

for today's Christian doctor

triple helix



Abortion

family, parent training programmes, paedophilia, youth crime, MMC and MTAS,
primary care chaplains, hardships, reviews, news from abroad

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Innocent blood

Whoever sheds the blood of man, by man shall his blood be shed; for in the image of God has God made man. (See Genesis 9:5,6)



This autumn we have probably the best opportunity in 40 years to change things

'40 years. 6.7 million abortions. Time for change!'¹ This strap line brings together churches, professional bodies and pro-life organisations to mark on Saturday 27 October the 40th anniversary of the passing of the 1967 Abortion Act.

6.7 million abortions. The numbers are staggering: more than the number of Jews who died in the Nazi holocaust. 420,000 Dunblanes.² 270,000 classrooms. 67 Wembleys. Over 10 million British citizens lost – many of the dead would now be parents! Britain has amongst the most liberal abortion practice in the western world. One in three women has an abortion. One in four pregnancies ends in abortion: one abortion every 2 minutes and 40 seconds, 600 per day, 200,000 per year.

There is now growing evidence that public (and parliamentary) opinion, especially on late abortion, is changing.³ Why? High resolution ultrasound videos; media stories of babies born alive following 'botched' abortions; doctors being forced against their conscience to refer women for abortion; reports of late abortions flouting the existing law; testimonies from women damaged or coerced into having abortions; the growing evidence in the medical literature of the links between abortion and mental illness, prematurity and (possibly) breast cancer; the sheer volume of spilt blood. People are beginning to wake up to reality.

Abortion is an inevitable consequence of sexual immorality, the breakdown of the family, and the desire for a life unencumbered by dependents. But it is against the Hippocratic Oath, against the Declaration of Geneva, against the historical position of the British Medical Association.⁴ And yet as a profession we are up to our necks in it. 6.7 million lives taken by British doctors and the BMA wants to liberalise the law even further.⁵

What does God think? 'You created my inmost being; you knit me together in my mother's womb...when I was made in the secret place... your eyes saw my unformed body' writes the Psalmist.⁶ God hates 'hands that shed innocent blood' warns the writer of Proverbs.⁷ God 'hides his eyes' from those whose 'hands are full of blood'.⁸ He will demand 'an accounting'.⁹ He was 'not willing to forgive' Manasseh who 'shed so much innocent blood that he filled Jerusalem from end to end'.¹⁰ Scripture links sexual immorality and the killing of children to idolatry;¹¹ they are sympto-

matic of a nation which has turned its back on God. By contrast God calls his people to 'rescue those being led away to death'¹² and to 'speak up for those who cannot speak for themselves'.¹³

How then does God view us as Christian doctors; keeping silent; playing it safe; embarrassed by those who dare to speak out; rationalising our involvement in the 'difficult cases'; perhaps even oiling the abortion machinery and participating in the killing?

We can be certain that God will bring justice. Judgment will come. Innocent blood will be paid for. And yet God, the supreme judge, is also the God of mercy and grace who withholds judgment to give people a chance to repent, who grants us forgiveness that we do not deserve, who sends his own son to have his innocent blood shed by evil men in order to pay the price for our sin. Judgment falls on Christ the innocent rather than upon us the guilty.¹⁴

And in response to this mercy and grace he calls us to follow him by carrying his cross and embracing lives of love and obedience: risking the contempt of the politically correct by being advocates for the unborn child; bearing the cost of providing compassionate alternatives to abortion for those who will accept them; being part of the solution rather than part of the problem.

This edition of *Triple Helix* is devoted to vulnerable children both born and unborn. This autumn we have probably the best opportunity in 40 years to change things; to reflect, repent and reorder our priorities; to speak out; to be advocates for the voiceless; to offer women in crisis something other than a curette; to tell the truth about the consequences of abortion for children, women and society.

God's word reminds us that righteousness exalts a nation.¹⁵ And warnings of judgment always come with promises of restoration and hope – provided we respond to God's call. The choice is ours.

If my people, who are called by my name, will humble themselves and pray and seek my face and turn from their wicked ways, then will I hear from heaven and will forgive their sin and will heal their land. (2 Chronicles 7:14)

Peter Saunders is CMF General Secretary

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Liberalising abortion law *A new parliamentary battle looms*

Review by **Peter Saunders**
CMF General Secretary

The Human Tissue and Embryos Bill, expected to be introduced into Parliament after the Queen's Speech this November, will open up the entire 1967 Abortion Act to amendment. Pro-choice MPs have pledged to liberalise the law¹ and intend to mark the Act's 40th anniversary on 27 October with a push to bring in 'abortion on request' (along with nurse and home abortion) in the first trimester.

This agenda is being supported by the national coalition Abortion Rights,² which works closely with the Parliamentary All Party Pro-choice and Sexual Health group³ and the Voice for Choice⁴ coalition of major abortion providers. It already has support from the British Medical Association (BMA),⁵ whose Medical Ethics Committee fully supports its agenda.⁶ This movement is well organised and well funded and, even if this autumn's initiative fails, there will be continuing pressure to change the law during the lifetime of the present Parliament.

The BMA at its annual representative meeting on 27 June passed by a margin of 67-33% a motion asking for abortion on

demand in the first trimester (ie on the basis of informed consent only).⁷ Further motions allowing trained nurses and midwives to perform abortions, and relaxing rules on approved premises (ie allowing medical abortions in GP surgeries and at home) were lost by 41-59% and 46-54% respectively.⁸ Concerns about safety guided those present, in a debate that never considered ethics. It is already BMA policy to extend the Abortion Act to Northern Ireland. In the week prior to the debate an online petition, calling on the BMA to reject its Ethics Committee proposals and instead to mount a properly evidence-based review that involved full consultation with its members and all frontline doctors, was signed by over 13,000 people including over 950 BMA members.⁹

The first stage of the coming parliamentary battle is a government consultation¹⁰ being carried out by the House of Commons Science and Technology Committee into scientific developments relating to the Abortion Act 1967. Written submissions have closed and oral evidence sessions have commenced. The findings will inform the later parliamentary debate.

CMF's submission, which we are seeking permission to make public, provides data on improving survival of neonates born at 23 and 24 weeks' gestation and marshals the latest evidence on the well established links between abortion and premature delivery and abortion and mental health. CMF has also played a lead role in forming Time for Change, a new coalition of church, professional and pro-life groups seeking to tighten the existing law.¹¹ Let us each ask God what part we ourselves should play.

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Modernising Medical Careers *An update*

Review by **Rantimi Atijosan**
Specialist registrar in trauma and orthopaedics and JDC MMC Rep

The first set of doctors to commence run-through training started work in August. Many others though face an uncertain future. MMC and MTAS have taken many casualties but the full extent is yet to be known – round two of appointments continues through to November. The government has released 1000 more training jobs for appointment after that date but eligibility for these jobs involves having been interviewed but not appointed in round two.

Back in May, unsupported by the BMA, Remedy UK launched an unsuccessful judicial review, challenging the legality of MTAS and MMC – the resulting disappointment amongst junior doctors was palpable. The presiding judge did however describe MTAS as a 'dreadful mess' and suggested that individual cases should be open to scrutiny by employment tribunals. The final report of the MMC Review Group expressed concern that large numbers of

British graduates will be unable to find training places in the future.¹ An independent review of the process for specialty posts, chaired by Professor Tooke, is due to report in December.

Promises abound, but integrity is often in short supply. During round two we are seeing stealth advertising with job applications posted and taken off the internet over a weekend. It is difficult to know whether the Department of Health's promise – that no junior in a substantive post would not be recruited – has been honoured as the BMA has not received co-operation in trying to assess this. Juniors are complaining to the BMA that NHS trusts are trying to get out of paying relocation fees.

There have been senior casualties too. March saw resignations by both Sir Alan Crookard and Professor Heard, as MMC National Director and National Clinical Advisor respectively. James Johnson resigned as Chair of the BMA in May after juniors

were slighted by his pro-MMC letter. Sir Liam Donaldson continues to face calls from senior BMA officials for his resignation.² Patricia Hewitt's demise as Health Secretary is seen by many as directly related to the issue of MMC.

This issue affects us all, seniors as well as juniors. We all need to act. Back in the spring I talked about affirming God's sovereignty, prayer, giving and taking advice and the need to fight for justice.³ Are you in a position of real influence within your royal college? Do you know juniors in need of support and prayer? Join a pressure group. Invite a junior round for dinner. Raise conversation with your colleagues. Above all, pray.

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Three threats

Informed debate imperative for HTE Bill

Review by **Andrea Minichiello Williams**
Public Policy Director, The Lawyers' Christian Fellowship

The government published its Human Tissue and Embryos (HTE) Bill in draft this spring.¹ There was the usual short consultation, and many groups gave evidence to a pre-legislative scrutiny committee. (CMF gave both written and oral evidence.²) The committee published its findings in July.^{3,4} It seems clear they did not think the public either knew about the issues in the bill or felt strongly about them. They certainly did not feel there had been any public outcry against the contents. Christian Concern for our Nation has produced a short downloadable video, ideal for communicating with church groups and the general public.⁵

Although the report contains some positive recommendations (such as abandoning the proposal to have a single body regulating both human tissue and embryology), there are also some very concerning issues. The bill constitutes a complete review of the law surrounding fertility treatment and embryology and, although the report did not consider it, abortion law will no doubt be debated

during the bill's passage.

The committee noted the bill had no foundational ethical principles and recommended Parliament should establish an ethical framework within it. Any such framework must recognise the special status of the human embryo as an entity worthy of greater protection.

The committee recognised that creating inter-species embryos was contentious, could not reach a consensus, and recommended the issue be put to a free vote in both houses. However, the Human Fertilisation Embryology Authority announced in September that they believe they can legally consider licensing applications to create animal-human hybrid embryos for research purposes,⁶ a move which clearly usurps the democratic process.

One of the most controversial parts of the draft bill was the removal of the requirement to consider a child's need for a father when considering the child's welfare in an IVF application. The committee recommended this too be put to a free vote in both houses, but this good news is

tempered by the suggestion that the 'father' role could be filled by a person of either sex.

The possibility that abortion law might be liberalised on the back of this bill threatens human life itself, creating inter-species embryos threatens human dignity, and various proposals strike at the very heart of our understanding of family structures. It is imperative that, when this bill comes before Parliament in the autumn, members of both houses know that people do care very deeply about these issues.

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Doctors, faith and trust

Professionals and their personal beliefs

Review by **Andrew Fergusson**
CMF Head of Communications

Shortly after the failed terrorist bombings in London and Glasgow at the end of June came a reliable report that an al-Qaeda leader in Iraq had earlier boasted that his group was going to attack UK targets, and that 'those who cure you will kill you'.¹ The original eight suspects were all young, Muslim, connected to the medical profession, and had come to Britain from Jordan, Iraq, other Middle Eastern countries and India. This particular story rapidly faded from the headlines, but the future security consequences are likely to make life even more difficult for overseas doctors.

Completely unrelated to these planned atrocities, the General Medical Council has been holding a consultation on its draft guidance on *Personal Beliefs and Medical Practice*.² It has advised that 'doctors may need to set aside personal and cultural preferences to provide effective patient care' and *BMA News* illustrated its notice

of the consultation with a picture of an Islamic woman's face and the suggestion that face coverings might have to be removed to facilitate effective communication with patients.³ CMF is making a corporate submission on this draft guidance suggesting that while it is constructive and generally uncontroversial it does raise questions of future interpretation, particularly about conscientious objection issues.

Turning away from questions of faith, though not necessarily abandoning its language, the *British Medical Journal* has been running a lively debate about whether there is a conspiracy between government and media to criticise doctors. In *Why this unholy trinity?* an editor suggested there is;⁴ Professor Roger Jones countered from surveys of patient concerns that between 14-17% of patients with recent direct medical contact had reservations or negative opinions about the

competence of doctors;⁵ and the BMA head of Health Policy and Economic Research reaffirmed that annual surveys show 90% or so of the population trusts doctors to tell the truth, higher than for any other profession.⁶

'Trust me, I'm a doctor' may occasionally evoke hollow laughter, but it seems most patients do. Let us all strive to make 'Trust me, I'm a Christian doctor' even more credible.

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Liz Jones reminds us of biblical priorities



THE FAMILY

biblical basics

key points

Family breakdown is widespread in our society and Christians are not exempt from domestic troubles.

The Bible contains a lot of wisdom for us about how to run our families. The author, a retired paediatrician, reviews the Bible's guidance on various familial relationships: between parents and children, adult children and elderly parents, and husband and wife.

She dispenses wise advice on child discipline and boundary setting, and discusses the challenges of caring for teenagers.

Jesus prayed that his people would be protected from the evil one while still living in the world.¹ Nowhere is this protection more needed than in the area of family life. In many ways, there is now a war on for the family. Alarming statistics and consequences are coming out of widespread family breakdown and, as a lot of what one learns about being a marriage partner and a parent is modelled by one's own parents, this trend does not leave room for much optimism about our society's future.

God's design

God's creation design was the marriage of one man to one woman and, within that committed relationship, the procreation of children who would then be nurtured by their parents through the developmental stages of their lives. The Bible teaches that a husband, the lover and protector, is the head of his family;² his wife is his helper and the bearer of new life;³ and children are under their parents' authority.⁴ This teaching is now being regularly challenged and undermined. Add to this the pressure of work that can so easily erode our time, and it is easy to see how our commitment to family and church can suffer. Life becomes a difficult balancing act: we need the Holy Spirit's wisdom to know what to prioritise and when.

Jesus' example

Children are developing human beings who therefore need special protection, encouragement and discipline. The Bible teaches that parents have a God-given responsibility to prepare their children to become independent adults. The gospel of Luke alludes to four dimensions of development during Jesus' childhood⁵ – the physical, intellectual, spiritual and social – and it is good to think carefully about these as we bring up our children.

Godly marriages

To give a child security, the husband-wife relationship needs to be strong and so prioritised and not neglected.⁶ The relationship between a child's parents will be his/her model of intimacy and a model for many of the relationships that child will make in his/her life and the way he/she will deal with the ups and downs of life. The different roles of husband and wife within the marriage relationship are a wonderful example of complementarity where both are needed to make a whole.

God did not design men and women to be the same... He wanted there to be a complementarity. He deliberately made men with greater physical strength – to protect and provide for others. He purposely made women with greater relational strength – to nurture and care for

others. The differences were designed to be a source of joy and satisfaction. The relationship between Christ and the church is, as it were, held up by God to a wondering universe, and he proclaims that that is what he designed the relationship between husband and wife to look like!⁷

Honour your father and mother

Children are to be under the authority of their parents,⁸ heirs but not adults,⁹ and the extended family are to support but not usurp the position of husband or wife. It is interesting that the commandment to honour father and mother is foundational to the second part of God's moral law.¹⁰ Honouring your father and mother may also involve caring for elderly parents. This requires wisdom and possibly sacrifice but 'it is pleasing to God'.¹¹

Boundaries

Having authority over one's children is not a reason to be harsh. Boundaries are very important but should be instilled with gentleness and patience and it is important we give our children much attention and much encouragement. An attention seeking child is often an attention needing child and parents cannot give attention if they are absent or pre-occupied with 'more important' issues. Fathers are encouraged not to exasperate their children but to 'bring them up in the training and instruction of the Lord'.¹² 'Bringing up' is an active term and requires us not to neglect our children, nor to idolise and so fail to correct them. We must receive them as a gift and responsibility from God and train them in his ways and remain teachable and subject to God's word ourselves. Discipline is 'guiding, educating and supervising a child's choices'.¹³

Watching out

The society in which our children are growing up is both unstable and stressful for them and their parents. Civilised societies have in the past relied on an unwritten code of behaviour between children and adults both in and outside the home. Children were expected to behave with respect towards their elders and in return most adults kept an eye open for children's safety and welfare. Over the last 25 years much of this seems to have evaporated and the goal posts are still moving; moral relativism makes child rearing very difficult. This increasing disconnection between children and adults is having far-reaching effects with experts linking it with young people's increased alcohol and drug abuse, violence and promiscuity.¹⁴

We also need to ask what our own children are watching, playing and hearing in our technology rich society. The media markets violent games at our little boys and throws tips on dieting and looking sexy at our little girls.

Increasingly too, the state is stepping in between children and their parents: the current push for the

compulsory, explicit sex education of young children; and the provision of the morning after pill and abortion to girls under 16 without their parents' knowledge are examples of this. The possibility of a children's database sharing information about every child in England could be another unwanted intrusion into family life. We must pray for our children's protection in this difficult and ungodly culture, and for their regeneration.

Teen troubles

Parenting through the teenage years has special challenges of its own. Puberty brings many changes in a young person's life both physically and emotionally and during this time it is normal for the peer group to assume more importance. This brings many tensions especially for Christian families, as much peer influence will not endorse the principles we hold dear and can be downright harmful. It is still important that parents 'hold on with an open hand' and allow a young person gradual and appropriate opportunity to function in a more independent way. Young people need to develop the skills to move on with confidence into the world of work or further education. They need to learn to regulate work and recreation and cope with sexual attraction, relationships and their own fertility in a mature and appropriate way.

The world is a difficult place for today's teenagers to negotiate. They are faced with an excessive number of choices, extreme or permissive experiences, pressure to succeed, less protection and less family support than in past years. As ever, good communication and availability are keys to positive relationships between parents and their teenagers. Make sure they know when you are pleased. It may be necessary to verbalise the conflicts, but do so treating them with dignity and respect; do not 'wound with words'. Love is unconditional. Teenagers need to know that whatever happens, there is always a way back.

Christian worldview

In a post modern culture where anything goes, we need to give our children a Christian worldview. The suggestion that Christians brainwash their children implies that the society we live in does *not* do so: secular society has an agenda of its own. The father of our Old Testament scriptures, Abraham, was singled out by God to 'direct his children and his household after him, to keep the way of the Lord by doing what is right and just'.¹⁵ And Jesus, our Lord said, 'The thief comes only to steal and kill and destroy' but that he had come that we 'may have life and have it to the full'.¹⁶ We need to identify the activities of the thief as he seeks to rob our families in so many ways. If we resist him he will flee,¹⁷ because 'the one who is in you is greater than the one who is in the world'.¹⁸

Liz Jones is a Lovewise trustee and a recently retired community paediatrician in Newcastle upon Tyne



Discipline is 'guiding, educating and supervising a child's choices'

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Sara Kundu shares her experiences



Photo: Sara Kundu

PARENT

training programmes

key points

Parenting is a complex job. Children, families and society at large suffer when it goes wrong. Research has demonstrated that poor parenting can be improved through education.

There are several proven training programmes, each tailored to different circumstances – parents' backgrounds, cultural factors, and whether or not the children have special needs of any kind.

The author, a psychiatrist, also relates her experience of setting up and running programmes within a church setting in Tower Hamlets.

Parenting is a complex, demanding and vital job for which there are no qualifications, no training, little support and maximum opprobrium when it goes wrong.¹

Hardly a day goes by without a news bulletin about uncontrollable ASBO kids, depressed and self-harming youngsters and violent teenagers. Why are our children in this mess, and what can we do about it?

It starts with the parents

Parents who form secure attachments with their infants will have children who are more socially competent, self-confident, popular, resilient and mature. Sadly the reverse is true of insecurely attached mother-infant pairs.² When parenting goes wrong, children suffer. Their development goes astray, resulting in emotional and behavioural difficulties.

Families characterised by conflict, aggression and cold relationships have children vulnerable to psychosocial problems, substance abuse and problems with biological stress-response regulatory systems. As well as increased risk for mental health disorders, this impacts on physical health as cardiovascular and immune system responses become over-taxed. Children become hyper-vigilant, unable to read social cues and poor at emotional self-regulation and reflection.³

Costly mistakes

Poor parenting is costly. Conduct disorder in childhood has a worldwide prevalence of around five percent and rising.^{4,5,6} If untreated, as well as being more likely to

abuse substances and leave school without qualifications, 40% of such adolescents will be repeatedly convicted of crimes.⁷ As adults they continue offending, have domestic violence problems, poor employment records and fail to integrate into society.⁸ Parents of such children tend to be harsh and inconsistent, though it is less clear whether this is cause, consequence or due to shared genetic predisposition;⁷ they pay attention to unwanted behaviour whilst ignoring desirable behaviour.⁹

By the age of 28, those who had conduct disorder at age ten were costing society ten times as much (£70,019) as those with no behavioural problems (£7,423) in terms of excess use of public services.¹⁰

Help is at hand

Vast amounts of research have been done to look at the effectiveness of parent training programmes in the treatment and prevention of such problems.

Dretzke looked at 37 randomised controlled trials of parenting programmes for the treatment of children with conduct disorder and found them to be effective.¹¹ The resulting review built on a large body of research and earlier reviews done on aspects of the same subject. There was evidence of long term effectiveness on children's behaviour, positive effects on other aspects of children's mental health (eg self esteem) and on parents' wellbeing, attitudes and behaviour.

There was also some comparison of different types of parenting programme. Behavioural programmes were most effective in modifying children's behaviour. Other approaches (eg humanistic ones) may have

important benefits such as on children's self esteem. Group-based trainings were more successful than individual approaches.

Parent training was found to be cost effective with costs per family ranging from £629 to £3,839 depending on the type of programme and setting. This compares favourably with the cost of dealing with individuals with conduct disorder.

There was not yet enough hard evidence to prove that parent training reduces child abuse but there was evidence that it improves some outcomes associated with physically abusive parenting. Some individual studies report success in this area.^{1,12}

Sandra and Daisy

Sandra, a 38 year old single mother of 20 month old Daisy, attended one of our courses because of difficulty coping with Daisy's tantrums and with her behaviour in public places. Things had got so bad that Sandra's friends didn't want Daisy to visit anymore. Sandra felt absolutely desperate.

On the course Sandra learned how to communicate with Daisy and make time to have fun; about dealing with tantrums; and how to share consistency in discipline with significant others in Daisy's life.

Sandra now feels more confident as a mother. Daisy's tantrums are much less frequent and shorter in duration. Her concentration has improved, she responds to limit setting and they can now enjoy days out together.

Which course to use?

- **The target group:** what ages are the children? What are their diagnoses? Are you aiming to prevent or treat? What educational, language and cultural backgrounds do the parents have? Are there other family vulnerabilities such as substance abuse and child protection?
- **Resources available:** how much do the resources cost? How easy is training to access? What level of staff competency is required? How much time do you have? Is a crèche or interpreter required?
- **Course specifics:** is there evidence of its effectiveness? Is it appropriate for your target group? Is its presentation style accessible? How are families supported during the course?

A useful resource book is *Parenting Programmes for Families at Risk*,¹³ a comprehensive review of the courses available. Courses in common use across the UK include:

- **Incredible Years series:** a thoroughly researched, well-established and cost-effective series of programmes proved for use in treating and preventing conduct disorders and also designed to promote the social, emotional and academic competence of children. Teacher and child programmes are also available.¹⁴
www.incredibleyears.com
- **Triple P (Positive Parenting Programme):** a well-researched, proven programme based on

enhancing parents' knowledge, skills and confidence. Different levels of intervention are available depending on need.¹⁵ www.triplep.net

■ **Strengthening Families Strengthening Communities:**

a community based programme designed to help families develop strong cultural roots, positive parent-child relationships, life skills and the ability to access community resources. A relatively new course, it has little published evaluation. www.reu.org.uk

The government is currently evaluating these three courses. Other popular UK courses include:

- **Mellow Parenting:** a course designed to support families who have relationship problems with their under-five children. It has proved effective in engaging families with severe problems who would generally be considered hard to reach. Its research base is not wide because it is relatively new. An evaluation by the Department of Health shows it to be effective in improving maternal well-being, parent-child interaction, child behaviour and development. www.mellowparenting.org
- **Family Caring Trust series:** Family Caring Trust provides materials for parenting and other courses. Evaluations so far show positive benefits for families and results from a rigorous study are due out this year. As an optional script is provided, facilitators do not need a high level of training. www.familycaring.co.uk

Church parenting

At the Good Shepherd Mission, a church in the London Borough of Tower Hamlets, we started running parenting courses using Family Caring Trust materials alongside our parent and toddler group in 1999.

Our aim was improve the mental health of both children and parents, reduce risks of abuse and later antisocial behaviour, and promote happier, better functioning family lives.

We also adapted Family Caring Trust's optional session on children's spiritual development to suit our own approach and found it an excellent opportunity to engage in respectful discussion about spiritual matters with parents who were interested.

Eight years on, we now receive referrals from local GPs and health visitors and have developed a working relationship with the local Sure Start Centre. We now also use the Incredible Years programme for families with more severe needs. We have seen remarkable changes in the lives of many families: parent-child relationships have blossomed, children's behaviour has improved and parents have said how much less stressed they feel. In some, we have also seen spiritual change and growth. For us, these are very good recommendations for any church or other organisation wishing to serve its local community.

Sara Kundu is a child psychiatrist working with parents in London



Photo: Sara Kundu

We have seen remarkable changes in the lives of many families

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Dominic Beer reviews the evidence and makes recommendations for rehabilitation

Not in my church?

child sex offenders

key points

The author summarises the characteristics of child sexual offenders and the legal provisions for managing them in the community.

The church can and should welcome child sexual abusers who become Christians. They should be helped to control their addiction and grow in faith, but leaders should be realistic about the difficulty offenders have changing their sexual beliefs.

Practical tips are given and in particular, a written contract should be signed to help the offender and protect the church and its children.

John is a 45 year old man recently released from prison after being convicted of a child sex offence. He says he has become a Christian in prison. Your church leader asks you to consider joining a group to help support him practically and spiritually. How can John be shown fellowship without causing uproar in the church and neighbourhood?

Characteristics of child sex offenders^{1,2}

- There are 28,994 registered child sex offenders in England and Wales.³
- These people have a sexual preference for children, usually of prepubertal or early pubertal age.
- Most abusers are men.
- One in sixty men in the population over the age of 40 has been convicted of a sexual offence.
- Most victims are already known to their abusers.⁴
- Many child sex offenders were themselves abused as children and experienced emotional problems.⁵
- They are often lonely people who have low self-esteem and find it hard to build adult relationships.
- Sex offending is addictive; fantasy and masturbation are frequently used; cure is unlikely so it is best to aim for control.
- Sex offenders have entrenched, distorted belief systems that allow them to think what they do is acceptable.

- They often minimise the extent of their offending or may deny it entirely.
- They may blame others – for example, their own parents, their victims’ perceived promiscuity or the behaviour of the police – to justify their actions.
- Sex offenders come from all backgrounds, classes and professions.
- Sex offenders use a process of grooming to target their victims and may work together with other sex offenders.
- Sex offenders often move around from job to job and place to place, so that their activities are not easily monitored.
- Sex offenders are known for their resistance to change. Treatment programmes may help control their activities, but changing beliefs is much harder.
- Sex offenders, especially those who have served a prison sentence, may have had a conversion experience and embraced the Christian faith. They may state wholeheartedly that they have been cured and unrealistically claim that they will never re-offend.
- Those who have embraced the Christian faith like people to believe they are nice guys and may try to impress others with the depth of their Christian commitment.

Public protection from sex offenders

John will have been placed on the Sex Offender Register as required by the Sex Offenders Act 1997

and he will have a probation officer. Offenders who pose the highest risk (2152 in 2004) are referred to a Multi-Agency Public Protection Panel (MAPPP); their cases are regularly scrutinised by senior representatives of local police, probation, prisons, housing, health and social services. In 2004, 26 men subject to a MAPPP were charged with a further serious sexual or violent offence.⁶

Sex Offender Treatment Programmes (SOTP)

John will have probably have completed a Sex Offender Treatment Programme in prison. If he has been assessed as having strong impulsive urges then he may also have agreed to take anti-libidinal medication such as cyproterone acetate. The standard treatment is cognitive behavioural therapy (CBT).

A meta-analysis of about 500 sex offenders found that CBT in groups may help reduce re-offending at twelve months.⁷ CBT challenges cognitive distortions such as 'I am fond of children; they like me; they need to know about sex; it's part of normal growing up to learn about sex; if I don't then someone else will; it's okay to do it if the child doesn't say no'. In CBT the therapist seeks to:⁴

- break down the person's denial of the offence;
- develop victim empathy;
- challenge the abuser's self justification for his actions;
- address lifestyle issues and try to lower fears of adult intimacy so as to increase self-esteem;
- modify deviant sexual fantasies (these denote a poor prognosis);
- prevent relapse by helping abusers recognise situations of temptation and their concomitant moods, feelings and thoughts so they can develop preventive strategies.

How can the church help rehabilitate child sex offenders?

Because sex offending is addictive, John will need much encouragement to motivate him in his resolve not to offend again. The Rt Rev Richard Harries wrote, 'the instinct of Christian compassion is to be generous, but this proper spirit needs to be tempered by the risk sex offenders pose and the manipulative strategies they use'.²

*The single most important factor predicting a successful outcome of treatment is the patient's motivation and willingness to enter into a therapeutic contract. Motivation is always a complex mixture of the threat of external sanction from the law, the wish not to return to prison, a wish to placate a spouse or partner, an insurance policy should re-offending occur, and a genuine wish to change, both to control the fantasies and, rarely, to relinquish the fantasies in favour of a more socially acceptable sexual structure.*⁸

It is important to get the balance between offering fellowship and maintaining explicit boundaries. Jesus did not condemn the woman found in adultery, but nor did he condone her behaviour. He said: 'Go now and leave your life of sin'.⁹

Church leaders – what to do

- Draw up a contract between yourselves and John, which must be signed and enforced rigidly. It should address the following: John must never work with children; must never be alone with children; must sit apart from children; must stay away from areas of the building where children meet; must decline hospitality where there are children; must attend a home group where there are no children; must attend designated meetings only.¹⁰ If the contract is broken, John should be banned from church and other church leaders, the probation officer and the child protection officers should then be informed. See reference one for a sample contract.
- Ensure, preferably through one nominated person, that you maintain close links with the probation officer, with MAPPP (if appropriate), and with the local child protection officers. It is best to obtain written consent from John for this interchange, but information can be shared without it. John's offending pattern, convictions, type of victim and grooming pattern all need to be known.
- Consider whether to tell the church and the reaction that may occur if you do. How to manage people's anger is important, because sex offenders are perceived as monsters. Jesus was angry at sin.^{11,12} Christians can be angry at sin but Paul says 'in your anger do not sin'.¹³ We should not condone sin but that does not mean that we cannot forgive.
- Provide close practical support with accommodation and employment, and pastoral care to improve self-esteem and help John understand how God views him. This might include setting up a small group to befriend and keep John accountable for his behaviour. Some find Circles of Support, a national community support system for sex offenders, very helpful.^{14,15}
- Importantly, understand how John's faith is functioning. An immature faith can be a way of deflecting offenders from the reality of their offending. As his faith matures it can challenge him to face up to the responsibility of addressing his problems in a way that recognises the distress his actions cause.

Conclusion

Child sexual abuse is an addiction. Treatment is rarely curative. Child sexual abusers who become Christians should be helped to control their addiction and grow in faith. Selected people in the local church should extend the hand of fellowship to offer practical and spiritual support. A written contract should be signed in order to help the offender and protect the church and its children.

Dominic Beer is consultant psychiatrist at Oxleas NHS Foundation Trust and honorary senior lecturer at the Institute of Psychiatry in London



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Elizabeth Guinness
considers the complex
causes of youth crime

Growing up WELL

key points

The author weaves together three strands. She describes recent scientific evidence for neuroplasticity, and explains how the genetic blueprint (nature) interacts with the psychosocial imprint (nurture) to form the personality.

Attachment failures, compounded in lone parent families, can place the young child on the pathway to delinquency. Adolescence offers a chance for recovery but structure and supervision are essential. Father involvement is a key protective factor.

Changes in families are reviewed, the tax structure and legal framework are criticised, and the largely negative influence of the media is considered. Properly lived out, the Christian model for marriage and family is the ideal one.

How important is the family? Is there compelling scientific evidence demonstrating its importance for mental public health? Is youth crime related to family breakdown?

This article weaves together three strands of evidence. First is the research on imprinting of the psychosocial environment in the neurological development of the brain.¹ Second is the data on family breakdown and the consequent impact on mental health set out in the recent Social Justice Policy Group report.² The third strand gives the perspective of a Christian child psychiatrist using Systems Theory (the basis of family therapy) to understand how the moral values of society hold the family together and determine the welfare of the next generation. This thesis is set out in the CMF book *Mad, Bad or Sad?*³

The Christian faith, which has shaped our family life for centuries, is no longer the dominant influence. The media nowadays dictates our moral code in the form of 'political correctness'.

Neuroplasticity

The nature/nurture debate has moved on. The genetic blueprint (nature) interacts with the psychosocial imprint (nurture) to form the

personality. The infant brain has few connections. It is like a highly sensitive photographic film. Whatever comes in repeatedly from the psychosocial environment through the five senses gets imprinted. This process is called neuroplasticity. It 'wires up' the brain by repeated passage of incoming stimuli 'treading out' new circuits. In infancy it programmes in the basic functions. In adolescence it remodels the brain to produce the complex cerebral networks for the higher cognitive functions of the adult brain.

Brain imaging techniques have mapped out the components. First comes a massive overgrowth of neurones just before and after birth, and again during puberty. This is followed by drastic pruning on a 'use it or lose it' basis. 'Neurones that fire, wire.' Unstimulated neurones die. Appropriate stimuli are expected by certain sensitive areas during specific critical periods. Some periods are very short, such as those for vision and hearing. The time scales for important psychological functions such as attachment formation and emotional regulation are longer – three years.

In the first year the pre-frontal cortex 'expects' the essential psychosocial stimuli related to bonding. These come from the relationship with the mother. Breast feeding provides the right environment

without any contrivance – through frequent and lengthy closeness, warmth, and eye contact. The mother picks up the baby's cues, initiating the beginnings of communication. She responds to him joyfully, interpreting to him that it is good to be human. John Bowlby, founder of Attachment Theory, said that a baby needs 'a besotted caretaker'. The quality of this primary attachment largely determines emotional health and future capacity to form relationships.

What can go wrong?

The attachment figure does not have to be the biological mother but must be a consistent one. Frequent changes of carer, such as in extensive crèche rearing of infants, can disturb attachment.⁴ The steep learning curve continues as the parents begin to socialise the child. Both warmth and authority are needed, with the setting of limits and with harmonious family dynamics. The father's role becomes increasingly important. Consistency is vital when 'the rules for living' are being imprinted upon the brain. Family breakdown imperils this. Lone parents find it hard to provide everything necessary single handed. Divorce tears attachments apart. Step families must forge a new family system. Multiply reconstituted families, in which the ground rules of the family keep changing, give a very confused imprint.

Good genetic endowment can protect. However, in the development of criminality, genetic vulnerability can be exacerbated by an adverse rearing environment.⁵ For example, there is a high rate of Attention Deficit Disorder (ADD) in the prison population but ADD *per se* does not produce criminality, but *only* when it is combined with harsh and inconsistent parenting. Good parenting with routine and structure can minimise the impact of ADD.

Attachment disorder

The most severe form of attachment disorder results from global stimulus neglect when the infant is left alone in a cot 24 hours a day, such as in badly run orphanages or with drug abusing mothers. The brain cannot develop properly. The Maudsley Romanian orphanage follow up study has explored the extent of this.

However, the commonest cause of attachment disorder is maternal depression. The withdrawn miserable mother cannot respond intuitively to her infant's cues. A severe impact can actually be demonstrated in the child's brain structure. The right frontal cortex, which is responsible for withdrawal and aggressive reactions, becomes overdeveloped compared with the left, which deals with positive social advances. The late result of maternal depression is a well recognised preventable child psychiatric disorder, Hostile Avoidant Attachment Disorder. It places the child on the pathway to delinquency.

There are now many health visitor programmes for the early detection of maternal depression.

A supportive father is vital for minimising the effect on the infant. Single parents are inevitably more vulnerable. In chaotic dysfunctional families the problem can be compounded by domestic violence. Chronic stress to the young child during the first three years of maximum neuroplasticity produces physical damage to the brain from high cortisol levels as well as an imprint of trauma and confusion. This scenario is common on the big dysfunctional inner city estates with their high crime rates.

A chance to put things right

Adolescence can be a chance to put things right because of the second phase of intense neuroplasticity, when the brain is remodelled into adult form.⁶ However, the time frame involved indicates the need for structure and supervision of teenagers. The initial surge in the part of the brain responsible for independence, social bonding and sexuality occurs at the start of puberty, around the age of twelve to thirteen. The adolescent has to cope with these strong feelings without the cognitive controls which develop three years later in the frontal cortex. These are vital for the mature adult personality. They include the ability to inhibit inappropriate behaviour, to perceive a situation from another person's perspective, to plan ahead, organise, contextualise, prioritise, and make judgments and decisions. Adverse psychosocial environments can jeopardise this vital development. Confused youth takes refuge in drugs and alcohol.

Father involvement is a key protective factor, giving authoritative parenting with warmth and boundaries. Gone are the customs which formerly structured adolescence. Negotiating modern youth culture is a hazardous passage. Local communities can help by creating a subculture with more positive values with which teenagers can identify (for example, a church youth group).

Changes in family structure

Clearly the family is a vital part of the 'human ecosystem'. It creates the psychosocial environment to be imprinted. Yet in the UK there has been a steady erosion of family life over the past 60 years. Births outside marriage have increased from 1.5 percent in 1960 to an astonishing 43 percent in 2005. Both cohabitation and solo mothering are increasing. Twenty-six percent of British children live in single parent households. Such children risk twice the rate of mental health problems compared with those in nuclear families. There used to be a painful stigma in illegitimacy but it had the same function as does bodily pain: it prevented further harm.

Many factors have contributed to these changes in families: demographic shifts, birth control, social mobility, the status of women, changes in sexual morality and the devaluing of motherhood. However, it is disconcerting to find that both the tax structure and the legal framework for family law

Consistency is vital when 'the rules for living' are being imprinted upon the brain

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Photo: AP Photo

have also contributed (for example, by removing the discrimination of illegitimacy from inheritance in 1987 Family Law Reform, and by reducing parental control over children's sexuality in the Gillick decision of 1985). Moreover, the welfare state has actually made it possible to be a single mother: the unemployed lone parent is the family model that maximises state benefits.

An interesting study on marriage in men's lives finds a difference in commitment between men and women (in terms of long term view of the relationship, and willingness to sacrifice).⁷ Women commit on attachment; men need formal commitment before witnesses. Yet outcome for the children reflects involvement of the father and 40 percent of cohabiting partners split up before the child is five years old. The decline in marriage suggests reluctance by men to accept this rite of passage to full responsible adulthood. Yet married men are healthier, happier, earn more and are less antisocial. Marriage is a support system.

There are many studies into the vexed question of divorce. The legacy for the children is impaired psychological well being, reduced educational attainment, and less marital success. Although high levels of marital conflict also harm children, surprisingly the harm has been found to be just as great when a low conflict partnership breaks up.⁸

Media influence on social sanctions

In traditional cultures religion delineated and enforced the responsibilities of family life. The World Health Organisation has warned how loss of these social safeguards in rapidly changing societies imperils mental health.⁹

Systems Theory is the best way of understanding how the media (among other factors) is altering the ground rules of society. Political correctness has become our new morality, replacing religion. It can be defined as the unacknowledged beliefs of the suprasystem. As such it dictates what we think and what is allowed.

Yet who controls it? The boundaries of socially acceptable behaviour are being pushed further away from former norms in the interests of advertisements and drama which exploit human passions. Television scripts for soaps do not have a high moral tone; that would not be politically correct. Children watch too much television and imbibe its values; indeed, a senior child psychotherapist has described

it as 'an open sewer running through the sitting room'. Browne has shown how screen violence promotes violent behaviour in young people who have already been sensitised to violence by chaotic family backgrounds.¹⁰ Ironically, teenage violence then causes media hype! Thus the media has a twofold impact in contributing to youth crime. First it erodes family life; secondly it models violent behaviour.

Moreover, the media message in general is often the opposite from that required to readjust the dysfunctional system. The bad guys win, sexual appetites are titillated, authority is questioned, and children are vaunted above parents. There needs to be a systemic re-evaluation of the place of the media in safeguarding the human ecosystem. This will be difficult. Morality is not popular and market forces are powerful.

The Christian model

Consider the Christian blueprint for family life. The Ten Commandments have two family related commands: 'Honour your father and your mother'¹¹ and 'You shall not commit adultery'.¹² These set out the mutual responsibility between the generations and between husband and wife. The biblical stricture limiting sex to the marriage relationship harnesses the power of the sexual instinct to energise the family. Man and wife are to complement each other rather than compete. This enshrines the innate differences in temperament between men and women that equip them for family life. Thus women are the emotional caregivers and men are the defenders and providers.

The husband is to be the head of the family but husbands are to 'love your wives, just as Christ loved the church and gave himself up for her'.¹³ This is a high ideal that gives no place for a dictatorial husband. Indeed, his leadership must cherish and empower his wife. A woman who gives out emotionally must be replenished by her husband. Moreover, in 'systems terms' a healthy family requires clear leadership, not disputed power. The children need a combination of warmth and authority. The headship of the father represents the authority of society. It teaches self-control and respect.

Elizabeth Guinness recently retired as a consultant child and adolescent psychiatrist in Surrey

Morality is not popular and market forces are powerful

resources



Founded in 2003, Lovewise is a charity that encourages young people to consider the God-given design of marriage and the rightness and benefits of keeping sex for marriage. Presenters go into secondary schools and youth groups using PowerPoint slides, video interviews and personal testimonies. Primary school material is also available for purchase. www.lovewise.org.uk

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Rantimi Atijosan and Matt Kehoe advise on dealing with MMC disappointment



Hope in the midst of mayhem

New things about MTAS and MMC are being written every week. So, instead, I will start by repeating myself¹ – whether or not you now have an ST number, God is still in control. That said, it is difficult to know how to respond to all that has happened over the last few months with MTAS and MMC. While we all hoped that some long lasting solution would by now be in sight, this does not seem to be the case.

Round two and beyond

Round two runs until the end of October. The government will then release 1000 more training jobs: to be eligible for these, you must have been interviewed in round two but *not* appointed. Next year's application process is now being looked at by the Department of Health and a number of key representative bodies. Professor Sir John Tooke is leading an independent inquiry into MMC, to which CMF has made a corporate submission. The MMC England Programme Board will be making recommendations on MMC from 2008 onwards. These interventions should take on board the problems encountered so far. But without post expansions, particularly of ST3 numbers, it seems inevitable that many talented doctors will still find themselves out of a training career in medicine.

Planning ahead

All those looking to apply into next year's process need to ensure that they are attaining competencies within the jobs they are doing for the specialties they hope to apply to. It is possible to create those opportunities: one of the F1s on my team is looking to do

ten-day 'mini-electives' in his specialty of choice.

Do you have a Plan B? Now is the time to be talking to family, friends and seniors about realistic options in and out of medicine, in and out of the UK. Not all consultants are fully up to date with the situation, so it is important to seek out wise and informed advice. Educational supervisors, college tutors and deanery staff are good information sources. Don't give up easily on what you *think* you want to do but, on the other hand, don't be too inflexible.

Our response

CMF's Junior Doctors Committee (JDC) does not want to add to the masses of data being thrown at you. Instead we want to be a source of encouragement. As you know, we recently attempted by email to gauge MMC's effects on you. Using the information gathered, we hope to tailor our response further to meet the needs of all affected CMF juniors.

At our November conference, Hope in the Midst of Mayhem, we'll be seeking encouragement from Peter's first letter to another set of Christians under pressure, the early church.² One of the conference seminars will be specifically looking at MMC issues and ways in which we can respond, corporately and individually.

In the midst of big battles, individuals can get left by the wayside. So please, if you are in need of support and guidance, do get in touch with us.³ We are here for you.

Rantimi Atijosan is JDC MMC Rep and a specialist registrar in trauma and orthopaedics in Oxford

So far, I've made six major medical career decisions – three correct ones, two equivocal ones and one definite mistake! Proverbs 3:5,6 advises, 'lean not on your own understanding; in all your ways acknowledge him, and he will make your paths straight'. Seek a broad range of perspectives – I once paid too much heed to godly non-medics who didn't understand my circumstances. Romans 8:28 really is true: 'in all things God works for the good of those who love him'.

Andrew Fergusson

is CMF Head of Communications

CMF junior Matt Kehoe tells his story

Matt, how did you end up in New Zealand?

In 2005 after house jobs and a year as a CMF relay worker, I found that I couldn't get an F2 job. After a dozen applications and no interviews, I starting thinking about going to New Zealand. An agency found me an A&E job in Tauranga and, one telephone interview later, I was arranging work permits and flights.

And you've stayed ever since?

Yes. As soon as I was offered that first post, I had a feeling that I could be here for years – and I am! I am now a New Zealand resident, have a training rotation and will stay until I sense it's time to move on.

Advice for UK juniors dealing with MMC disaster?

All the major positive turns in my life have appeared after significant obstructions to my carefully laid plans! Great things are happening in CMF New Zealand. I'm meeting fellow Christians, Kiwi and Aussie medics. We've just had our first national conference in 20 years!

My parting shot

Remembering that God invariably has a better plan for you makes dealing with uncertainty much easier.

Matt Kehoe is an A&E doctor in Auckland, New Zealand

Is God nudging you towards CMF?

The Bible is full of closed doors and forced rethinks that led to great opportunities for God's kingdom. If you've ever wished you had time to work for CMF, why not get in touch to explore some options? We have opportunities with student support or office-based ministry, as staffworkers or interns. Contact Mark Pickering, our head of student ministries (mark.pickering@cmf.org.uk) if you're interested.

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Ross Bryson and Anne Hughes recommend chaplaincy in primary health care



Chaplain in the practice

key points

A general practice in Birmingham discovered that patients' issues were not being adequately addressed. These spiritual concerns included a need for love, for feeling worthwhile, and for meaning and purpose.

The GP describes extending the primary health care team to include a chaplain. Despite funding difficulties, the community has benefited, the primary care team and counsellors value it, and patients appreciate it.

With short histories the chaplain illustrates how she can offer listening, discern 'signs of life', bring hope, and provide significant ritual and healing prayer. She concludes that practice chaplaincy is demanding but rewarding.

The GP

Looking after patients in a GP setting affords a unique opportunity to care for them as people, where their illness is seen within the rich complexity of their lives. Despite the increasing technical skills of modern medicine, or maybe because of them, there is a powerful movement from patients and professionals alike to safeguard and develop this person-

centred, holistic patient care.

But what does it mean to help patients recognise they have 'existential' or 'spiritual' characteristics which are profoundly important to them as people, and may be relevant to how they handle disease and suffering?

I have worked as a GP in a large partnership in central Birmingham, covering areas of high depri-

The Chaplain

My job description states my purpose is to 'provide the pastoral and spiritual care of patients and staff'. Who is referred? Anyone,

regardless of faith! The patients I see often come from the GPs, some from the nurses or counsellors, and about 25 percent are self-referrals. The reasons vary. Working with the bereaved and dying is important and significant, and I see people coming to terms with change, illness, trauma, loss, or difficult decisions.

Some patients come with 'spiritual' issues – guilt, forgiveness, wanting to find God, or looking for meaning. Patients of different faiths, who already have a faith structure, are often open to receiving strength from God in different ways.

What can the chaplain offer?

Listening

Henri Nouwen describes listening as 'the highest form of hospitality of the sort that does not set out to change people but to offer them space where change can take place'. Many patients do not have a social network where they can be listened to and under-

stood. I can offer a place of safety to be listened to without being judged or hurried.

Discerning the signs of life

Many come with feelings of depression, anxiety and low self worth. I encourage some patients to 'review the day' – to look back over it and pick out one small moment of pleasure. Initially some report that nothing in their grey lives brought any glimmer of joy. Yet over a period, they may describe walking in the park, listening to music, or cooking a meal made them aware of stirrings of life for which they could begin to give thanks.

Recognising the signs of life emerging out of despondent situations, and giving thanks, is an important key to health and points to the Giver and Creator.

Bringing hope

It is challenging to sit with people when there are no easy answers or quick fixes. Some patients can only understand God as cruel or, at best, disinterested. He is a God who allowed their child to die or

vation, for nearly 20 years. Our practice has aimed at whole person healthcare delivered by a large primary health care team. Having seen the team develop to include practice and district nurses, health visitors, counsellors, family therapists, and a physiotherapist, chiropodist and dietician, there was some sense of reaching this goal. However, we were aware that patients were still presenting with issues we were not adequately addressing.

Spiritual needs

There existed in their lives a wide spectrum of needs, sometimes hard to define, including loneliness, loss of connection with any meaningful community, low self worth, and absence of a sense of purpose. Only sometimes would patients volunteer they were looking for some spiritual answer to life's complexity, but often they felt estranged from any previous religious community. Although some of these issues could be dismissed as 'social problems', they were clearly relevant to the patient's health and we found it helpful to use the term 'spiritual needs'. These included a need to be loved, a need to feel worthwhile, and a need for meaning and purpose.

The then primary health care team could not fully address these needs and we thought we might be doing patients a disservice by raising awareness without possessing resources to respond appropriately. So in 1996 the concept of extending the primary health care team to include a chaplain came into being.

Some years on – what is the reality?

■ Health service managers support but don't fund

There is clear evidence favouring professionals seeking to be holistic, and the NHS has committed

itself to addressing spiritual needs of patients and staff, so there are no grounds for resisting expanding a primary health care team to include a chaplain. However, NHS funding will always be in short supply. Initially we funded the post through fund-holding savings, later through efficiency savings, and currently there is no funding stream.

■ The community has benefited

The chaplain initially formed a group of local clergy who wanted to work together to address unmet needs. They established a registered charity, which has worked with the elderly, asylum seekers and families with young children. It formed a partnership with numerous community organisations allowing the birth of a Sure Start programme, where it was lead body for several years. The chaplain remains closely involved with the charity and together they hold regular lunchtime meetings for Christian workers to meet and pray together.

■ The primary care team and counsellors value it

All sections of the team refer patients, and there is close liaison between counsellors and chaplain, who sometimes refer patients to each other. Patients understand that the chaplain is not there to counsel, but is able to give time to listen, reflect and offer support for as long as is appropriate.

■ Patients appreciate it

The most important criterion of 'success' has to be the experience of the individuals who have risked revealing their personal and often painful experiences to someone they may not have expected to find at the doctor's surgery!

Ross Bryson is a GP at the Karis Medical Centre in Birmingham



Photo: Photos

we found it helpful to use the term 'spiritual needs'

who did not protect them from being raped. I must stand with each of them in their 'Easter Saturday', a time that seems helpless and hopeless, for as long as it takes. Yet I do not do this without hope, for I believe in resurrection and new life.

Over time, I have seen patients take small yet courageous steps out of despair towards healing and forgiveness. A nun commented to me once: 'God can take the s**t of our lives and turn it into manure!' I quoted this to a patient who had suffered bitter betrayal. She said, 'You mean the roses can grow again!' They did.

Ritual

Ritual is important as a means of acting out and making sense of events. One Ugandan asylum seeker had not been able to attend the funeral of her two children. I held a short service in which she said her goodbyes and this enabled her to move on in her grief.

Another man, a Muslim consumed with guilt after adultery, found making his confession enabled him to move on. I encourage some to write a letter expressing their anguish to someone who has wronged them, and then to burn it. Patients describe this symbol of letting go as a significant turning point.

Prayer

I always ask permission to pray, explaining what I mean. Only one patient out of hundreds has declined, and she asked if I would pray for her in her absence. I pray with the 'laying on of hands', and explain this is a sign that, although we cannot see him, God is close to us and embraces us as we are.

In prayer I declare each patient's value and worth to God. So many carry negative beliefs about themselves and it is important for them to hear the truth spoken. I often observe tears spring to their eyes at this point. I then bring their requests before God. These may be for comfort in sorrow, peace in anxiety, light in darkness, or healing in their situation. Some patients ask, when they come for a further appointment, 'You will pray at the end again?'

Conclusion

I have found practice chaplaincy challenging, demanding and immensely rewarding. I hope there will be many more such appointments in other practices.

Anne Hughes is lay chaplain at Karis Medical Centre in Birmingham

In prayer I declare each patient's value and worth to God

Nick Wooding hits hard on the developing world challenge

Hardship, heaven and healthcare

We must go through many hardships to enter the kingdom of God.

(Acts 14:22)

The Apostle Paul knew all about hardships. He spoke these words soon after being stoned and left for dead. Perhaps the main hardship some doctors have faced recently (apart from MTAS) will have been the interest rate rises and higher mortgage repayments. Even as Christian doctors we may rely more on our salaries than on God. We are called to suffer hardships for the kingdom of God but we rarely do so.

The day after studying this passage I was at a medical charity discussing a missionary who was struggling as the only doctor running a Christian hospital in a Muslim area in Africa. Someone said, 'Surely people in CMF could go to help?'

The next day the *BMJ* arrived with two challenging articles. The first was by Professor Chris Lavy, *Ten years in Malawi: was it worth it?*¹ He described how, having just become a consultant and started up private practice in orthopaedics, he gave it up to go to Malawi, a country with the same population as London but no orthopaedic surgeon. He mentioned the difficulties of reintegrating into an NHS that does not recognise work abroad. The second article, by another CMF member working in Afghanistan, described possible future problems in the NHS if he could not do a face-to-face appraisal. He therefore would not be able to work as a locum in the UK when on leave.²

I was able to relate to these articles. Three years ago I returned from running a mission hospital in Uganda. I did a GP returner scheme, for which there is now no funding locally. It was a useful reintroduction in a safe environment to UK life. Had I returned any later I would have had to sit exams. Post-Shipman, it seems there is a knee jerk reaction to check up on everyone, even those whose time out of the NHS was spent doing medicine. What can CMF members do?

Fill gaps

First, we can fill the gaps in other health systems. Statistics show the need for this.³

COUNTRY	DOCTORS/100,000 POPULATION (2004)	RANK
Italy	606.5	1
USA	548.9	4
UK	166.5	72
Afghanistan	18.6	148
Uganda	4.7	174
Malawi	1.1	185

We might think we have staffing problems in the UK but we are still 150 times better off than Malawi. There are supposedly many unemployed junior doctors: some must be Christians who could use this time profitably serving abroad. It would be easier health-wise for a younger person, rather than a retired doctor, to work near the Sahara. The experience would be invaluable. A surgeon does more operating in

a mission hospital than on a training scheme. This is one of the hardships we need to consider if we call ourselves Christians – to get off the career ladder and get stuck into the developing world. Do we want to make money or make a difference? We have bought too much into the lifestyle aspirations of the western world.

Lobby

Secondly, we can lobby for change. Are there CMF members in high places in the medical establishment? I would hope so. Are they speaking up for those who work abroad or who would like to? I do not know. Are they pushing the Royal Colleges to recognise experience abroad? And recommending doctors gain it? Can we foresee a time when CVs will be rejected if candidates have not spent time in the developing world? But maybe those suggestions make us feel uncomfortable because they mean we would have to go ourselves?

Use our leave

Thirdly, we can think about using our leave to do appraisals abroad, or to help a single-handed doctor get leave or administration time. As Chris Lavy wrote, this could help doctors become global citizens: 'I recommend that all UK doctors spend some time in the developing world so that they can ground themselves in the realities of what is happening on our planet'.

Give

Fourthly, if for career reasons we do not go, then instead we can always give financially. Jesus said, 'From everyone who has been given much, much will be demanded; and from the one who has been entrusted with much, much more will be asked'.⁴ When it comes to suffering hardships for the Kingdom of God, this may be the hardest. Are we willing to live simply so that others may simply live? How counter-cultural is our way of life among our affluent peers?

Could we have stepped in?

One day we will enter heaven and worship with every tribe, nation, colour and tongue. The people dying now because we neither went nor gave are in areas of the world where the majority would call themselves Christian. One day we will have to look them in the face. Could we have stepped into their suffering, relieving their hardships by increasing ours just a little?

Nick Wooding is a GP who spent six years as medical superintendent of Kiwoko Hospital in Uganda. He is doing further studies with a view to returning abroad.

references

1. Lavy C. Ten years in Malawi: was it worth it? *BMJ* 2006; 333:976
2. Duncan A. Appraising UK doctors working overseas: open letter to the chief medical officer. *BMJ* 2006; 333:977
3. www.globalhealthfacts.org/topic.jsp?i=53
4. Luke 12:48

ABC

'Abstinence, be faithful, condoms' has been a successful ABC in helping reduce HIV transmission in Uganda, but A for abstinence is apparently no longer a family planning choice. A new wall chart, produced by collaboration between the Johns Hopkins Bloomberg School of Public Health, WHO and USAID, is entitled *Do you know your family planning choices?* and offers a brief overview of eleven contraceptive methods. Abstinence is not one of them. Perhaps the chart is solely focused on the sexually active, but a reminder to them of another choice might not have come amiss. (www.infoforhealth.org/globalhandbook/wallchart/wallchrt.doc)

ABCD

Adapting the resuscitation mnemonic 'ABC – for airway, breathing, circulation' to a palliative care situation and adding another initial, Chochinov has brought dignity to the fore as an essential core element of all patient care. A is attitude, B is changing behaviour, C is ensuring compassion, and D actually stands for dialogue. Together they enhance patient dignity, which the *Oxford English Dictionary* defines as 'the state of being worthy of honour or respect'. (*BMJ* 2007; 335:167-8)

The book of Job

The *BMJ* has a series on 'Medical Classics' and recently ran an article on the book of Job. John Launer, senior clinical lecturer at the Tavistock Clinic, writes: 'A friend of mine, a Catholic priest, once described to me how he had to perform the funeral of a small child. He told me that there was only one way that it was possible for him to do it with any degree of honesty or authenticity: to offer no explanations, no pretence of understanding, no defence of his faith. Good doctors, and good counsellors, do likewise. The God of the book of Job is not the reasonable, bland God of wishful liberals, nor the vengeful and punishing God of fundamentalists. He is as he is. That is what makes this book possibly the most challenging in the whole Bible, and the most enduring handbook for any of us who have to deal professionally with tragedy, loss and despair.' (*BMJ* 2007; 335:453)

Prophets

Paying tribute in the *British Journal of General Practice* to a deceased GP hero, Peter Toon suggests he was a 'prophet'. This role he describes as 'prophesying not in the Harry Potter sense of predicting the future with uncertain accuracy, but as in the Old Testament, whose prophets denounce injustice and wrongdoing, and whose lives, speech, and writings transformed their society'. Good stuff, as is the following description of Amos, but Eutyclus is less sure that 'Jeremiah's bizarre public behaviour and ranting would these days undoubtedly gain the attention of the local mental health team' and disagrees with 'we don't know what substances Ezekiel took, but they must have been pretty powerful, judging from his visions'. (*BJGP* 2007; September:758)

No miracle cures

'There will be none of the promised miracle cures from embryonic stem cell research' begins an Australian article, before continuing 'embryonic stem cell research has suffered a major blow with a major Singaporean/Australian company abandoning work on therapies due to lack of success and soaring costs'. The company, ESI, was attempting to turn embryonic stem cells into insulin-producing cells to treat diabetes and cardiac muscle cells to counter congestive heart failure. (*The Courier-Mail* 2007; 26 July. www.news.com.au/couriermail/)

Adult stem cell success

By contrast, *The Independent* champions research led by the famous heart transplant surgeon, Professor Magdi Yacoub, where there are good results from stem cells taken from bone marrow being used to grow heart valves and muscle in the laboratory. The technique could be ready for human trials within three to five years. (*The Independent* 3 2007; September: www.news.independent.co.uk/health/article2921880.ece)

O tempora, o mores

Eutyclus can remember qualified colleagues being sent away from ward rounds for being improperly dressed, never mind medical students, so was saddened to read in an excellent article about school students getting work experience in medicine that 'Students are advised about appropriate dress: no plunging necklines, bare midriffs, or jeans. This area has been the source of more resistance and adverse comment about the scheme than any other'. And when they arrive: 'We supply ties to those who come dressed too casually and occasionally show them how to tie them'. (*BMJ Careers* 2007; 1 September:GP88)

Care of Catholic patients

A new website has been launched which aims to promote the Catholic ethos of care and to give guidance to doctors treating Catholic patients. The emphasis is on the church's vision of care for the whole person. (www.catholicsinhealthcare.org.uk)

Good for the brain

Private religious practices and higher levels of spirituality are associated with slower progression of Alzheimer's disease, but quality of life and speed of decline were not correlated. Seventy patients with probable Alzheimer's were followed in a longitudinal study, with cognitive decline being monitored by the mini-mental state examination. (*Neurology* 2007; 68:1509-14)

Good all round – for women

Attending religious services is linked with better physical and psychological health. For highly functioning elderly women, but not men, attending one or more religious services a week improved 'allostatic load', a measure of cumulative physiological dysfunction including blood pressure. This relationship was independent of better physical or social functioning. (*Psychosomatic Medicine* 2007; 69:464-72)



Can it be me?
Marjory Foyle

- Christian Medical Fellowship 2006
- £8.00 Pb 152pp
- ISBN 0 90674 7368

CMF member Marjory Foyle is a recognised expert on the effects of stress in Christians working cross-culturally. *Can it be me?* is her autobiography, detailing a life spent serving God as a medical missionary in India and Nepal and later as a psychiatrist.

Marjory stepped out in faith as a young woman fresh from medical school and let God lead her overseas. She travelled to India and began working as an obstetrician and gynaecologist. As a female doctor, she was a rare breed on the mission field and her skills were desperately needed as many women would rather die than be treated by a male doctor. Her hours were long but she was sustained through regular prayer and continual communication with God and other Christians. She recounts many anecdotal stories of the operations she performed and the unusual conditions that were rife in her population.

God then called her from India to Nepal. Initially this was difficult for her to accept, but she went on to establish vital medical infrastructure in the country and was instrumental in the building of a new hospital.

Her work was gruelling and there was little time for rest. During her time overseas, she became clinically depressed. Later she began to recognise the inherent stressors for Christians working in cross-cultural mission. She returned to the UK and successfully obtained her diploma in psychiatry, a fore-runner to the modern-day MRCPsych. At the time, there wasn't any psychi-

atric provision for Christian workers in India so Marjory pioneered and later directed the Nur Manzil Christian Psychiatric Centre in Lucknow.

Marjory writes beautifully and *Can it be me?* contains many humorous stories

Marjory's stamina is phenomenal. After retiring from conventional medical mission work aged 60, she still continues to travel and establish mental health services for missionaries. This book is relevant to every Christian, medical missionary or not, as it is packed full of reminders that God is faithful if we entrust our lives to him.

Marjory writes beautifully and *Can it be me?* contains many humorous stories of her experiences. She traces the change in mission from the forties where women had to dress in long skirts with hats to the more liberal shorts and T-shirts of the sixties and seventies! There are also many personal photographs, spanning 40 years, of the people whose lives she has touched and the places she has influenced. I was extremely encouraged by Marjory's constant praying and the delight she takes in Scripture through all adversity. *Can it be me?* is a lesson to us all when we face trials in our earthly lives.

Liz Croton is a GP Registrar in Birmingham



Transforming Care
A Christian Vision of Nursing Practice
Mary Molewyk Doornbos et al

- Wm B Eerdmans Publishing Company 2005
- £9.00 Pb 211pp
- ISBN 0 20282 8744

This book explores the distinctives that Christians bring to their professional practice. Starting with theological perspectives on nursing practice, personhood, health and healing, the authors explore the values and interpersonal ethics that underpin a consistent Christian ethic of nursing.

They go on to look at how these values are worked out in practice in mental health, community and acute nursing. Vignettes explore the practical outworking of the theoretical sections and the authors seek to show how biblical faith should act as a springboard to treating patients and colleagues in a

distinctively Christian manner. This is a useful book to start a serious exploration of how faith and practice intersect. However, this book raises more questions than it answers. It eschews a didactic approach for one that explores issues through illustrative narratives and reflective questioning. This may be frustrating for some, but can be very helpful in enabling us to think around the issues.

While this book is squarely aimed at American nurses, it asks questions highly relevant to non-American doctors and medical students as well.

Steven Fouch is a nurse and supports allied professions at CMF



The Morning After Pill
John Ling

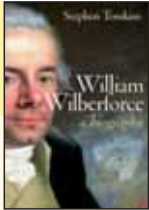
- The Christian Institute 2007
- FREE (0191 281 5664) Pb 88pp
- ISBN 1 90108 6364

'Human life begins when a man's sperm fertilises a woman's ovum.' This is the starting point for John Ling's elegant, thoroughly researched but hard hitting book on the morning after pill (MAP).

Ling reviews MAP's history and social/personal impact. Then he demonstrates how society has been brainwashed into accepting a 'new biology' that states that, since life begins post-fertilisation, drugs such as the MAP are contraceptives not abortifacients. Ling provides extremely useful pointers from Scripture and simple logic to refute this new biology and the counterarguments that are used to defend the MAP. Finally, he suggests

what our Christian response should be. Not everyone will like this book. Ling writes with a passion that may be construed as confrontational. Some Christians will not agree with his definition of the beginning of life whilst others see the MAP as the 'lesser evil' in the abortion debate. However, this accessible book has a usefulness that goes beyond its subject matter and could be used as a handbook for anyone wishing to apply Christian ethics in a firm but loving manner. I strongly recommend it.

Oluseyi Hotonu is a specialist registrar in obstetrics and gynaecology in Wylam



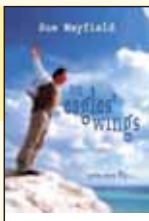
William Wilberforce
A Biography
 Stephen Tomkins

- Lion Books 2007
- £8.99 Pb 256pp
- ISBN 0 80282 5931

I have always been fascinated by Wilberforce: we were both born and bred in Hull and even attended the same school, admittedly 200 years apart! He was a truly great Christian, using his immense wealth and power to achieve his life-long mission statement: 'God has set before me two great objects, the suppression of the Slave Trade and the Reformation of Manners'. Stephen Tomkins reveals fascinating details about Wilberforce's upbringing, exposure to Methodism and education, and political career. I was moved by the account of his conversion and discovery of God's call on his life. His momentous perseverance – the

abolition of slavery took up the rest of his life – made particularly sobering reading. Tomkins has been particularly fair when weighing up conflicting literary evidence – Wilberforce's sons' huge biography of their father disagrees in places with other abolitionists' accounts. This is a middleweight biography – meatier than Piper's spiritually orientated *Amazing Grace in the Life of William Wilberforce*, yet lighter than Hague's incredibly referenced *William Wilberforce*. This is essential reading for every modern-day Christian campaigner!

Rachael Pickering is a GP in London



On Eagles' Wings
 Sue Mayfield

- Lion Books 2004
- £4.99 Pb 144pp
- ISBN 0 74594 8901

Losing a parent as a teenager is devastating and these books deal sensitively with this difficult subject. They tell the story of Tony, a fifteen year old boy whose mother is dying from multiple sclerosis. His father is the local vicar and Tony has to juggle schoolwork with nursing his mum and fending off questions about her from concerned friends and teachers.

On Eagles' Wings is set in the final weeks of his mother's life and *Patterns in the Sand* picks up the story one year after her death so ideally they are best read in succession. I lost my father at the age of 14 and was impressed with the author's intuitive writing style. Tony's

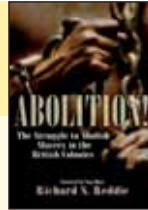
Patterns in the Sand
 Sue Mayfield

- Lion Books 2004
- £4.99 Pb 142pp
- ISBN 0 74594 891X

emotional rollercoaster is very believable. Brought up as a Christian, he burns with anger towards the God who has taken his mum from him. Happily though he eventually rediscovers faith.

The Christian thread through both books is thoughtfully written and so would be ideal for non-Christians to read. I would happily recommend them, when appropriate, to my patients. Both books though do contain mild swear words and sexual references and so may not be suitable for younger children.

Liz Croton is a GP registrar in Birmingham



Abolition

The struggle to abolish slavery in the British Colonies
 Richard S Reddie

- Lion 2007
- £9.99 Pb 235pp
- ISBN 0 74595 2291

British colonial slavery was finally outlawed in 1838 after 276 years. The British were not the first to start this outrage, but they were the first to end it.

Abolition is a well presented book. Richard Reddie describes three types of African slavery: Trans-Saharan slavery, African indigenous Chattel slavery, and the infamous Transatlantic Triangular slave trade. In addition to Wilberforce, he pays tribute to the Quakers, Thomas Clarkson and Olaudah Equiano, John Newton and John Wesley.

Bristol, Liverpool and London were the main British profiteering seaports. Surprisingly, famous

Elizabethans such as Sir Francis Drake and Sir John Hawkins (who transported 1200 slaves) profited from the slave trade, as did Queen Elizabeth I herself. The Transatlantic slave trade started in earnest under Charles II around 1662 with the development of the West Indian Colonies.

Crucial dates are 1807 (the ending of transatlantic slavery), 1833 (the total abolition of colonial slavery) and 1838 (final freedom from the deceptive apprenticeship system). The book is full of little known facts and makes fascinating reading.

Jeremy Franklin is a retired GP in London



DVD: Romance Academy

No Sex Please – we're teenagers

- IWC Media 2005
- Available from CMF for £20.00 (£10.00 for students) inclusive of postage & packaging

Can twelve teenagers give up all sexual activity for five months? Can they explore the value of relationships, learn about themselves and develop confidence and self esteem? Only one is a virgin and most have been sexually active for years. But as they abstain from sex, they experience more, not less, respect from their friends.

This DVD charts two Christian youth workers taking the group on a five month journey that includes visiting the USA to see evangelical abstinence projects such as the Silver Ring Thing. Their faith and commitment to these young people shines throughout the series. Some of

the group appear to make a Christian commitment; all of them grow in maturity and confidence.

Watch this with your teenagers and discuss what they and their friends think, say and do – and why. Pass it on to your youth leader or your local secondary school. Challenge the apparent norm in society and give our young people some reasons – other than 'you shouldn't' – for abstaining from sex. Stocks of this brilliant resource are running low so email alex@cmf.org.uk for your copy today.

Liz Walker is a GP in Farnborough

We are told to ask the Lord of the harvest to send out more labourers into the field ripe for harvest, and many of us are doing that. We know he hears our cries – so why do I receive so many requests from members overseas for other medics to come alongside them or replace them when they have to leave? Extracts from emails show the needs:

■ Pakistan

Where are the doctors we need? We need someone with surgical skills, a female paediatrician and a radiologist who could make regular visits and advise. Our single handed doctor is getting burned out. JS

■ Tanzania

After many months of advertising, we need a replacement doctor to head up the work at St Luke's as we prepare to move on. RT

■ Malawi

The doctor heading up our hospital leaves in December and we are desperately looking for someone to replace her. The person would need some basic skills in obstetrics and surgery. It's a beautiful but busy place on the lake shore. SW

■ Bangladesh

We desperately need replacements and especially an experienced female obstetrician (preferably two). FM, writing from LAMB Hospital where two senior doctors are about to leave.

■ Zambia

We require a generalist with anaesthetic or obstetric experience, ideal for a doctor taking early retirement. VD, a retiree, writing from Kalene Hospital.

■ China

On a similar note, our friends in JHF write of the needs there. Visit the medical and social services pages on their website at www.jhf-china.org

And so it goes on. Please pray in earnest about these and other situations known to you. Perhaps you know those who could fill these posts; perhaps it might even be you? Details can be found at www.healthserve.org/overseas_opportunities/

Starting points

If you want a taster of what working abroad might be like, a number of agencies that offer short mission exposure trips with various types of experience are listed on this website, and some of our members who are already involved might well be prepared to take you with them on such a trip.

If you need contact addresses of agencies that you could work with, go to www.healthserve.org/pages/pages.asp?page=section&id=1. You will also find contact addresses of agencies that can advise how to go about it, or please feel free to contact me at the CMF Office on 020 7234 9660.

If you are wondering how to resource time abroad, it would be worth reading Myles Wilson's book, *Funding the Family Business*

(ISBN 978 0 9553320 0 5) or attending one of his workshops. Phone Stewardship Services on 020 8502 8585 for details.

Working Abroad

A new edition of our *Short Term Mission Handbook* (renamed *Working Abroad*) is about to be published as hard copy and is already up on the overseas website, www.healthserve.org/pubs/ Sometimes I am asked, 'Is it safe to go abroad'? This handbook considers some of the answers to this question:

There is a telling contrast between the attitudes of society today – with its emphasis on health and safety, caution and desire to have everything under control – and the attitudes of those who went overseas in the 19th and much of the 20th century. We face risks wherever we go, it would be wrong to ignore them, but any healthcare worker overseas who wishes to identify with the people who he/she serves should recognise that too much attention to their personal security could hinder their relationships.

Working with refugees in a conflict zone

Neil Fletcher is one such person who has just stepped out of his comfort zone into a dangerous and difficult situation. He has sent us his first impressions:

Chad is one of the poorest countries in the world, ranked as 167th out of 176 countries in the UN Human Development Report. My mission here, working with MSF, is to bring primary medical care to the inhabitants of a refugee camp in Goz Beida, Eastern Chad. Armed conflict and insecurity in the area have hampered relief efforts. The camp contains thousands of internally displaced Chadians and refugees from Darfur who have fled the murderous Janjaweed of Western Sudan.

These patients are amongst the most poverty stricken and disease ridden people on earth. A hundred years ago they were inaccessible as our neighbours but now, in this global village of cyberspace, satellites and jumbo jets, they are our neighbours. And as such we must love them as we do ourselves. That doesn't just mean feeling some sentimental emotion towards them – it means helping them out of disease, poverty and suffering in whatever way we can.

Mean life expectancy here is 44 years and childhood mortality is close to 25 percent. Most of these deaths are from diseases that are simply, easily and cheaply preventable and treatable – malaria, diarrhoea, measles, malnutrition and pneumonia. The global scale of such problems equates to a death toll the size of September 11th every two hours of every day of every year, year in, year out. And that is just the kids! Bin Laden may be guilty of causing death by commission. If I ignore these people then I am guilty of allowing death by omission.

My role as a doctor here will have several different components. The focus of my work will be primary care and nutrition. A lot of my work will involve teaching and training the Chadian national staff. I'll spend a lot of time seeing and treating patients – generally those clinical cases that are too sick or too complicated for the national staff to manage safely.

Peter Armon is CMF Head of Overseas Ministries

abortion: a christian doctor's response

1. We affirm that man and woman are created in the image of God, that all life originates with our creator, and that all life, from conception to death, is of inestimable value to our creator
2. We recognise that God has given us the choice between life and death
3. We recognise that we live in a culture of death and have become part of that culture, where we have chosen death over life and have not fought harder against the evil of abortion
4. We affirm that for several thousand years since the Hippocratic Oath, we as the medical profession have historically been opposed to abortion
5. We confess that before 1967 most of us were firmly against abortion but, as soon as the law was changed, we abandoned our principles and forsook our Hippocratic tradition
6. We confess that we have failed millions of mothers, fathers, and their unborn babies, by being silent when we should have spoken out, and passive when we should have been active
7. We confess that there has been a slippery slope and we now effectively have abortion on demand
8. We confess that consequently life has been devalued; the disabled, the vulnerable and the elderly have suffered; and there are more pressures to legalise euthanasia and assisted suicide
9. We ask God Almighty to have mercy on all of us in the medical profession who have been involved in abortion in any way, active or passive, and we pray that God may restore our profession to the highest moral standards
10. We ask God Almighty to have mercy on all of us, on our families, and on our society
11. We pledge to work and to pray to preserve life from conception to natural death
12. We pledge to work and to pray for a culture of life, so that abortion will become very rare and that life once again will become precious



christian medical fellowship

uniting and equipping christian doctors

To find out more, telephone 020 7234 9660 or visit our website www.cmf.org.uk

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