goals (MDGS) to halve global poverty and dramatically reduce chid and maternal mortality are in some trouble less than halfway towards their target deadline of 2015.[4] Asia, some of Eastern Europe and Latin America are doing well in reducing hunger, poverty and the burden of disease, but in Sub-Saharan Africa the problems are getting worse, not better, as AIDS, war and famine exacerbate the problems caused by corruption, unjust trade rules and spiralling debt problems.

However the fact that these issues are being talked about at the G8 and the UN at all (AIDS was only discussed at the UN General Assembly for the first time in 2001) shows that Christians can exert influence. Christians started the Jubilee 2000 campaign in the late nineties to see a cancellation of debt amongst the poorest nations and it began to change things. Make Poverty History last year moved things further forward. In 2007, a new global Christian movement, the Micah Challenge[5] launches another campaign to get the British churches engaging with the issues of global poverty, and calling on our government, and the governments of the world to meet their commitments to the MDGs and the other promises made.

The Blow the Whistle campaign will be part of a ten year long project by Micah Challenge to remind Christians of the biblical call to 'act justly, love mercy and walk humbly with our God',[6] to 'give voice to the poor and oppressed, and stand up for justice'.[7] CMF is getting behind this campaign, because we believe that justice for the poor is on God's heart, and that fighting global health problems is an issue of justice as well as of good public health policy and medical care.

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Claire Stark Toller looks at the need for increasing palliative care provision

PALLIATING
THE FUTURE

key points

Persistent requests for assisted dying are extremely rare when good palliative care is available. However palliative care, which should ideally be provided by both generalists and specialists, is unevenly available throughout the UK is mainly funded by the voluntary centre and is focussed on hospices. In spite of recent funding boosts, the provision of generalist, non-cancer and children's palliative care is particularly lacking. Recent initiatives like the National End of Life Care Programme, the Liverpool Care Pathway and the Gold Standards Framework have brought much needed improvements, but more funding and research is needed for the needs of dying patients in the UK to be met effectively.

Has there ever been another parliamentary bill to rival Lord Joffe's direct challenges both to Christian morality and to the prevailing ethos of medicine? Thankfully, his Assisted Dying for the Terminally Ill Bill, which sought to legalise physician-assisted suicide, was defeated in May.[1] One of the most powerful arguments used in the fight against it was that, if palliative care was available to everyone needing it, then very few patients would ask for assisted dying. The force behind this argument is the experience of palliative care doctors, 94 percent of whom oppose assisted dying legalisation.[2] But what are the key issues, ongoing needs and future challenges in the world of palliative medicine?

Inequalities

Ideally palliative care should be provided by generalists and specialists working together. Generalist palliative care (GPC) is provided by GPs, district nurses and hospital staff; whereas specialist palliative care (SPC) providers with specialist training - clinical nurse specialists and palliative care doctors - work in patients' homes, hospitals and hospices. Sadly though, palliative care services are unequally distributed around the UK. To understand why, we need to look at foundation and funding issues.

Postcode lottery

The majority of UK hospices were established because of local perception of need and charitable effort, resulting in uneven geographical distribution. Only recently, the North of England had a 30 percent above average need for palliative care but only half the average number of SPC beds; in contrast, Surrey had a need 20 percent below average but one of the highest ratios of SPC beds to population in the country.[3] In 1999 the voluntary sector provided an estimated £170 million of the £300 million budget for all adult palliative care.[4] However, little of this voluntary funding is directed towards GPC.

Cancer versus chronic disease

Patients with cancer access 95 percent of hospice and SPC services. Yet only 25 percent of the population die of cancer, whilst a further 300,000 patients with non-cancer related terminal illnesses would benefit from palliative care.[5] The Alzheimer's Society suggested that ageism and stigmatisation have resulted in few dementia patients being offered palliative care, and The British Lung Foundation noted that patients with chronic lung diseases have limited access compared to patients with cancer.[6] Furthermore, it is cancer that underlies the mapping and distribution of palliative care funding, and forms the basis for NICE guidance on palliative care.[7]

Children's care

The accessibility and availability of children's palliative care is still patchier. Most organisations support parents in caring for their children at home, with hospices providing respite care and complex symptom management. In 2004 there were 34 children's hospices but none had NHS funded beds.[8] Different agencies compete for the small amount of available funding, leading to service fragmentation. The needs of adolescents and young adults are particularly poorly served.[9] Furthermore, there is no consistent national strategy on children's palliative services.

Final resting place

Only four percent of deaths occur in hospices, in contrast to 56 percent in hospitals, 20 percent at home and 20 percent in care homes.[10] So far, SPC provision has largely focussed on cancer patients in hospices and the community; it would be neither possible nor desirable to build sufficient hospices to manage more non-cancer deaths. So, the greatest need is for increased GPC and SPC provision for patients with non-cancer diagnoses in hospitals and at home.

Further funding

The New Opportunities Fund from the National Lottery allocated over £45 million in 2002 to support home palliative care services to patients in the most deprived areas, and improve access for black and ethnic minority groups.[11,12] From 2002-2005 an additional £50 million per annum was provided for SPC only.[13] £50 million has been given to Primary Care Trusts (PCT) since 2005 on the understanding that they support recurrent costs such as specialists' salaries. The Department of Health is also training community nurses in GPC.[14] And since 2004 the government has been providing £12 million over three years to fund the National End of Life Care Programme. For children, in May the government announced an extra £27 million funding, in line with announcements in the Our Health, Our Care, Our Say White Paper and the Children's National Service Framework.[15]

In spite of these funding boosts, the more recent figures show that still only 35 percent of funding for English adult hospice and SPC services comes from the NHS. If these services are to continue, they will need to find ongoing funding from elsewhere. And in 2008 SPC funding will be radically altered by the introduction of Payment by Results. National tariffs will determine how much a PCT should pay for particular services such as inpatient hospice stays. Furthermore, PCTs will be obliged to fund core palliative care services (as outlined by NICE) instead of relying on the voluntary sector;[16] this additional cost could be as much as £150-200 million. It is unlikely that PCTs will be able to meet this demand. One solution may be for the government to hold a central budget for adult palliative care services, as is the case already with children's palliative care services.[17]

Education, tools and research

Palliative care is an evolving specialty with new drugs and approaches being developed. Individuals wishing to improve their palliative care could consider either attending a course or undertaking self-directed e-learning modules.[18,19]

GPC providers can enhance their practice through the use of tools as promoted by The National End of Life Care Programme. The Liverpool Care Pathway promotes the hospice care model in hospitals and has been introduced in 60 percent of all acute trusts.[20] The Gold Standards Framework offers primary health care teams an evidenced based programme to improve planning for the last nine months of life.[21] And the Preferred Place of Care plan is a patient-held document with patients' thoughts and choices for their future care. By December 2005, 28 percent of GP practices and 0.75 percent of care homes were using a tool.[22] These are encouraging figures, but the majority of dying patients remain uncovered.

Palliative care is an evolving specialty with new drugs and approaches being developed

Palliative care's research base remains small. Presently the needs of everyone with a life-threatening ilness cannot be successfully palliated. If every group of patients' needs are to be met then further research is needed, especially with regards to the palliation of non-cancer diagnoses.

Non-cancer diagnoses

Perhaps the greatest challenge to palliative care is to widen its focus from patients with cancer to those with non-cancer diagnoses. The emphasis of palliative care is shifting from being perceived as a 'dying service' to focusing on improving patients' symptoms and quality of life months and even years from death. Specialists may need to step outside their comfort zones, and other healthcare professionals should consider asking for palliative care advice when managing patients with large symptom burdens.

Future mandate

No doubt there will be further attempts to legalise assisted dying, but there will be less sympathy for those of us opposing it if we continue to rely on the same argument of lack of palliative care. Together we need to support the fight for better funding and to ensure that our palliative skills, whether GPC and SPC, are optimal.

Claire Stark Toller *is a specialist registrar in palliative medicine in the Oxford Deanery*

Photo Wellcome

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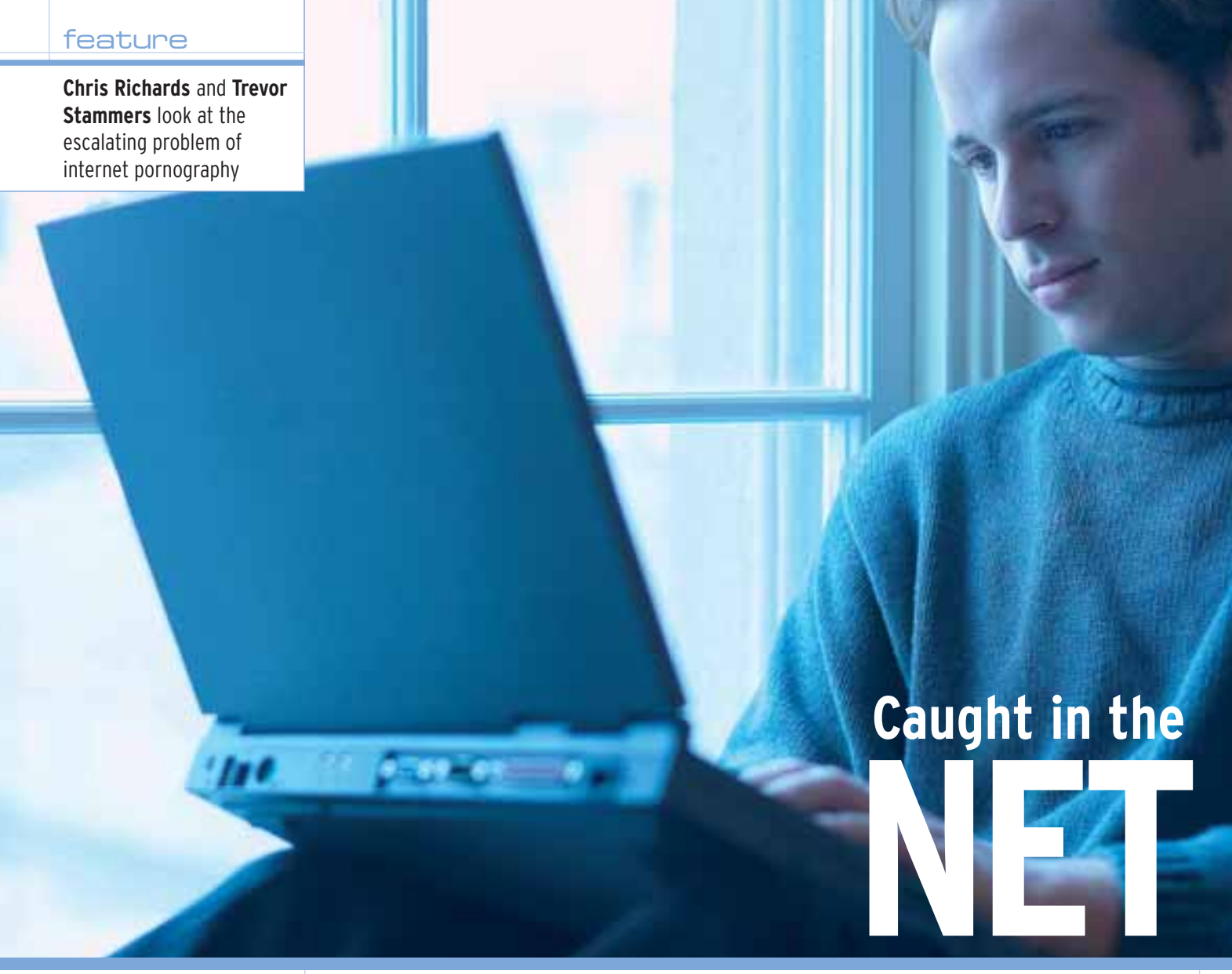
Chris Richards and **Trevor Stammers** look at the escalating problem of internet pornography



Caught in the NET

key points

The ready availability of sexual images on the internet has led to an explosion in pornography use and addiction and Christians are not immune from the pressures. By offering stimulation without consequences and intimacy without responsibility, pornography brings unreal and damaging expectations into relationships. Furthermore, by encouraging unfaithful thoughts, the use of porn clearly violates God's commandments and undermines marriage. Warnings from the Old Testament prophets are chillingly relevant today. Christians need to recognise the risks of pornography, seek God's forgiveness for involvement and embrace practical measures that will help them resist the temptation to get involved.

Despite pornography rarely being *out* of the newspapers, the media recently reported that all is not well in the airbrushed garden. The *Daily Mail* was alarmed that more than nine million men - almost 40 percent of the adult male population - logged onto sex websites last year. The number of women downloading internet porn soared 30 percent to 1.4 million.[1] The more liberal papers showed concern as well. The *Independent on Sunday* gave it front page coverage and four pages of analysis.[2] However, it also allowed a porn user two pages to explain why he wasn't a monster.[3]

Christians on the net

Christians are not immune from the pressures of living in a sex-saturated society: Operation Ore, a United States-led investigation into an online service offering thousands of images of abused children, led to the identification (from credit card details) of more than 7,250 British subscribers and resulted in 2,000 prosecutions. Several Christians were among those arrested, their ministries shipwrecked and their families devastated. But for every person who gets involved in viewing child pornography, there are thousands viewing legal and easily accessible adult material that many would claim is harmless or even therapeutic. How can we respond to this issue, both personally and in our professional dealings with patients seeking help?

Size does matter

What is the extent of the problem? The UK is one of the most affected countries in the world – our porn industry is worth an estimated £1bn share of the £20bn world market. UK internet surfers look up the word 'porn' more than anyone in the English-speaking world. And 2.5 million men, a quarter of the male population aged between 25 and 49, have accessed an 'adult website' in the past month. The number of men downloading pornography has quadrupled over the past six years in the UK whilst, not surprisingly, sales of pornographic magazine titles have halved. Printed material cannot compete with the internet, which is affordable or even free, accessible around the clock, and anonymous.

Women are also increasingly using the internet for sexual purposes though in different ways, preferring to use chat rooms. Even online, women still seek sexual outlets in the context of relationships. Cybersex may also prove appealing because it reduces the social stigma that is often attached to women who enjoy frequent sex, and it forms a safe haven to concentrate on sexual activity in an

uninhibited way. Anna Span, the UK's leading female porn director, makes films 'from a female point of view': characters are 'more three-dimensional…there is more foreplay and we have eye contact between the characters….' [4]

Not all women are so enthusiastic about pornography. Liberal Democrat shadow health spokesperson Sandra Gidley MP said she was 'alarmed by the type of material accessible to people…and concerned that the boundaries are being pushed on what is acceptable'. [5]

God on porn

What does the Bible have to say about porn? Obviously its modern form was not known in ancient Israel, but the Ten Commandments include three very relevant edicts: 'You shall not make for yourself an idol… You shall not commit adultery… You shall not covet your neighbour's wife'. [6] Taken together, these laws establish that God regards anything which causes a person to desire sexually anyone other than his/her spouse as totally wrong.

In the book of Ezekiel, God exposes the full extent of the hidden decadence of Israel's spiritual leaders. The 'idol that made the Lord so angry' was probably that of Asherah, the Canaanite goddess of fertility whose worship entailed *porneia* (the Greek word often translated as fornication or sexual immorality) and self-gratification. [7] God instructs Ezekiel to view initially through a hole in the wall to see what the leaders 'are doing with their idols in dark rooms...saying "The Lord doesn't see us"'. [8] However, nothing is hidden from God's eyes and eventually the whole wall is torn away, exposing the evil within. The application to the Christian, whether doctor or patient, who views pornography is obvious: God still sees and grieves over the deeds done in dark rooms illuminated by the seductive glow of such pornographic images today.

In chapter 23, with striking contemporary relevance, Ezekiel turns his attention to women, using the parable of the sexually-addicted sisters Oholah and Oholibah (allegorically referring to Israel and Judah). Not only did they lust after handsome young men, but Oholibah carried what Ezekiel calls 'her prostitution' still further by lusting after *pictures* of men 'portrayed in red, with belts around their waists and flowing turbans on their heads'. [9] Though expressed in cultural terms appropriate to Ezekiel's time, this detail echoes the specificity of certain items of clothing used to enhance stimulation in pornographic images today, a specificity which search engines are well designed to find. The passage also speaks graphically of the phenomenon of 'genitalisation', of focussing on the size of sexual organs as a measure of sexual stimulation. [10] God's verdict on such behaviour is clear: 'The shame of your prostitution will be exposed'. [11]

The battle for hearts and minds

In the New Testament, Jesus takes things one stage further: 'You have heard it said "Do not commit adultery". But I tell you that anyone who looks on a woman lustfully has already committed adultery with her in his heart'. [12]

It is not just our actions that matter, but also our thoughts and attitudes. Pornography threatens the integrity of sex because it encourages unfaithful thoughts and undermines marital fidelity. Many men also testify to on-going intrusive thoughts about other women, the remains of their pornographic past.

Based on a false image of reality, pornography brings unreal and damaging expectations into relationships; as one woman describes: 'The real reason I hated *Playboy* was that the models established a standard I could never attain without the help of implants, soft lighting and airbrushing. It's a standard that equates sexuality with youth and beauty. I didn't want him buying into this definition of sexuality. I was planning a future with this man and I wanted to feel secure in the knowledge that, even after two kids and 20 years, he would still find me sexy'. [13]

Escape from the net

How can we stay free and help our patients to do so? Remarkably, in the Christian faith there is no sin too serious, no life too awful and no person too hopeless to be beyond God's reach. Jesus has already paid the price for the worst of sins imaginable when he hung on the cross. None of us has lived the blameless life that approaches the perfect holiness of God: 'All have sinned and fallen short of the glory of God'. [14] There are only two types of people – those who have received God's forgiveness and those who need to! There is no other way to freedom.

When taking radical steps to deal with pornography, confession to God may be augmented by confession to a trusted Christian friend or counsellor. [15] The principle of 'confess your sins to one another' can be of enormous help when dealing with sexual sin. [16] Admitting the full extent of pornography addiction is very difficult; the temptation to hide aspects of it is always there. Fully exposing the issues means that healing can go as deep as it needs to and the chances of relapse are reduced.

Conclusion

'There is a way that seems right to a man, but in the end it leads to death.' [17] Pornography can seem so attractive, offering stimulation without consequences, intimacy without responsibility. But its rewards are as shallow as the page or flat screen, its reality as false as the sugary smiles and makeup, and its damage long outlasts its transient thrills.

Chris Richards *is a consultant paediatrician and director of Lovewise in Newcastle and* ***Trevor Stammers*** *is a GP in London*

Adapted with kind permission of Christian Viewpoint for Men

Practical help

- Place the highest level of filter on your internet.
- Only view the internet in an open place.
- Find an accountability partner to discuss your progress with honestly.
- Install a programme that sends your weekly website hits to your accountability partner:-
  www.cvmen.org.uk/resources.html
  www.covenanteyes.com
  www.xxxchurch.com
- Bowring L (Ed). *Searching for Intimacy: Pornography, the Internet and the XXX Factor*. Milton Keynes: Authentic Media, 2005
- Care for the Family
  www.care.org.uk/anon
- Lovewise
  www.lovewise.org.uk

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9. Ezekiel 23:14-15
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11. Ezekiel 23:29
12. Matthew 5:27
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15. Psalm 32:5
16. James 5:16
17. Proverbs 14:12

Ruth Coggan reflects on her return to Pakistan

Earthquake ZONE

After nearly 30 years as a gynaecologist in the North West Frontier Province of Pakistan, I decided to retire in 1999, a year earlier than originally intended. My sick sister and elderly parents needed care. I thought there would be no question of returning to work so I abandoned everything medical: I gave away my stethoscope, textbooks and white coats, and cancelled my journal subscriptions.

Call to return

On 8 October 2005 a massive earthquake hit Kashmir. The epicentre was less than 50 miles from Bach Hospital where I had worked for the last seven years of my career. At first it didn't occur to me to do anything except donate money and pray.

Then, three days later, three Swedish former colleagues called me as they passed through London on their way to 'help out at Bach'. They gave me a jolt. I continued to pray and chatted with friends, and felt that I should get in touch with Bach's medical superintendent. Secretly, I hoped he wouldn't have need of me. But in the 24 hours it took for him to reply, the Lord changed my heart and I found myself really wanting to go. So I was delighted to respond to his warm, enthusiastic invitation to come and assist.

The Lord calls us to do only those things which he is prepared to equip us to do. Over the next 24 hours I cleared my diary for three months – and discovered how easily dispensable I was – and flew out.

Earthquake wake

Instead of chaos, I found the hospital, whose inpatient numbers had trebled in just a few days, working in a calm and orderly fashion. Just two weeks earlier, the hospital authorities had drawn up a major emergency plan, in anticipation of a bomb or gun attack such as several Christian institutions had seen in recent years. Then the earthquake had happened and the newly-formed emergency plan had been immediately put into good effect. All the staff were working twelve hour shifts and all off duty had been cancelled.

The extra patients and their relatives were accommodated in two enormous tents outside the hospital buildings. Local mosque volunteers were coming in three times a day to supply them with food and drink. Too terrified by the earthquake to sleep indoors, staff families were living in makeshift tents in the hospital grounds, alongside a couple of NGO (non-government organisation) base camps. Aftershocks, many of them frighteningly strong, were occurring frequently and helicopters were constantly flying overhead, delivering relief to cut-off villages. On top of all this, large numbers of visitors passing through the hospital were being fed and accommodated as required.

Fitting back in

The gynaecologist who had succeeded me at Bach was on home leave. So, duly kitted out with a borrowed purple stethoscope and clad in an enormous white coat with 'cardiac surgeon' embroidered on the pocket, I fell back into my old job. I was very aware of my limitations as medicine had moved on in the six years since I had last thought about it. I felt particularly out of my depth trying to prescribe for medical conditions but the regular staff were all extremely supportive. I was surprised, delighted and very thankful that my linguistic, obstetric and surgical skills returned so easily. Taking over some of the obs and gynae oncalls, I was able to release the overworked general surgeons to a certain degree, enabling them to attend to the injured and even get a little much needed time off.

Valued presence

From the outset the medical superintendent of the hospital made it plain that, even if I didn't see a single patient, my presence was valued. There can't be many superintendents in the world like that! It made me realise that my contribution was more than just being another pair of hands. Knowing the languages and having experience of the culture meant that I could listen sympathetically to patients and their relatives. I held their hands, wept and prayed with them. I was able to visit what was left of their homes and held a clinic in an area that could only be reached by helicopter.

> The Lord calls us to do only those things which he is prepared to equip us to do

Trauma

It was not only the patients who were traumatised. The staff had been working long hours, dealing with horrific trauma and listening to stories of suffering and loss; they too needed to come to terms with the situation and have their stories heard. So another of my roles was to go for walks with them, listen to and pray with them. After a while, we began to celebrate birthdays again. And when it came, we celebrated Christmas in style.

Back to normal?

After three months my time was up. As I left, the hospital's workload was almost back to normal. But outside the grounds things were still far from normal. The homeless were waiting for the snow to melt before starting to rebuild, fearing what would happen to their weakened hillside houses in the monsoon rains. The threat of further quakes was still ever present.

There is so much more work to be done in earthquake-ravaged Kashmir (see the overseas opportunities page) but I am so grateful to God for my small part in the relief effort.

***Ruth Coggan** is a retired missionary gynaecologist living in Winchester*

Clare Cooper looks at humankind's obsession with genealogy and heritage

Searching for roots

The desire to know our roots is very strong, almost instinctive. Around the world people are seeking knowledge of their origins – ancient ancestors, forefathers of recent centuries or immediate family. We all belong to one, huge human family, yet we seem to need a sense of belonging to a certain group or place. We seek a sense of who we are and where we belong. But deep down, what are we really searching for?

Searching for ancestors

The Genographic Project, launched in April 2005 by the National Geographic Society and IBM, is a five-year genetic anthropology study to map the ancient human migrations across the continents. It aims to collect DNA samples from hundreds of thousands of people including indigenous populations, using ten research centres around the world.[1] Project director and population geneticist Spencer Wells considers that humans descended from an African ancestor who lived about 60,000 years ago. The study of the subsequent migratory routes, he says, needs to be done before our geographic and cultural diversity is lost. He bases his evidence on Y chromosome studies, which propose more recent dates than mitochondrial DNA data for early man. The Genographic Project also hopes to determine the world's oldest populations and the origins of differences between human groups. Using random mutations as genetic markers, the origin of a new lineage may be found and possibly traced to a geographical location. Assumptions are made about the rate at which mutations accumulate, in order to create a time scale. The team of researchers may well find more questions than answers as the project develops.

Most researchers estimate a common African ancestor 150,000 years ago, as first put forward by Cann and Wilson using mitochondrial DNA data.[2] Watson and Berry agree with Wells that early man travelled via the coast of South Asia to Australia, colonising the continent 60,000 years ago.[3] The Americas were reached much later, perhaps 12,000 years ago, by a small group of individuals. Only two major classes of Y chromosome sequences have been detected in the Amerindians; mitochondrial DNA variations are more extensive though, indicating a small founding population with more women than men.

Studies in European populations have shown unexpected results. For example, the male chromosomes of the Basques are almost identical to those of the Welsh. It is postulated that they are both the direct descendants of the earliest Europeans of 50,000 years ago.[4] However, the autosomal chromosomes and mitochondrial DNA of Welsh people hardly differ from those of the English, indicating that English men have not been drawn into Welsh society as English women have.

Searching for family

Besides extensive population studies such as the Genographic Project, much research is being done on a smaller, local scale. A visit to the UK's Family Record Centre in London will reveal a crowd of people from far-off countries eagerly and carefully searching for documented evidence of their British ancestors. They seek a place and a people group from which they came, not always realising that, for example, with 64 great great great great grandparents, their roots go far and wide. Nevertheless, it can be very satisfying to research recent generations, even if it may raise more questions than answers.

When a desire for knowledge of ancestry is thwarted by modern clinical interventions and legislation, the resulting emotions can be overwhelming. Barry was 18 when his mother told him he was conceived by donor insemination. Initial shock gave way to curiosity: Barry started searching for information about his biological family. He discovered two half-siblings but knows there could be many more. 'I do think wanting to know where you come from is a right. And although, unlike many people in my position I'm not opposed to donor insemination, the doctors who advocated it as a problem-free solution to infertility were mistaken.'[5] Concerns about genetic bewilderment, and feelings of distress and loss have led to the April 2005 change in UK law. Now anyone who donates their eggs or sperm must give identifying information including their name and date of birth, to be made available to any child born from the donation if they request it after reaching the age of 18.[6] The new law though will not help Barry.

Searching for significance

So why do we have such deep longings to know our roots? Is it in fact because we want to know that we have significance, that we matter and are loved? Human beings gain a huge amount of security and love by belonging to a supportive family unit, but ultimately our sense of significance should stem from the discovery of humankind's ultimate origin - we are loved and created beings, made in our Creator's image.[7]

> *'You come from the Lord Adam and the Lady Eve', said Aslan. 'And that is both honour enough to erect the head of the poorest beggar…*
>
> *CS Lewis, Prince Caspian*

The Bible assures us that whoever seeks God will find him.[8] And he who finds God and eternal life through Jesus Christ becomes part of a huge extended family: 'a great multitude that no-one could count, from every nation, tribe, people and language, standing before the throne and in front of the Lamb'.[9]

***Clare Cooper** is CMF Medical Secretary*

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Dominic Beer looks at new evidence

Psychological effects after ABORTION

key points

Ill effects from abortion in women with previous psychiatric problems is well documented but new evidence has now demonstrated that those without any past mental health problems are also at risk. A large longitudinal, methodologically robust study from New Zealand has set a new landmark and led to the American Psychological Association withdrawing an official statement which denied a link between abortion and psychological harm. The findings of other recent major studies and reviews mean that a woman having an abortion can no longer be said to have a low risk of suffering from psychiatric conditions like depression. Doctors have a duty to warn every woman considering an abortion that there may be long-term adverse psychological consequences.

Back in 2002 I reviewed the evidence regarding psychological ill effects after abortion and concluded that these reactions did occur; risk factors included a previous psychiatric history and the lack of a supportive relationship.[1] The Royal College of Obstetricians and Gynaecologists was not adequately warning about this risk, despite representatives from the Royal College of Psychiatrists stating that there was no psychiatric justification for abortion.[2]

Important new evidence

The most significant new evidence is that psychological ill effects have been shown to occur after abortion, even in women with *no* previous psychological problems.[3] This very important prospective longitudinal study followed up 500 New Zealand girls and young women from the time of their birth to 25 years of age. Each woman's mental health was measured at 16, 18, 21 and 25. Ninety reported having had an abortion, and these women experienced nearly twice the level of mental health problems as those who had either given birth or never been pregnant. They also had three times the risk of major depressive illness compared to the other groups. These results were statistically significant even after controlling for previous mental health.

The epidemiologist author Fergusson, himself pro-choice and not religious, was told by the New Zealand Abortion Supervisory Committee that it would be '…undesirable to publish the results in their "unclarified state"'.[4] Fergusson replied that it would be scientifically irresponsible not to publish these results: '…the findings did surprise me, but the results appear to be very robust because they persist across a series of (mental) disorders and a series of ages'.[5]

Current controversies

The robustness of abortion studies has been a key issue over the last four years. The methodology is hotly debated. How should we interpret the data? Fergusson's study controlled for social background, education, ethnicity, previous mental health and exposure to sexual abuse. He recognised that potential limitations remained: that further confounding factors may exist; that probably only 81 percent of abortions had been found; and that contextual factors such as an unwanted pregnancy's effects need to be addressed. Nevertheless, this study's findings cannot be ignored.

Fergusson quoted and was critical of a statement by the American Psychological Association – 'Well-designed studies of psychological responses following abortion have consistently shown that risk

of psychological harm is low… the percentage of women who experience clinically relevant distress is small and appears to be no greater than in general samples of women of reproductive age' – because it did not appear to take note of studies that reported different findings.[6] Instead, it had reported on only a small number of studies with severe limitations: limited controls; lack of comparison groups; and lack of comprehensive mental disorder assessment. Following this criticism, the APA withdrew their statement.[7]

One of these omitted studies was Cougle and Reardon's United States National Longitudinal Study of Youth (NLSY): this study found that, eight years after pregnancy, married women who had an abortion were 65 percent more likely to score in the high risk range for clinical depression than those who gave birth.[8] They controlled for age, race, socio-economic status, education and history of divorce but not for previous mental health. And again, they calculated 60 percent of abortion non-reporting.

Another study also looked at the NLSY data and claimed the evidence that having an abortion led to a higher risk of depression than giving birth is 'inconclusive'.[9] Reardon, a biomedical ethicist, replied that any woman who thought of continuing the pregnancy was excluded, a group whose ambivalence might place them at risk of emotional problems.[10]

Reardon also studied psychiatric admissions up to four years after abortion and childbirth.[11] It found the abortion group had significantly more admissions for depression (both single episode and recurrent), for bipolar and for adjustment disorders. California-based psychologist Major criticised this study: '…it is more appropriate to compare women who abort an unwanted pregnancy with women who are denied or unable to obtain an abortion, and hence are forced to carry to term a pregnancy that is unwanted. Another appropriate comparison group would be women who deliver a child and give it up for adoption. [This] partly is controlling for the "wantedness" of pregnancy'.[12] She concluded: 'A truly definitive study of the psychological effects of abortion is impossible, as such a study would involve randomly assigning women with unwanted pregnancies to continue or abort their pregnancies, a prospect that is clearly unethical'.

Review articles

There have been three review articles, though they have not looked at the most recent literature. Firstly, Thorp *et al* reviewed a number of studies up to 2002 which contained more than 100 women per study, all followed up for more than 60 days.[13] Their summary: '… induced abortion increased the risks for pre-term delivery and mood disorders substantial enough to provoke attempts of self harm. Thus, we conclude that informed consent before induced abortion should include information about the subsequent risk of pre-term delivery and depression'.

Secondly, forming the opposite opinion, Bradshaw reviewed six studies dating from 1990 to 2000, and concluded that there were no long term differences between those who had abortions and those who gave birth.[14]

Lastly, Reardon reported on 35 studies that identified those statistically validated risk factors which most reliably predict women likely to report negative reactions.[15]

Post-traumatic stress disorder

One large study found significant rates of long term post-traumatic stress disorder in women after abortion.[16] Of 254 women followed up two to five years after abortion for fetal anomaly before 24 weeks, 17.3 percent had pathological scores of post-traumatic stress disorder (PTSD). Risk factors were poor educational attainment, inadequate partner support, longer gestational age, and finding that the fetal anomaly was compatible with life.

In another study, PTSD was found in 14.3 percent of 217 US women ten years after abortion, though in only 0.9 percent of 331 Russian women after six years.[17] The authors concluded that abortion can increase stress and decrease coping abilities in women with histories of adverse childhood events and previous traumas.

Comparing abortion with miscarriage

A Norwegian study found that women who had abortions were more likely to suffer from depression and anxiety.[18] Researchers compared 80 women who underwent abortion and 40 who miscarried, following them up after 10 days, six months, two and five years. Compared with the general population, the abortion group experienced more anxiety at all four interviews and more depression at ten days and six months, whereas the miscarriage group had higher anxiety at ten days only. Predictors at six months and five years for anxiety and depression were previous psychiatric history and life events. Depression at six months was associated with doubt about the decision to abort. Anxiety at six months and five years was associated with a negative attitude to abortion.

Conclusion

There is strengthening evidence that there are psychological ill effects after abortion. Although methodological issues remain problematic in many studies, a large longitudinal, methodologically robust study from New Zealand has set a new landmark. A woman having an abortion can no longer be said to have a low risk of suffering from psychiatric conditions like depression. It is our duty to warn every woman considering an abortion that there may be long-term adverse psychological effects.

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Photo: Emlos

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Jacky Engel asks whether single Christian doctors should embrace twenty-first century dating techniques

Meeting DR. RIGHT

The biggest danger of speed and internet dating is idolising the notion of being in a relationship

'Most of us continue to survive because we're convinced that somewhere along the line, with grit and determination and perseverance, we will end up in some magical union with somebody. It's a fallacy, of course, but it's a form of religion...' [1]

I've sometimes wondered how many years you can live through thinking that sooner or later you will meet your life partner. As a youngster you assume 'it' will happen, either at university or somewhere along the way. Then, as you get older, you realise you could easily go another ten years waiting for 'it' to arrive. As a Christian woman, it's tempting to think that being single is caused by the lack of single men in the church and the limited circles from which to choose, compared to our non-Christian girlfriends. But it is a bit more complex than that.

Statistics do indicate that things are hardest for Christian women. At least a quarter of adult church attendees are single women, whilst single men make up only a tenth. [2] However, it's not just Christian women finding it difficult to meet a partner. The 2001 and 2002 censuses showed that 30 percent and rising of all adults remain single, with up to 51 percent of Londoners going it alone. [3] Western society as a whole is experiencing a change in the way our relational futures develop.

So, as a twenty-first century single Christian doctor who wants to meet that someone special, what are your options?

The proactive approach

The number of online dating facilitators available for Christians mirrors the online and speed dating options that have developed for non-Christians over the last

Interview with Dating Agency Friends First

Katharine, why did you set up Friends First?
I heard theologian Elaine Storkey challenge my church to do something for single people. And, I must say, the church in general has been incredibly supportive!

What's the different between Friends First and an online dating agency?
We offer a much more personalised service. Contacting and meeting people you don't know can be nerve-racking. We help, encourage and support people and that leads to a greater success rate than online agencies.

Aren't a lot of your clients sad, lonely and desperate?!
Very few! Most are just lovely people who for some reasons haven't met Mr or Miss Right. We also have lots of older clients, from 40 to 85!

What about doctors and nurses?
Loads of nurses, and a good number of doctors though many get snapped up quickly! See Charles and Andrea's story on our website. If you really are too busy to write any initial emails to the contacts you get from us, we do have a bespoke service as

decade. They can be a positive solution to a very real problem. With internet based dating, a single Christian unable to find love in a church setting can expand his or her pool of Christians with whom to develop friendships. Claire found her husband this way:

First of all I tried speed-dating – but only once! It proved a dismal experience with everyone trying to make an impression, asking bizarre questions and giving ridiculous replies. I really couldn't find out about anyone's personality or interests. Writing a personal advert proved more inspiring. It was a good way to date men from different professions. Of course you only meet one person at a time with adverts, and I stumbled across the perfect compromise solution when I heard about singles dinners. It was much more natural than speed-dating and at the very first dinner I met my husband-to-be. The rest, as they say, is history!

Breeding discontent?

Many Christians agree with Claire: twenty-first dating techniques are perfectly compatible with contemporary Christianity and they can produce lasting relationships for some! But others have strong reservations:

How am I judging the guy sat opposite me for three minutes? Paul tells Timothy that young men must treat young women as they would their sisters, and I'm sure the opposite applies![4] The atmosphere of many singles events doesn't help us in this! Furthermore, proactively pursuing a relationship in this way may breed discontentment. I am struck by theologian John Piper's words: 'God is most glorified in us when we are most satisfied in him'.[5] To me the biggest danger of speed and internet dating is idolising the notion of being in a relationship. (Anonymous junior)

Smug marrieds – happy-ever-after?

Simply being married does not in itself guarantee a happy-ever-after for Christian juniors. Every singleton should ponder the question: 'Apart from sex, what are my motives for dating and wanting to be married?' What are our preconceptions about married life? Do we think, for instance, that our sexual struggles will be over once we're married? Is there one most important factor in a Christian marriage? Anna shares her story:

Sexual purity as a Christian junior is often really tough. The amount of time you spend away from Christian contacts can be a problem. You are forced into close relationships with your medical peers, working, eating and resting together. Tiredness and the loneliness of shift work can be overwhelming. And it's all too easy to turn admiration for a colleague's clinical skills into romantic attachment. As an SHO I watched two of my Christian house officers drift away from God via such affairs with non-Christian senior colleagues.

There is no question that having a romantic relationship with a fellow believer can help you through the junior doctor years, but that alone is no guarantee of a happy-ever-after…Despite being a smug married myself, I too managed to fall for a non-Christian colleague. In the end, after a really painful time, only the remnants of my underlying faith brought me back to a right relationship with my husband and with God. Looking back, it may not have happened at all had I spent more time reading God's word, praying, and concentrating on my marriage. Instead, I'd let doctoring take first place in my life. So, whatever your marital status, do keep your relationship with God as your number one priority.

Godly guidance

At the end of the day, no matter whether we chose traditional or internet dates, the most important ingredient in all Christian relationships should be God. Medically qualified pastor Jason Roach suggests some helpful principles:

- **Be content in Christ** – it's hard but aim to learn the secret of being content in any and every situation.[6]
- **Look for character** – 'charm is deceptive, and beauty is fleeting; but a woman who fears the Lord is to be praised.'[7] Don't value appearances above anything else.
- **Cultivate friendship** – deepen relationships in ways that do not bypass the friendship stage. This honours God and protects us from premature emotional commitment.[8]
- **Stay as two of a crowd** – we need the encouragement and accountability of other Christians. Try not to let a fledgling relationship crowd out others.[9]
- **Seek God's help** – all human relationships have good times and bad ones. Recognising God's sovereignty and blessing in our current situation and praying to him will sustain us.[10]

***Jacky Engel** is CMF Research and Publications Assistant*

Web-based Christian dating sites

- **Big Church** *www.bigchurch.com*
- **Christian Café** *www.christiancafe.com*
- **Christian Connection** *www.christianconnection.co.uk*
- **Christian Cupid** *www.christiancupid.com*
- **Christians UK** *www.christiansuk.com*
- **Friends First** *www.friends1st.co.uk*
- **Fusion 101** *www.fusion101.com*
- **Link Christians** *www.linkchristians.co.uk*
- **Relationships.com** *www.relationships.com*
- **Seeking Christian.com** *www.seekingchristian.com*
- **Single Christian Network** *www.singlec.com*

Christian social events sites

- **Events for Christians** *www.eventsforchristians.co.uk*
- **Foundating** *www.foundating.com*
- **Southern Christian Solos** *www.geocities.com/southcs*

What do you think to speed and online dating? Join the debate on the online CMF Juniors Forum at *www.cmf.org.uk/forum*

well to do the initial leg work for you.

Don't people get judged by their looks?
No because we don't post pictures on our site. So, actually, people are judged less quickly by their looks than when meeting in other walks of life.

What do you call a success?
We call success when two people, who wouldn't otherwise have met, become friends. Many people don't tell us when they've made new friends, got engaged or married; but, so far we've had at least 40 couples tie the knot.

And have you met Mr Right via the web?
Indirectly! I met my fiance whilst exhibiting our separate companies. I tried to persuade him to join Friends First but he said he was far more interested in taking the boss out!

And what can you offer CMF members?
A 15 percent discount on our fees until the end of 2006.

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John Steley revisits the Christian smacking debate

Researching the rod

I feel sorry for parents today, caught up in the kind of culture war recently highlighted in *Triple Helix*.[1] 'Experts' tell them not to smack their children, claiming that it only modifies behaviour in the short-term. Apparently, it may even teach them to be violent. If a child's behaviour must be changed then, they are told, it can be more effectively done by other, non-violent means. The logic of these arguments, based as they are on the social psychology of aggression and the behaviourist theory of reinforcement, seems to be irrefutable.

Yet many parents remember being smacked as children and do not believe it did them any harm. The older generation often advise them to be stricter and to use 'a good smack' if needed. In addition, Christian parents find that the Bible seems to endorse physical punishment, as do some more conservative churches.[2] Even within the Christian medical fold, there is considerable disagreement over the smacking question.[3]

So what are parents to do? Nobody wants to be responsible for bringing up violent children. But is sparing the rod actually resulting in non-violent children? Do we in fact simply have a generation of riotous children developing into uncontrollable teenagers?

Conditional smacking research

A recent meta-analysis concluded that smacking is no less effective, and may sometimes be better, than other disciplinary tactics in modifying children's long term behaviour.[4] It was also concluded that, contrary to the social psychology theory of aggression, smacking does not promote any more, and sometimes promotes less, anti-social violence than other disciplinary techniques.

Importantly, the authors distinguished between different types of smacking. 'Conditional' smacking is non-abusively smacking a child who responds defiantly to milder tactics such as time out. 'Customary' smacking is smacking as it is typically used, based mostly on studies of smacking frequency without specifying how it was used. 'Overly severe' smacking describes the use of excessive force or slapping the face. Finally, 'predominant' smacking is the term used when smacking is the parent's primary disciplinary method.

Conditional smacking reduced anti-social behaviour significantly more than did ten of thirteen alternative disciplinary tactics (such as reasoning, privilege removal, love withdrawal, ignoring and restraint). There was no difference compared to the other three tactics: a brief forced isolation (based on three studies), a combination of non-physical punishment and reasoning (one study) and verbal prohibition (one study).

Most research on conditional smacking has used two to six year old children. Only overly severe and predominant smacking compared unfavourably with other disciplinary responses. It would appear that age-appropriate, conditional smacking to enforce milder disciplinary tactics can form part of an effective package of responses for both the short and long term. When so used, milder disciplinary tactics become more effective by themselves, rendering smacking less necessary subsequently.

Religious families

My own research into child discipline seems to indicate that religiously active parents have been fairly successful in their child rearing techniques.[5] People who had been brought up by parents who read the Bible, attended church, prayed and talked about God and faith were no more likely than others to have experienced physical punishment up to the age of twelve; after that they actually reported less physical punishment.

What I found most interesting was that people who had religiously active parents were more likely to say that the physical punishment they experienced was due to a *child oriented* reason; in other words, they were smacked because they had broken a known rule. They were less likely to say that the punishment they received was due to a *parent oriented* reason; that is, out of parental anger, the need to inflict pain or to show who's boss.

Religiously active parents were also less likely to discipline by the withdrawal of affection or approval. Overall, religiously active parents were rated more highly by their children in terms of sensitivity to needs, fairness of discipline, understanding of feelings and the degree of trust the child had in their parent. The essential element appeared to be whether the parent talked about God and faith. I found that these results were the same regardless of whether the child had continued with religious activity.

Where do we go from here?

So what should Christian parents do? It would seem that, if used correctly, smacking can be an effective disciplinary tactic. While nobody is ever perfect, the track record of Christians as parents is on the whole quite impressive. I suspect that this is due, at least in part, to their biblical understanding of who a child is. Every child is created in God's image and is therefore capable of doing good, but is also fallen and so capable of doing evil. Once this is recognised, parents can begin to respond to both good and bad behaviour appropriately.

No parent is ever perfect. However, I believe that the decision as to which disciplinary techniques to use must be left to individual parents, within a legal framework to protect children from abuse.

John Steley *is a psychologist at the Mission Practice and InterHealth Worldwide in London*

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eutychus

Depressed 'could get help to die'

Assisted suicide could be offered to Britons who are chronically depressed rather than terminally ill, the head of a controversial Swiss group has said. Ludwig Minelli announced that his organisation, *Dignitas*, is asking the Swiss Supreme court to allow a change in the law. Existing laws have already allowed *Dignitas* to help 54 Britons to die and Mr Ludwig said another British man was due to follow. Speaking at the Liberal Democrats conference, he urged the UK to drop its suicide laws. (*BBC News* 2006; 20 September) Minelli's comments have drawn huge criticism from both anti-and pro-euthanasia groups (*Daily Mail* 2006; 20 September) and led to a series of newspaper testimonies from patients who had been successfully treated for depression, thankful that there was no law allowing assisted suicide during their illnesses. (*Daily Mail* 2006; 21 September, *Daily Telegraph* 2006; 22 September)

Many not funding old age care

Two-thirds of the baby boomer generation have made no plans for their future care needs, a poll suggests. A survey of 942 adults for the charity Help the Aged showed 62% of 45-65 year olds had made no provision for care. One in five admitted they felt 'life is too short' to worry about something which may not happen - and many were ill-informed about the current rules. A government consultation on reform of NHS-funded continuing care is due to end this week. (*BBC News* 2006; 19 September)

Vegetative patient 'communicates'

A patient in a vegetative state has communicated just through using her thoughts, according to research. A UK/Belgium team studied a 23-year-old woman who had suffered a severe brain injury in a road accident, which left her apparently unable to communicate. By scanning her brain, they discovered she could understand spoken commands and even imagine playing tennis. They said their findings, published in *Science*, were 'startling', but cautioned this could be a one-off case. (*BBC News* 2006; 7 September)

Alcohol worse in pregnancy than previously thought

Pregnant women are drinking over the recommended alcohol limit and are putting their babies at risk of permanent brain damage, a children's charity has claimed. A survey of 1,100 pregnant women conducted by the charity Tommy's found that one in 20 pregnant women regularly admitted to going over the recommended limit of one or two units of alcohol once or twice a week. Tommy's wants the recommendation changed to a total ban. Heavy drinking during pregnancy can cause fetal alcohol syndrome; about one in 1,000 babies are born with the syndrome each year worldwide. But a milder condition, fetal alcohol spectrum disorder, is far more common – affecting one in 100 children – and is now the leading cause of learning difficulties. More and more doctors believe that this can be triggered by moderate drinking. Children with the milder condition can suffer from severe learning difficulties and behavioural problems, may be small for their age and have impaired sight and hearing. (*The Times* 2006; 19 September)

New stem cell centre

A £2 million stem cell research centre is to be built in Scotland. The Roslin Cell Centre, which is to be set up in Edinburgh, has the support of Edinburgh University, the Roslin Institute and the Scottish National Blood Transfusion Service. It will provide stem cell lines for research and therapy and, according to a spokesman for Scottish Enterprise Edinburgh and Lothian, 'act as a catalyst for the future development of the stem cell sector'. (*The Scotsman* 2006; 27 September, reported in *SPUC Digest*)

Spiritual issues in the care of dying patients

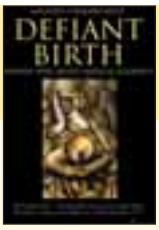
Spiritual issues arise frequently in the care of dying patients, yet health care professionals may not recognize them, may not believe they have a duty to address these issues, and may not understand how best to respond to their patients' spiritual needs. A recent article in the September 2006 issue of the *Journal of the American Medical Association* distinguishes spirituality from religion; describes the salient spiritual needs of patients at the end of life as encompassing questions of meaning, value, and relationship; delineates the role physicians ought to play in ascertaining and responding to those needs; and discusses the particular issue of miracles, arguing that expectations of miraculous cure ought not preclude referral to hospice care. (*JAMA* 2006; 296(11):1385-92)

Australian inquiry into complementary medicines

An ethical debate has arisen among Australia's doctors after the federal government announced plans to investigate the sale of complementary medicines by GPs. The Australian Medical Association said that doctors' purchase of vitamins on a wholesale basis to sell to patients was an ethical minefield. But a former president of the association, Kerryn Phelps, has rejected allegations of conflict of interest, saying that there is little difference between doctors selling complementary medicines and veterinarians selling dog food. Queensland GP Scott Masters told *The Australian* newspaper that a colleague in nutritional medicine was buying $A10,000 (£4,000) worth of vitamin E supplements at the start of each year and then selling them to patients at ten times the purchase price. (*The Australian News* 2006; 21 September)

Spiritual Care in the PICU

Spiritual issues are hugely important for the parents of dying children and need to be better addressed, argues an article in the September 2006 edition of *Paediatrics*. The Boston Massachusetts survey of 56 parents whose children had died in PICUs after the withdrawal of life-sustaining therapies, concluded that many parents drew on and relied on their spirituality – including prayer, faith, access to and care from clergy, and belief in the transcendent quality of the parent-child relationship that endures beyond death - to guide them in end-of-life decision-making, to make meaning of the loss, and to sustain them emotionally. The study concluded by encouraging 'staff members, hospital chaplains, and community clergy to be explicit in their hospitality to parents' spirituality and religious faith, to foster a culture of acceptance and integration of spiritual perspectives, and to work collaboratively to deliver spiritual care'. (*Pediatrics* 2006; 118(3):e719-29)



Defiant Birth

Women Who Resist Medical Eugenics
Melinda Tankard Reist

- Spinifex Press 2006
- £12.95 Pb 338pp
- ISBN 1 8767 5659 4

Russell T Davies, writer of the current 'Doctor Who' series, may well applaud this book. Discussing the insane cyber controller's vision of eradicating all human weakness and sickness, Doctor Who warns him of the result: 'a metal earth, with metal men and metal thoughts'. Sadly, in the real world, those who believe all weakness should be eradicated are not written off as insane but, in some cases (such as Peter Singer and Julian Savulescu), given chairs in some of the most prestigious universities in the Western world. Equally sadly, those with the voice of reason, such as Melinda Tankard Reist, do not have the influence and power of a Doctor Who, but are a largely unheard, underground movement.

Initially, the title of this book jarred with this comfortable, middle-class reviewer. It contains thirteen narratives by able-bodied women who continued with pregnancies despite diagnoses of disability in the unborn child. Defiant? Surely not. As Teresa Streckfuss, who continued with not one but two pregnancies despite prenatal diagnoses of anencephaly writes: 'It's about love. It's about our babies'. There are five other narratives by disabled women, and one collection of stories from HIV-positive women. They understand that in today's climate, such love is truly defiant because it flies in the face of the insidious process of shaming imperfection that is growing in our society.

Ms Tankard Reist is an Australian researcher and freelance journalist with an interest in bioethics and women's issues. This book does not take a specifically Christian viewpoint, but there is a danger that in this post-modern age, even Christians may become unquestioning and uncritical. If that is you, then read this book. The narratives are preceded by a meticulous, carefully annotated and referenced overview of how current thinking relates to the policies in our hospital and genetics departments today. It paints a terrifying picture. If you are still unconvinced, you need only look at the antipathy and venom with which Ms Tankard Reist is treated by the 'pro-choice' movement on the internet to see that liberalism is not the harmless thing we might have thought.

Can this book make a difference? Medical staff do not come out of it well so maybe it will change your practice. In the afterword, Melinda Tankard Reist writes of her hope that the narratives will give courage to other women. Unfortunately the very lengthy 72 page introduction would be daunting for most and maybe, for her hope to be realised, the book should be published in a more digestible form, with the narratives forming the first part and her excellent introduction and afterword combined in chapters as a second part. This book does, however, deserve to be widely read.

Karen Palmer *is a staff grade psychiatrist in Glasgow*

A Reason for Hope

Gaining strength in your fight against cancer
Michael S Barry.

- Life Journey (Kingsway)
- £6.81 Hb 126pp
- ISBN 6 12503 8831

The author is a medical doctor and Christian pastor at an American cancer treatment centre. He is therefore familiar with people's reactions both at diagnosis and during the trials of often long drawn out therapy. For all this, his message is upbeat. God is pro-life and has designed the body for self-healing, from a cut finger through to malignant disease. It is postulated that to give way to fear and pessimism insults the immune system, predisposing to slow decline. Dr Barry cites instances of miraculous healing where the injection of hope, even at an apparently terminal stage, transformed the outlook and cured the disease. 'Every form of cancer known to man has been survived' is the hope offered, backed by reliance on God's ability to heal.

'The diagnosis of cancer is not in itself a death sentence' and though acknowledging that full recovery does not always happen, Dr Barry does not dwell on this. In this, he joins company with so many other authors of books about miraculous healing. Throughout, his emphasis is on the expectation that God can heal even the worst of conditions if we rely on him.

There is no doubt about God's ability to heal, both in New Testament days and today, and we can trustfully commit all sickness to him for his will to be done. However, there is a delicate balance between this and insisting that he obeys our will. His healing is not necessarily what we would call curing, and many sufferers from advanced cancer have found that he has enabled them to live joyfully and trustfully, whether or not he chooses to remove the disease. The application of palliative care to the whole person can contribute enormously to such an outcome. That it receives little detailed attention here is a sad omission. Unfortunately, sufferers reading this book could be left with the impression that failure to recover is somehow their own fault and that there is little more to be done about it.

> sufferers reading this book could be left with the impression that failure to recover is somehow their own fault

The last section of the book suggests ideas for self-help in arresting the disease, such as the exercise of forgiveness in overcoming disabling bitterness. Dr Barry's unswerving optimism has doubtless encouraged many of his patients to live hopefully with cancer but it is not clear that he also shares with them a lively hope beyond the grave. It is good for us to be reminded that our own prayerful reliance on the God of hope is something to be shared with our patients. They need to know that he is indeed pro-life – life everlasting.

Janet Goodall *is an emeritus consultant paediatrician in Stoke on Trent*

Euthanasia. A License to kill?

Anthony M Smith

- Kingsway 2006
- £6.99 Pb 175 pp
- ISBN 1 84291 249 6

The assisted dying debate, fuelled by a succession of Bills put before the House of Lords by Lord Joffe, is not going to go away. It is an issue of huge importance, and has the potential to change the practice of medicine profoundly. Yet the debate is often superficial. Many in our churches, and indeed in medicine, appear uninformed and even confused about the issues.

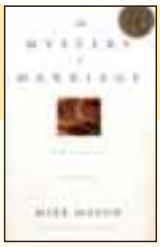
Anthony Smith's book tackles a wide range of issues relating to assisted dying in a clear and logical way. The arguments for and against euthanasia are detailed, as well as the experience of legalised euthanasia overseas. Physician assisted suicide is given special mention, recognising that this is now the focus of the effort to change the law in the UK. The difference between euthanasia and the withdrawing and withholding of treatment, including food and fluids where appropriate, is clearly and helpfully explained, as are the benefits and potential pitfalls of advance directives. The positive alternative of palliative care, and the current limitations of its provision both in the UK and worldwide are also discussed.

The book is illustrated throughout with patient stories drawn from Dr Smith's long experience as a hospice physician. Wilfred is an elderly man with metastatic cancer whose son asks whether anything can be done to stop him suffering. Cheryl's dad has Alzheimer's, recently suffered a stroke and now has pneumonia. Should he be treated with antibiotics? The stories that have hit the headlines such as those of Tony Bland, Diane Pretty, Terry Schiavo and Harold Shipman are also described.

Aimed explicitly at the Christian reader, the book considers the biblical viewpoint on euthanasia. It also addresses the wider issues of suffering and hope from a Christian perspective. I found these sections particularly powerful. They encourage us to lift our eyes from the relatively narrow focus of assisted dying up to our loving Lord, who suffered on our behalf and provides strength for today and eternal hope for the future.

This is a concise and helpful book, taking only a couple of hours or so to read. It is accessible for a non-medical readership, but has much to offer health professionals as well, especially those with less experience than Dr Smith of caring for terminally ill patients. The book will equip Christians with a greater understanding of the issues around assisted dying, and enable us to engage more fully in the ongoing debate. It also encourages us to confront the issue of our own mortality both at a practical and spiritual level.

***Claire Hookey** is Medical Director of Douglas MacMillan Hospice, Stoke on Trent*



The Mystery of Marriage

Meditations on the Miracle

Mike Mason

- Multnomah Press 2005
- £6.99 Pb 219pp
- ISBN 1 59052 374 1

This book fully deserves this revised and expanded 20th anniversary edition. I enjoyed reading it for the first time years ago and valued greatly rereading it with another decade of married experience behind me. The author is a Canadian who intended to become a monk but fell in love with and married a doctor. Without doubt, this is one of the best books on Christian marriage and it deserves to be more widely known in the UK.

The book is beautifully written with extended allegorical illustrations. The opening story of hawks soaring over the monastery gives the flavour of the book instantly. Mason looks at predictable issues such as love, intimacy and sex, as well as less well-travelled terrain such as death, brokenness and submission in marriage.

On submission, for example, those looking for endorsement of patriarchy will be sorely disappointed. If men are fortunate enough to be treated like kings at home it is only, in Mason's view, that they 'might better be enabled to become a servant'. He sees no distinction in Paul's words to husbands and wives in Ephesians 5:22-25 because for Mason, 'to love is to submit and to submit is to love'. Brokenness is viewed as being at the heart of intimacy. What is tough in marriage is what's tough in encountering God – the strain of living in the light of a conscience other than our own. The only way it can be done is in the strength of God's love which overcomes our pettiness and exposes our selfishness.

There are many thought-provoking applications of Scripture. On 1 Corinthians 7:4, for example, Mason writes: 'In marriage not just the body is given but the heart. One heart is given in exchange for another, and in this mutual proprietorship is found the deepest and most radical expression of intimacy. It might almost be said that love is the total willingness to be owned'.

There are also some superb one-liners. On sex, for example, he believes that for many it is 'the most powerful and moving experience that life has to offer, and more overwhelmingly holy than anything that happens in church'. On the sense of feeling trapped in marriage he suggests, 'When the prison door of love clangs shut, the only thing to do is to become more in love than ever'.

Perhaps one of the reasons this book has not been widely promoted is that we increasingly live in an age of instant 'fix-it' solutions. It does not fit into that mould and is much more of a 'Why?' rather than a 'How?' book on marriage. 'Why?' is however, an increasingly relevant question as the role of marriage is constantly undermined, marriage-rates are falling and many young people, including Christians, opt to live together instead.

I have a cluster of weddings coming up and this book will be among our gifts for each couple. If you need a fresh touch from God upon your marriage, or know others who do, then this book may help.

***Trevor Stammers** is a GP in London and Chairman of the CMF Public Policy Committee*

obituaries

Isobel Adeney
(*q* Dundee 1938; *d* 28 March 2006)

Isobel Adeney (nee Anderson) qualified in 1938 and then became casualty officer at the Mildmay Mission Hospital in London where she met Harold, whom she married in 1939. They sailed for Africa that year where together they served the Lord in Burundi and Rwanda. Isobel, as well as caring for her four children, all born in Burundi, worked with her husband in little mission hospitals. Isobel specialised in obstetrics and the care of the under-fives. For a time she was principal of the Buye Training School for assistant nurse-midwives. Completing their missionary service in 1982 they returned to England. Isobel then served on the overseas committee of the Mothers' Union where her knowledge of the needs of African women was greatly valued. Her friends all speak of her gentle smile and soft Scottish voice as she welcomed them to the hospitality of her home. She died aged 90 after a long illness.

David and Harold Adeney

John Anderson
(*q* Middlesex 1952; *d* 16 June 2006)

John, known to everyone as Jock, was born in Lincolnshire. At 16 he committed his life to Christ and soon formed a conviction that he should serve God in the Muslim world. Deciding the best way to do this would be as a doctor, he studied natural sciences at Cambridge and medicine at the Middlesex. In 1955, with his wife Gwendy and young daughter Ruth, he travelled to Pakistan with the Bible and Medical Missionary Fellowship (now Interserve). Concerned about the needs of blind people in remote areas, he developed a caravan hospital which brought medical, surgical and ophthalmic treatment to many thousands. In 1967 Jock helped establish the first eye hospital in Kabul. This and other work in Afghanistan resulted in him being awarded the OBE in 1981. On returning to the UK he worked at Moorfields Eye Hospital where he was appointed honorary consultant in 1984. Despite ill health in his later years he remained gracious and cheerful. He is survived by Gwendy, their three children and nine grandchildren.

John Davies

William Evan Anwyl
(*q* Westminster 1944; *d* 18 July 2006)

Enjoying a cliff-top camp in Norfolk when aged twelve was Evan's first involvement in Scripture Union camps, the beginning of sixty years dedicated service as camp leader. Always patient and ready to help in any way, even after retirement Evan and his wife Mary would holiday nearby to help with transport.

Evan was brought up in Berkhamsted. After qualifying as a doctor he worked as a surgeon in British Somaliland, where he married Mary in 1953. In 1960 the British had to leave the country and Evan spent two years as medical officer for an oil company. On returning to England he worked in public health and occupational medicine in Trowbridge. Evan leaves his wife Mary, who remarks, 'We have enjoyed the company of our Lord Jesus Christ all our married life', and their three children.

Mary Anwyl and Randal Cousins

Lord Chan
(*q* Guy's 1964; *d* 21 January 2006)

Michael Chan was chosen in 2001 to be a 'people's peer' and sat on the crossbenches of the House of Lords.

Born in Singapore, he studied medicine at Guy's and returned to Singapore for several years before settling in England. Here he became a paediatrician with an interest in blood disorders. He was later appointed Visiting Professor in Ethnic Health at the University of Liverpool. He served the Chinese community through committee and charitable work and was awarded the MBE in 1991. Lord Chan was involved in many matters; he sat on the Sentencing Advisory Panel and the Press Complaints Commission, was chairman of the Chinese Overseas Christian Mission and led the Chinese in Britain Forum. He also chaired the key meeting to establish the Care Not Killing Alliance.

His gentle manner and deep knowledge won him great respect. He is survived by his wife and two children.

from The Times, 8 February 2006

Baroness Lloyd of Highbury (RCPCH)
(*q* Bristol 1951; *d* 28 June 2006)

June Lloyd, who was on the Council of Reference of CMF, played an important part in the establishment of the Royal College of Paediatrics and Child Health (RCPCH). So much so that she is featured in the college's coat of arms. For many years she was a leading paediatrician and served on national committees, including the Medical Research Council. In 1985 she was appointed Nuffield Professor of Child Health at Great Ormond Street, her main research interest being in lipid metabolism. She was appointed DBE for her services to child health and in 1997 was made a life peer. Unfortunately before she took her seat in the House of Lords she suffered a major stroke that prevented her from playing an active part in the House. June lived for a further eight years and died peacefully. She did not marry, and is survived by her brother.

Bill Benson

Janet Ruth Plumptre
(*q* Royal Free 1958; *d* 23 March 2005)

After qualifying in 1958 Janet did house jobs and an SHO post in paediatrics, taking the DCH and later the DTM&H. Janet met Martin when they were both medical students and they were married in the Queen Alexandra's Hospital Chapel at Millbank. Janet became a captain in the Royal Army Medical Corps. She joined the paediatric department at the Royal South Hants Hospital, becoming a medical assistant in the spina bifida and hydrocephalic clinic, when Martin went into general practice in Southampton. She also did many locums in general practice and was considered the perfect locum by one senior GP. Her advice and support were much valued by her husband.

From early Christian Union days onwards her faith and work went hand in hand and she was much loved by her patients. She enjoyed playing the organ and did so for many churches, especially during her retirement in Church Stretton. Her last year was dogged with ill health but she was always well supported by Martin, their four children and eleven grandchildren.

Martin Plumptre

Richard William Porter
(*q* Edinburgh 1958; *d* 20 July 2005)

Former professor of orthopaedic surgery at Aberdeen University, Richard was highly innovative and devised several new orthopaedic procedures. His major research interests were in spine and osteoporosis research. He won international prizes for this work, including the first Volvo Award in 1979 for work on spinal stenosis. He developed commercial machines to measure osteoporosis and pioneered ways of treating club foot.

As a Methodist local preacher he supported renewal in the church, and wrote a popular novel *Journey to Eden*, which encompassed ideas that synthesise biblical and scientific worldviews.

Richard leaves his wife, Christine, who was his faithful support for over 40 years; four sons; and eleven grandchildren. His epitaph: 'Loving husband, father and grandfather, friend to many'.

Daniel Porter, for the BMJ

Frances Priestman OBE
(*q* Royal Free 1936; *d* 25 October 2004)

Frances served with the Sudan United Mission (SUM) almost all her working life. In 1938 SUM opened a leprosy settlement at Maiduguri in northern Nigeria, estimating that about 4,000 people in the area had leprosy. Soon Frances was in charge here, the chief organiser of leprosy control, and subsequently many patients came willingly for early treatment. She trained some treated patients as nurses. As a result of years of patient work by Frances and her fellow missionaries the whole work of SUM in Borno province multiplied greatly. A second leprosy settlement opened at Mongu in 1949 and she worked here in a less hot and humid climate. In later years she oversaw more than 100 clinics on mission stations and villages, opening a hospital in the region in 1960. Her work for leprosy was recognised by the award of an OBE. Frances retired in 1979.

Kathleen Priestman
(*q* Royal Free 1934; *d* 26 May 2006)

Kathleen was a well known general practitioner in Hendon, north London and was greatly missed by her patients when she retired in the 1980s. She became a Fellow of the Faculty of Homeopathy in 1955 and was later in charge of the children's department of the Royal London Homoeopathic Hospital. Having a strong interest in overseas mission, Kathleen was president of the Missionary School of Medicine from 1981 to 1991. In retirement she enjoyed craftwork, reading, bird watching and gardening. Her strong Christian faith sustained her to the end.

Kathleen and Frances Priestman were two of six daughters of a Quaker family in Cottingham, near Hull. They retired to the family home at Crowborough, East Sussex where they are survived by one remaining sister, Kitty.

Kitty Priestman and Anita Davies

Leslie Scott
(*q* Guy's 1939; *d* 26 March 2006)

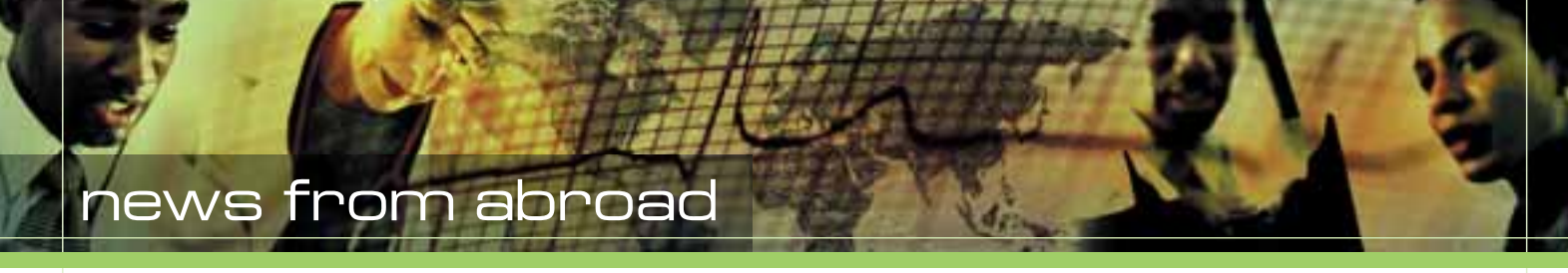
Leslie's first medical posting to Tunbridge Wells included treating Dunkirk evacuees as they moved up from the channel ports, and then Battle of Britain pilots shot down over the local countryside. He observed the pioneering treatment of burns by MacIndoe at East Grinstead. When a committee chaired by Sir Alexander Fleming was assembled to decide how the new wonder cure – penicillin – should be distributed, Leslie represented the junior doctors.

Joining the Royal Air Force, he served as a medical officer in North Africa and Italy. After the war Leslie specialised in paediatrics. He studied at Great Ormond Street Hospital, and in 1950 was appointed a consultant to the Eastbourne and Hastings group of hospitals. He spent the next thirty years building up the paediatric service and took a special interest in the treatment of asthma, challenging the received wisdom that sea air would cure patients. He was medical officer to Pilgrims School for the severely asthmatic.

He took an active part in church life and was cofounder of the Bexhill Crusaders. In retirement he was church secretary, a Vice President of Invalid Children's Aid Nationwide, and pursued his interest in cricket and his garden. In 1947 he married Esme Pascall, who died in 1989. He is survived by three daughters and two sons.

Christopher Scott

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.



news from abroad

It is always both a challenge and an encouragement to meet folk at the Developing Health Course (see the report in *CMF News*) who are working overseas and to hear something of their story. The problems they face may be common to all - working in difficult and trying circumstances - but with added stress of very minimal resources, language and cultural differences, isolation and, on occasions, the real the threat of physical danger. However, the joy and fulfilment that flows from being where God has called you to be, make it all so very worth-while – and they go back for more!

It's all a matter of perspective

One member, working in Africa, described a recent journey to a church they were visiting with their four children one Sunday morning. It involved a long dusty drive along rutted tracks only to find that, for the final phase of the journey, they needed to abandon the vehicle, climb into a dugout canoe and paddle down a crocodile infested river to get there. A terrifying experience from a mother's perspective but seen from the children's point of view – 'A real cool day!'

Another member writes about a patient brought into hospital in obstructed labour from a village some 50 miles away. It had taken over 48 hours to reach the hospital by ox cart. Talking to the patient, it quickly became apparent that she had never left her village before, had never seen a hospital, had never been in a room with an electric light and had never seen a white man! From the point of view of the western students who visit the hospital, it seems like another world too – no telephones or internet, no bank or supermarket, erratic electricity and irregular water supplies and atrocious roads! It's all a matter of perspective.

Where are the men?

Such situations are not for the faint hearted – a challenge for any macho man - and yet when I look at the break down of participants at the Developing Health Course, 38 of the 51 attendees were female. The majority of missionaries you meet at healthcare fora are female. Eleven of the twelve CMF members that I currently know are preparing to work overseas, short or longer term, are female.

I ask myself, 'Where are the men?' I remember, at one point during our time in Tanzania 30 years ago, there were some 35 single ladies working in the immediate vicinity and only two single men. The ratio hadn't changed when I was involved in a work in North Africa 25 years later. It seems as though men answer God's call with the response, 'Here am I Lord, send my sister!' Obviously, in an Islamic culture, it is entirely appropriate that the gynaecologist is a woman but that doesn't apply to every branch of medicine nor to other needy situations. The women are doing an amazing work, often in very trying circumstances, but where are the men?

Where are the surgeons?

I was interested to read an article in *Tropical Doctor*, co-authored by a CMF member recently returned for Malawi, Chris Lavy.[1] The paper reports the results of a 2003 national survey of surgical activity in Malawi. A small but densely populated country, Malawi is ranked as one of the poorest countries in Africa. The writers point out that none of the 21 district hospitals in the country has a resident surgeon. Very little major surgery is carried out anywhere. Caesarean section and D&C account for 44% of the operations performed, the rest being mainly minor surgery.

I found it a very depressing read, looking back and realising that the situation was better when I first entered the country in 1967. Numbers offering to work overseas have decreased and the 'brain drain' has worsened but the needs have increased, particularly for those who will come alongside to teach and train younger overseas nationals. It will remain a vital area of Christian service for many years to come. The opportunities are there for those who seek them.

While on the theme of surgical needs, a CMF members, working in Madagascar requests a surgeon locum in the spring of 2007 - see *www.mandritsara.org.uk* . General surgeons are also needed at Galmi Hospital in Niger, Mukinge Hospital in Zambia, Rumingae Hospital in Papua New Guinea and Meskine in Cameroun – all for the longer term – see our overseas website for more details.

www.healthserve.org/overseas_opportunites/20050000.htm .

Prayer concerns

It is not possible to be specific in these pages but do please continue to uphold those of our members who are working abroad. Several have been on home assignment during the last few months and are now returning abroad. Some have been sick themselves and need to experience the Father's healing touch. All need fresh strength for the days ahead. Pray for the families too and for those with the added responsibility of home schooling.

If you have a particular interest in a particular country, you might like to be praying for those of our members who are working there. Please let me know and I will seek their permission to put you in touch. There are so many ways we can demonstrate our support for those working overseas. Just to know someone is faithfully praying can be an enormous encouragement. To receive the occasional email or small gift - chocolate or sometimes a jar of marmite - is always welcome and can work wonders for the morale. It's all just a small part of our fulfilling our role as a fellowship of Christian healthcare professionals.

Known Current needs

The posts offered are all salaried.

- Bach Hospital in Pakistan. There is a particular need for a locum obstetrician (either sex) from 23 February to 16 March 2007. In the longer term there is a need for an anaesthetist and dentist and a female obstetrician.
- The Oasis Hospital, UAE is looking for doctors in several specialities.
- Cure International Hospital in Afghanistan have vacancies for a paediatrician, anaesthetist, GPs (2) and pathologist.
- Cure International, Malawi need an orthopaedic surgeon in Blantyre.
- LAMB Hospital, Bangladesh desperately need a female obstetrician.
- Crosslinks need a GP to replace one of our members who is completing a time of service in a rural hospital in Tanzania.
- Medair need medical co-ordinators for their work in DR Congo and Sudan.

You can find full details of these and other overseas vacancies on our overseas website *www.healthserve.org/overseas_opportunites/*

Peter Armon *is CMF Overseas Secretary*

references

1. Steinlechner C *et al*. National survey of surgical activity in hospitals in Malawi. *Tropical Doctor* 2006; 36.3:158-160

Paul Dakin asks how we really view God

GUILT AND GRACE

If I'm honest, there were times when I dreaded attending our university Christian Union. We would gather on Thursday lunchtimes in an old panelled room used for storage, secreted behind heavy wooden doors. With winning smiles we would sing and pray. There was great friendliness, even heartiness, but often I left feeling worse than when I arrived. My view of God didn't help. From somewhere I had developed the idea that the Almighty was a cross between a headmaster and a bank manager, constantly imposing impossible standards and only too delighted to catch me out.

I felt I had to pray and worship in acceptable forms and I dreaded mission meetings most of all. I felt there was a tacit implication that all Christians at medical school would inevitably become overseas missionaries. Like many others, I would sit in terrified, tense silence, feeling the inherent pressure of the meeting. I hadn't dared to miss it, but somehow I hoped that I would escape the awful will of God. Preferring colder climates, I believed that God would force me into a tropical rainforest, if only to prove his sovereignty!

You probably already think that I must have had deep-seated problems to come up with such a strange idea of God but I've since discovered that my experience is far from unique. Many Christians do struggle with a sense of slavery, rather than knowing the pleasure of being a son; they practise religion rather than a having a living relationship with God.

Since those early days God has been patiently teaching me the reality of what Jesus meant when he said, 'when you are set free, you are free indeed'.[1] My understanding of God has changed. Amazingly, I've since discovered that he accepts us as we are, not as what we should be. I have discovered that there is now *no* condemnation, that God doesn't accuse us, but is on our side and in our corner, that he is committed to us and has identified with us.[2]

God's will isn't harsh, vindictive or difficult to understand. How many of us have wrestled in prayer, only to hear him shout that he had already shown us his will! He doesn't try to trick or punish us. His will is not a narrow tightrope from which it is easy to fall. He allows us to move along it at different paces, maybe even pausing and perhaps going in different directions. God is big enough to cope, even when we get it hopelessly wrong. And he knows our hopes, fears, strengths, weaknesses, skills, responsibilities and preferences as well as we know them ourselves. He has shaped each of us for a purpose. This awareness has changed my own self-understanding.

To continually grovel before God about what miserable sinners we are is a travesty of the gospel of grace, and surely denies the reality of the cross. Because of redemption we are privileged sons not defeated sinners.[3] Our fundamental natures have changed. The Holy Spirit now lives within us, prompting us; he makes it easier for us to conform to the image of Jesus.[4] We have moved from guilt to grace. We have been freed from slavery to sin, and set free to love and serve God. And as we really come to grips with the freedom we really have in Christ, then other people we meet, including colleagues and patients, will notice the difference. We will intrigue them. They'll discover what makes us tick, and they'll want what we have.

Paul Dakin *is a GP in London*

references

1. John 8.36
2. Romans 8:1
3. Romans 8:15
4. Romans 8:29, 12:2

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