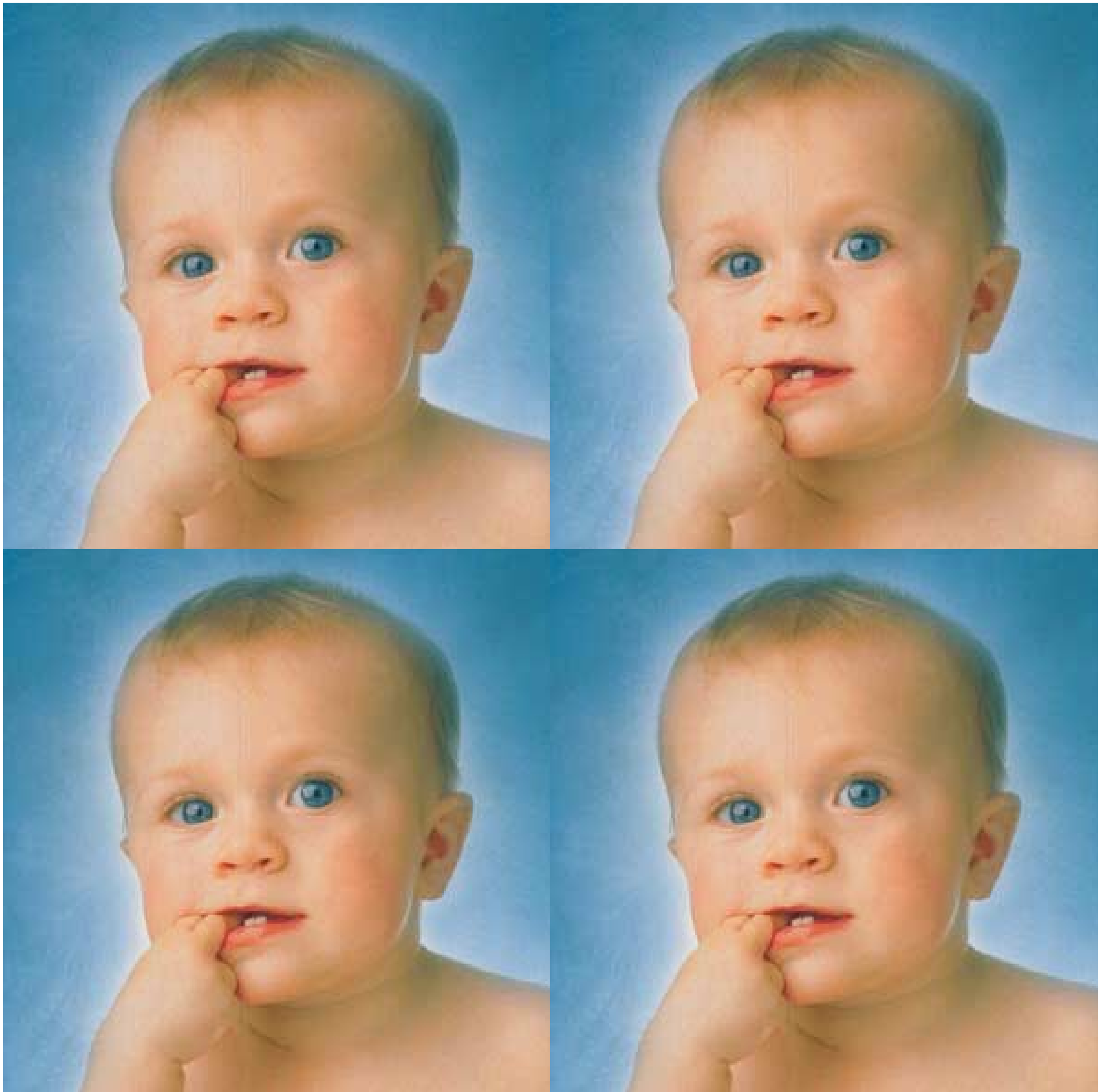
Triple Helix

Christian dimensions in healthcare

Cloning - a double take on the issue
The Hippocratic Oath - new better than old?
Where is God when it hurts?



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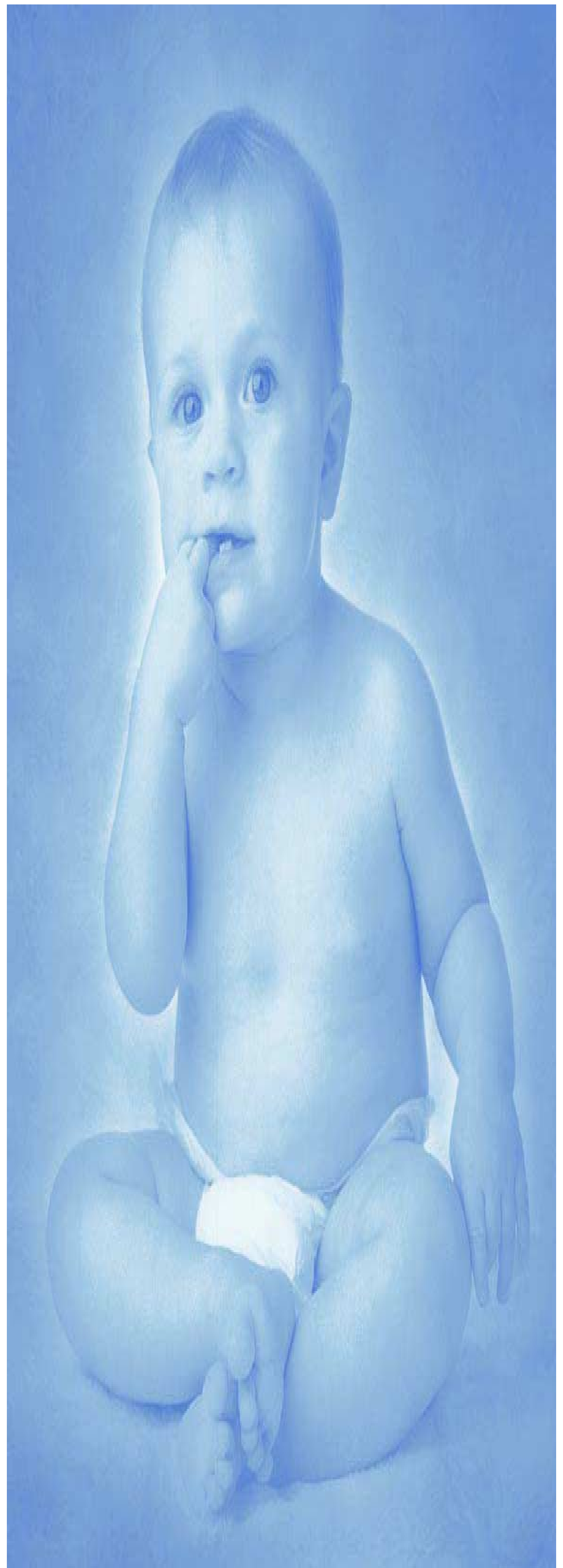

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this mortal coil

In the famous 'To be, or not to be' soliloquy in Shakespeare's *Hamlet*, the title character continues his muse on life and death with the words:

'To die, to sleep -
No more; and by a sleep to say we end
The heart-ache and the thousand natural shocks
That flesh is heir to. 'Tis a consummation
Devoutly to be wished. To die, to sleep;
To sleep, perchance to dream. Ay, there's the rub;
For in that sleep of death what dreams may come,
When we have shuffled off this mortal coil,
Must give us pause.'

Health professionals are involved with life and death, with sleep and insomnia, with 'the heart-ache and the thousand natural shocks' that occur on 'this mortal coil'. Most of the time we press on, generally doing a good job, but like Hamlet sometimes we must muse. What (if anything) is the meaning of life? What (if anything) takes place after death? 'Ay, there's the rub.'

Triple Helix is a new multidisciplinary magazine which seeks to explore questions like these within the context of healthcare. It launches at a time of two significant anniversaries - the 50th of the Nuremberg Trial verdicts when some Nazi doctors were hanged for medical atrocities, and the 30th since the passing of the UK Abortion Act, since when there have been more than 4,000,000 abortions.

This edition takes a hard look at suffering, considers the potential for cloning humans (no longer the stuff of science fiction), and reviews a proposed update of the Hippocratic Oath. *Among All Nations* gives an international perspective right at the heart of the magazine, appropriately reflecting the professions' global responsibilities as the jet and the Net make the world ever smaller.

Triple Helix is Christian, in a quietly confident way. We don't have all the answers, but we believe we have better answers (and better focused questions?) than any other health magazine on the market. We hope you enjoy considering the Christian dimensions in healthcare. We hope it helps 'give us pause'.

Andrew Fergusson

Second thoughts from a cloning society

D Gareth Jones

It's 2060. Human clones are all around, though often we have no idea who's a clone and who isn't. The other day I got a great surprise when a friend told me she was one. I would never have guessed. Of every 1,000 babies born now, 20 are cloned. We have laws to govern cloning just as we have laws to protect human embryos and control surrogacy. Animal cloning has revolutionised agriculture, and many pharmaceuticals now come via cloning in animals.

This all stemmed from groundbreaking work back in the late 1990s. Research on sheep showed that by transplanting the nucleus from the cell of one adult sheep (A) into an egg of another sheep (B), the egg with the transplanted nucleus acted as if it had been fertilised by a sperm. The resulting lamb was genetically identical to A.

The attraction of adult-cell cloning was always that outcome was known. Once an animal with a desired trait had been obtained, for example, a sheep genetically engineered to produce milk laced with an enzyme or a drug, then numerous further copies could be produced. This proved a highly effective biological means of pharmaceutical production.

In 2060 we recognise three forms of human cloning:

Ego cloning is cloning for social reasons: public figures and ordinary people wanted 'another me';

Medical cloning is for overcoming conditions like infertility, where the male is sterile, or for some genetic disorders;

Research cloning, which could be used to produce tissues for other people, including cell lines and organs.

Ego clones

Ego cloning was always controlled by legislation but it's had its problems. Individuals got frustrated when 'my' clone had my failings, as well as my strengths. Frequently, clones turned out to have totally different interests from the cloned individual. The new 'me' was more unlike 'me' than I would ever have thought possible. There was the case of the self-made businessman-cum-philanthropist whose clone turned out to be a budding philosopher uninterested in money and abysmal at making it!

Surprisingly, lots of Christian groups went in for cloning. Certain churches decided to clone their good preachers, and some worked well. A few leading preachers today are clones. But some clones were - it seemed - ghastly mistakes: they were not even Christians, let alone great preachers. The mistake people made was to think that God was limited by genetics, but genetic similarity between two individuals does not ensure spiritual similarity.

Clones are far more human than people in the past ever imagined. They are just like you and me - assuming you are not a clone; (I'm not . . . at least, I'm pretty sure I'm not). God looks upon clones as truly human persons, and they are just as responsible for their motives and actions as anyone else. They can have a personal relationship with God through Christ, in exactly the same way as non-clones, or they can reject God. Just because they are cloned replicas of their faithful fathers (or mothers) does not mean they themselves will end up faithful disciples.

Ego cloning proved a failure in families where the clones were treated as slaves, created to do their master's will. What went wrong was that clones were not treated as equals; they were downgraded. That's where the problems lie. I'm not suggesting ego cloning is a good thing, but the biggest problems arise when clones are forced to behave as others expect them to behave. But then, why did you clone yourself in the first place? Why should you accept someone as different from you when you brought them into the world precisely to be like you?

Even when clones turned out well as human beings, many of us were left with nagging doubts, because the individuality and unpredictability of human life had gone. Reflecting on this, Christians glimpsed in a fresh way how God deals with us - as unique individuals. We dare not deal otherwise with each other, cloning or no.

In certain respects, cloning did not turn out as bad as some expected, but it didn't achieve much either. If individuals are given freedom and allowed truly to become themselves, ego cloning becomes redundant. It is a farce; an all-too-obvious example of tragic technical excess.

Medical cloning

They found many medical reasons in favour of cloning. It proved beneficial for couples whose infertility was successfully by-passed. It is hard to condemn those couples, and the resulting clones (children) give the impression of being as well-adjusted as any other children. This is because they were brought into existence to be themselves. They weren't created

in order to be genetically identical to one 'parent'. They were created to be loved and to love.

Medical cloning has been widely used to enable single women and lesbian couples to have children. Gay men, and the occasional single man, have also used it, but of course they have needed to employ women as surrogates, the 'male womb' still not being quite perfected. The practice became very difficult to control. Once the technique was available the drive to use it everywhere imaginable was strong.

Cloning also became divorced (was it ever not divorced?) from moral values. It was simply used as a way to enable absolutely anyone at all to have children outside any conventional commitment relationship. Perhaps the controls were always ineffective because the technique itself so completely emphasised the manufacturing side of reproduction?

But what has been the real cost of producing these children, not just for individuals, but for society? The price society is paying for having accepted cloning into its midst is not the horror some imagined. It is far more subtle than that. It is in the changed expectations we have of children, in the new way we look at them, and in the new things we can do to ourselves and to them.

Should we be bringing 'another me' into existence, even for good reasons? Has cloning, even for the most humanitarian reasons, brought us unnervingly close to the disposable society? Medical cloning is done from different motives than ego cloning, but do I really want 'another me', even to overcome infertility or genetic disease? Perhaps having no children is better than having a cloned child, but neither way is easy. Children truly are 'made' with this technique; this is both its biological potential and its moral uncertainty.

Research clones

This proved the most challenging of the three categories. Ethical discussion tended over the years to focus here because it was closest to science fiction scenarios. Aldous Huxley almost got it right in the 1930s in *Brave New World*. The problems he foresaw are the same ones that confronted our policy makers.

How can you possibly perform research ethically on human clones when producing them to be the source of cell lines and organs means that the clones themselves can have no say in what is done to them? It amounts to producing human beings (clones) in order to sacrifice them when organs or tissues are required.

We were clear here, and there have been no moves - at least, none that I know of - to produce research clones. There have been extensive experiments with animal clones, but not human ones. We recognised that would be taking us back to the dark days of dubious human experimentation, rather than into some glorious future. Some scientists exerted considerable pressure to make us go that way but society thankfully concluded the drawbacks were too great.

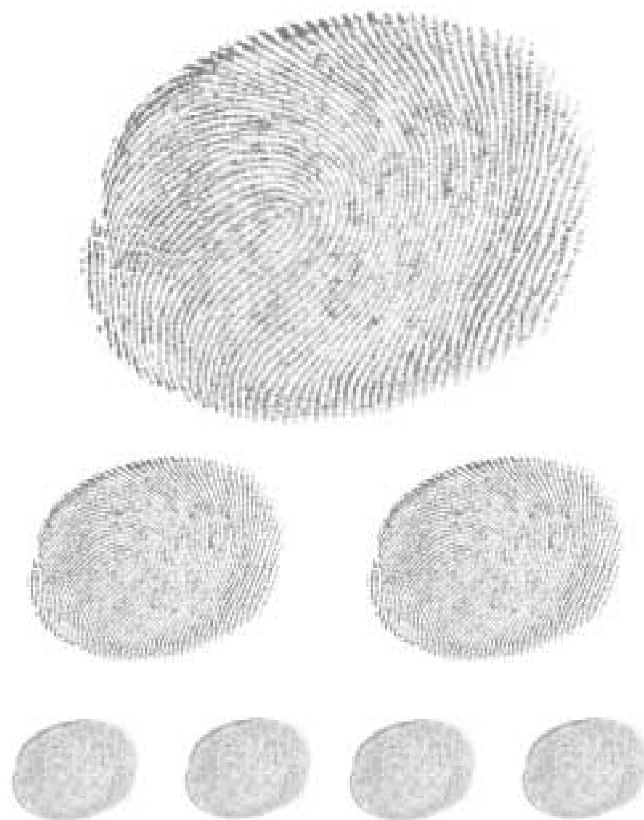
To destroy human clones so others might live was considered outlandish even by the ethically illiterate. We could not tolerate such gross undervaluation of human beings. A clone born in 2060 is treated in the same way as any other human being.

What should we have done?

The new procedures became established in the early years of this 21st century, and we can now see their good and their bad features in a way not possible before their introduction. We can learn from our mistakes, perhaps.

Cloning proved a two-edged sword. The pressures it unleashed have been similar to those unleashed by all the technologies used to control and manipulate human reproduction. Society has been changed for ever and Christian standards have been under great threat.

Technologies like these can be harnessed, and if to be used at all must be harnessed for good ends, but different agendas made this extremely difficult. Perhaps they made it impossible?



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where is God when it hurts?

Hugh James reflects on a personal journey of suffering

My justification for daring to write on this subject is that, having been diagnosed with multiple sclerosis (MS) 13 years ago, I have some experience of what it's like to be on both sides of the fence. For young doctors, it is usually only in our patients that we confront suffering. When I was diagnosed with MS at 38, I was the odd one out. Now, two of my circle of friends have developed major chronic illnesses.

Many Christians facing suffering tend to react like the author Joni Eareckson who became quadriplegic in a diving accident. She recalls 'A part of the quiet rage I experienced was anger against God. Inwardly and very quietly I ranted and raved at him in my spirit. Now I think it is better to get angry at God than to walk away from him. It is better honestly to confront our real feelings and let him know this is how we feel . . . Far better than pasting on a toothpaste smile and going around . . . pretending you are not hurting.'[1]

I can understand her feelings. I respect her for recording them. I can only say that I was spared them, as my experience was rather different. As a medical student I obviously met suffering. I did so again working as a doctor in a poverty-stricken rural hospital in Burundi. Even though we were present during a genocide where 1-200,000 people were killed, somehow the 'problem of suffering' didn't become a personal issue for me.

Later the problem did become an issue for me. On my return to England I was senior registrar at the Brook Hospital in South London and was deeply involved in running the Intensive Care Unit. It was my job to console the relatives. It fell to me to tell parents that their 10-year-old daughter was brain dead or that their teenage son was unlikely to survive. I wept with them. I put my arm around them. But a question troubled me: as a Christian should I not be able to say something? I found I had nothing to say, and that spurred me to pray and study my faith. Here are some of my thoughts and conclusions.

The suffering God

The complaint against God is often 'How could God do this?' This suggests a God who sits on high, throwing suffering at an innocent human race. Another common question is 'Why him?' The victim was such a nice person. Is God unjust? As Christians our understanding of God the Father is informed by what we know of Christ his Son. When Philip asked 'show us the Father', Jesus' answer was that 'Anyone who has seen me has seen the Father'.[2] So if we want to know God's character, we must look at Jesus.

When we study Jesus we find someone who suffered. The linking of Jesus and suffering occurs over and over. It is predicted by the prophet Isaiah: 'He was despised and rejected by men, a man of sorrows, and familiar with suffering'.[3] Even the Christmas tinsel does not mask the suffering of the incarnation - Christ's poverty, homelessness, persecution and refugee status.

In 1946 the World Health Organisation defined health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. It could be paraphrased: 'the absence of suffering'. By this definition, Jesus was not enjoying health. He was sharing human suffering. But he came not only to share our sufferings, he came to save us.

'To save' has many meanings. It concerns the whole person. Ultimately it means being saved for eternity. But nearly a third of the references to salvation in the New Testament concern being set free from specific ills and the sufferings of life, ie imprisonment, disease, or demon possession. Throughout the New Testament Christ's eyes are on his principal goal, the cross. He said 'The Son of Man must suffer many things and be rejected by the elders, chief priests and teachers of the law, and he must be killed and on the third day be raised to life'.[4]

Have you ever studied a crucifix? It reminds us of the physical contortions of Christ's body on the cross: the wounds, the nails, the lash wounds, the blood, the sweat, the fatigue; in sum, his sufferings.

This is not a distant God throwing suffering at us. This is God suffering with us, here on earth. This is God suffering for us. I do not understand why there is no way to be reunited with God the Father other than through Christ's death. But I am certain that if there had been, Christ would have taken it.

The suffering Church

So, as I looked for an answer, I found that suffering is at the centre of our faith. I found, too, that suffering is integral to the experience of the church. As St Paul observed 'We also rejoice in our sufferings, because we know that suffering produces perseverance'.[5] The early Christians experienced a whole catalogue of suffering: the martyrdom of Stephen and James heralded decades of imprisonment, torture and death for thousands of believers. Suffering took various forms. St Paul was shipwrecked. The church suffered poverty and famine. Suffering is a hallmark of the church in many parts of the world today.

I found that suffering is inherent in this fallen world. Thus St Paul writes 'We know that the whole creation has been groaning as in the pains of childbirth right up to the present time'.[6] So I came to the conclusion that suffering is not an aberrance. It is integral to Christianity. God does not inflict suffering on us. He shares it with us. So as part of a suffering world, it is inevitable that we will suffer with it. Indeed, Christians are called to do so. Anything else would produce 'Rice Christians'.

All these realisations brought me peace. God does care. God is not capricious. He is a suffering God. But even that did not give me a pat answer for parents in anguish. All I could do was to continue to put my arm around their shoulders and cry with them.

My daughter's accident

Three years later, after taking up my consultant's post, my daughter was severely injured. One morning I routinely dropped her off at school. On her way home an out-of-control car mounted the pavement and mowed her down.

Late that night I found myself returning home, leaving her in the Intensive Care Unit. She was gravely injured, with brain damage, on a ventilator. We did not know whether she would live or die. Much of those days is a distant blur, but I remember the journey home. Our parents had joined us. 'I'll drive' said my father. 'I don't think you're up to it.' He was probably right, but it was I who was alert enough to scream 'Dad, the lights are red!'

I remember another conversation on that journey. I turned to my father and said 'Dad, do you know, I'm not asking "Why me?"' All the theoretical deliberations begun at the Brook Hospital had become a reality when our family was involved.

My own illness

Just three years later it was I myself who was sick, having been diagnosed with MS. And yet I found that this understanding of suffering still held true. I still do not find myself asking 'Why does God do it?' or 'Why me?' Why not me? If my Lord suffered, why should not I? Why should I be exempt from the sufferings of our world?

If we are asking 'Where is God when it hurts?', then one of the answers will be: 'In his people, in his church, bringing help and encouragement'. St James reminds us 'Religion that God our father accepts as pure and faultless is this: to look after orphans and widows in their distress and keep oneself from being polluted by the world'.[7] Jesus, likewise, is emphatic. To care for those who are thirsty, hungry, sick, or in prison means no less than that 'you did it for me'.[8]

Reactions of other Christians

Sadly, Christians today are often as hopeless in helping someone who is facing suffering as were Job's three friends 4,000 years ago. When he heard of my diagnosis, a Baptist pastor whom our family had known for many years came up to me and said 'Hugh, are you sure you have no unconfessed sin?' I said 'No', but in truth I should have said 'Probably, what about you?' Which of us keeps perfect accounts with God?

Another response to me was 'You just need faith'. This advice was usually accompanied by a tape from the person's favourite preacher. After quoting Jesus' promises for those who pray in faith they concluded 'You pray, you believe, you will be healed'. How do we square Bible verses about the power of prayer to remove a mountain[9] with Jesus' own prayer in the Garden of Gethsemane, 'Father, if it is possible, may this cup be taken from me'?[10] Or St Paul's prayer for removal of his thorn in the flesh?[11] Unlike the claims of these preachers, God's answer to Jesus was 'No!' It was 'No!' to St Paul, too. It may be 'No!' for us, too.

A lady came up to Rabbi Lionel Blue. 'O Rabbi' she said, 'I do like the way you Jews call a spade a spade!' 'Not at all Madam,' said the Rabbi. 'We Jews call a spade a bulldozer!' Jesus was a Jew. Could it be that when he spoke of faith moving mountains he was using dramatic exaggeration to emphasise the importance of faith and prayer? Are we Westerners taking as literal and universal what was never meant to be so? If we can't accept that, are we committing the double whammy, implying that the one who is suffering is at fault because they lack faith?

Some people have told me 'You are healed but you just do not recognise it'. I find that utterly meaningless. Others have said 'Your healing is in heaven'. So what? In heaven we will all be freed of physical limitations, even the infirmities of old age.

Another reaction I met was disappointment. When my diagnosis was known many people prayed for me. I'm grateful. Our church had known a number of answers to prayer. But as it became clear that God was not healing me, some were disappointed. I felt a sense of isolation as some individuals seemed to avoid me. There was a sense of embarrassment. Even our home group folded as several people confessed they felt unable to mention their own needs when obviously I had a greater need. That destroyed any possibility of pastoral care.

Healing has become a prime subject, even a fashion, in churches today. Many modern hymns echo the idea that Christ died for our sickness. It is uncomfortable to be told this repeatedly, especially when it is evident that Christ is not healing you of your own sickness. I think the more extreme proponents overstate the 'healing' connotation of salvation at the expense of other dimensions.

When I was first diagnosed I frequently prayed to be healed, both in my private prayers and at prayer for healing in church. But it always left me restless. I wanted to be what I was not. Finally I prayed: 'Lord, I am asking for healing this last time. If you say "No!" I will accept that as your will for me and stop praying for healing.'

God did not heal me, and, with a few special exceptions, I have not prayed for healing again. A little while later I discussed this with my vicar. He pointed out that in the cases of Jesus in the Garden and St Paul's prayer about the thorn in the flesh, both prayed three times, then stopped. As Ecclesiastes 3: 6 says, there is 'a time to search and a time to give up'.

Footprints by Margaret Fishback Powers is a poem that has inspired millions. The writer tells how walking through the sands of life left a double track of footprints because God was beside her every step. However, in times of trouble, there was only a single set of footprints. When she questions God, he replies 'That was where I carried you'. At the blackest times I did not feel close to God. I found prayer and Bible study difficult. But I was grateful and drew strength when others would join with me and pray for me. And in retrospect I can see how the Lord has carried me.

Dr R Hugh James is a Consultant Anaesthetist responsible for Audit at Leicester Royal Infirmary.

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People with disabilities: four common mistakes

1. Does he take sugar?

You may think this attitude has disappeared. It has not. Vivien, my wife, and I met an old acquaintance. He turned to her and asked, 'Can he shake hands?' Another time we entered a strange vicarage drawing room. 'Would your husband like an upright chair?', the vicar's wife asked Vivien. This is people's reaction to me and I look fairly normal above the waist, can talk, reason, see and listen normally. What must it be like for those of greater disability?

2. I know what he needs.

It's hard to reject well-meaning help. Yet those who offer it are often getting in the way. A prime example is people who grab my elbows to support me. Fine, but if your legs don't work, how can you lever forward if your arms are firmly fixed? I well remember tripping over at a wedding reception and being pinioned, helpless, by a consultant neurologist from Queen Square. He should have known better.

3. Inaccessible buildings.

Another gripe is with institutions who proudly proclaim 'Facilities for the Disabled'. Most often this means a ramp at the back door 100 yards away. So often the 'disabled' just means 'wheelchair users', but most people with mobility problems are not necessarily in wheelchairs. What I and many elderly people need is a handrail at the front steps, or on any other steps. How accessible, for example, is your church?

4. People who get in the way.

They hold open a door but produce an aperture too small for someone with a stick and a wide gait. Or they open the door just when I've put my weight on it. I risk falling in a heap at their feet.

Never forget. The humble 'How can I help?' is always much more welcome.

RHJ

Among All Nations

Christian healthcare worldwide

Photo: Church Mission Society

Partnership among all nations

'That thy way may be known upon earth,
Thy saving health among all nations.'
(Psalm 67: 2 AV.)

Partnership among all nations was always in God's plan for his creation. The psalmist saw this. The plan would result in joy since the nations would be ruled justly and in plenty, with the land being farmed sustainably.

The psalmist called this wholeness 'saving health'. The plan has two sets of ingredients - the human race is invited to know, understand and obey God's ways, but the plan can only work if God makes it work. The psalmist called this 'God's blessing'.

Among All Nations wants to see more Christian health professionals share in that partnership among all nations, and experience that coming blessing.

Among All Nations is produced in partnership with the **Medical Missionary Association** and **Christians in Health Care** as the international section of *Triple Helix*. They also produce the magazine *Saving Health*, which has more articles on healthcare with mission, and a more comprehensive list of multidisciplinary service opportunities. Details on p15.

Jenny Blackman, on a medical student elective in north-east Zaire, discovered surprising contrasts with work back home

When Lightning Strikes

It was late October in the rainy season, with thunderstorms occurring on most of the otherwise hot, dry days. Eric Kibondo, a 27-year-old nursing student, was at the house of his friend, Patrick. It was early afternoon. He was sitting at a table revising.

Suddenly there was a bolt of lightning, simultaneous with its thunder. Later someone described it as 'the sort of ominous crack that sends shudders down your spine because you know that something has been hit'. That 'something' was Eric.

The current had been conducted through a metal bar supporting the roof above Eric. It caused a cardiac arrest. Patrick was hit too and initially appeared very confused as he went to seek help. Several nursing students tried to administer heart massage but it took another 10 minutes before proper cardiopulmonary resuscitation cycles commenced.

Ever since returning to Bristol, I have thought more about cardiac arrest management and compared the crash teams here with the events in Zaire. Medical staff in the UK also take several minutes to arrive at an arrest, but they usually expect to have an ECG, an anaesthetist to intubate, oxygen and a defibrillator to shock the heart into a regular rhythm. Instead, having asked for an Ambu bag from theatre to ventilate Eric more effectively, a non-medical friend rushed back with the bag used for newborn babies!

More important than differences in resources and frustrations with the limitations of medical management in rural Africa, however, is the power of prayer. Regrettably, this is not part of the standard protocol for doctors in UK hospitals as they hurry along corridors to a crash call. In Boga, students, hospital staff and friends immediately joined together to pray, and this earnest corporate prayer continued late into the evening and beyond.

Lonu, a close friend of Eric, set up an IV and gave 1mg of adrenaline, 20 minutes after Eric's heart had stopped beating. The heart restarted, with a good output. Eric was carried by stretcher to the intensive care unit in the hospital. He was extubated a short while later when his voluntary respiratory effort returned. Although he did not speak, or show signs of being able to see, he was extremely agitated. There were movements of all four limbs and he had to be restrained, the danger of masking signs without monitoring equipment ruling out sedation.

Eric had a superficial burn from the top of his head down to his chest, with an exit burn on his legs, but with no equipment for further investigations to assess internal damage, the outlook was uncertain. Prayers changed from petitions for his survival to trying to place into God's hands the fear of this bright, fit, young student going into a persistent vegetative state.

Lightning injuries often cause death, mainly through cardiac arrest. However, the chance for successful resuscitation is usually greater because the majority of victims are relatively young and healthy and seldom have significant heart disease. Nevertheless, the spectrum of neurological lesions includes the entire neuroaxis from cerebral hemispheres to the peripheral nerves. Morbidity also follows burn injury to other organs lying in the pathway of the current, and from damage caused to the brain and other organs by anoxia during cardiac arrest.

Therefore, next morning, Eric's threat in jumbled Swahili and Lingala brought both relief and great joy: 'Na kobeta yo . . . acha mi' - 'I'll hit you . . . leave me alone'!

Over the following weeks his recovery continued. Short term memory loss, confusion and unsteadiness on walking were understandable. But he was determined to join us several days later on the grass bank overlooking the volleyball pitch to watch a very important match, the nurses versus the fourth year student team.

I have several further reflections about Eric's case:

1. Lightning injuries are reported to affect about 1,000 persons worldwide each year, but this must be a great underestimate. In equatorial Zaire in the heart of Africa during the rainy season, the threat of lightning is a daily reality.

2. This reinforces the importance of basic life support skills. I arranged small group teaching in Boga for nurses and nursing students, in French and using an old resuscitation mannequin. The students were not only keen to learn, but very aware of the importance of CPR because of Eric.

3. The dedication to prayer of Eric's colleagues, the power of prayer, and their response in thanksgiving made a tremendous impression on me. I still feel amazingly challenged. For many in Boga, this incident gave local people new strength and unity in prayer, and faith in God's plan for renewal in their crumbling land. My prayers now are for peace to be restored to Zaire, Rwanda and Burundi.

Jenny Blackman did her elective in Boga, Zaire in October-November 1996, just before the outbreak of the recent civil war.

tears for **Sudan**

Hope abounds amid deprivation and suffering in war-torn southern Sudan. Raymond Givan reports

In 1996 I was asked: 'Would you consider organising a vaccination team in the southern Sudan?' Sudan is ten times the size of the British Isles, with a population of 25 million people. Five million live in the country's southern provinces. Most of the south is covered with swamps and rivers and is fairly inhospitable. Civil war has raged there since 1982, but from the beginning I felt God was drawing me to serve these people.

The first step was a pilot expedition. This helped formulate clear goals: to seek and encourage the embattled Church and to bring relief through medicines and vaccinations. A few months later we flew to the northern borders of Kenya and boarded a DC3 for a four-hour flight into Sudan. We had emergency backpacks in case it was necessary to walk back. An enthusiastic welcome awaited us. The plane stuck in the mud and had to be dug out and pushed by hundreds of tribesmen. We walked to our base camp.

We trained three teams in the art of giving injections. In the first two days 350 children were immunised. Then in the next three days the teams were sent out, immunising about 1,000 a day. I learned that in the months prior to our visit about 700 babies had died in this area in a measles epidemic, and I saw many malnourished as a result. There were also some cases of active polio. On the previous visit, the local dialect version of the *Jesus* film had been left, along with a small generator. It had been shown 26 times. While we were there it was shown twice. At one location, on a tributary to the Nile, there must have been 1,000 people in attendance.

Only the New Testament has been written in their dialect. The Old Testament stories are heard secondhand or read in Arabic or English, the language of education in the south. There is no currency. The people plant crops but the army comes down to steal, rape, and burn their crops. The barter system is based on salt, sugar and soap. There is much corruption and I was unsure I could trust anyone. The people feel betrayed by the free world.

Many Christians are paying the ultimate sacrifice for their faith. There are reports of Christians crucified upside down. Many children have been taken into slavery by raiding forces from the north.

Despite all the agony and deprivation caused by war, the churches are growing. To visit one we trekked 14 miles, sometimes up to the neck in swamps, and crossing two rivers. In all it took eight hours. We were met by hundreds of people singing praises to God. The church, made of mud in the shape

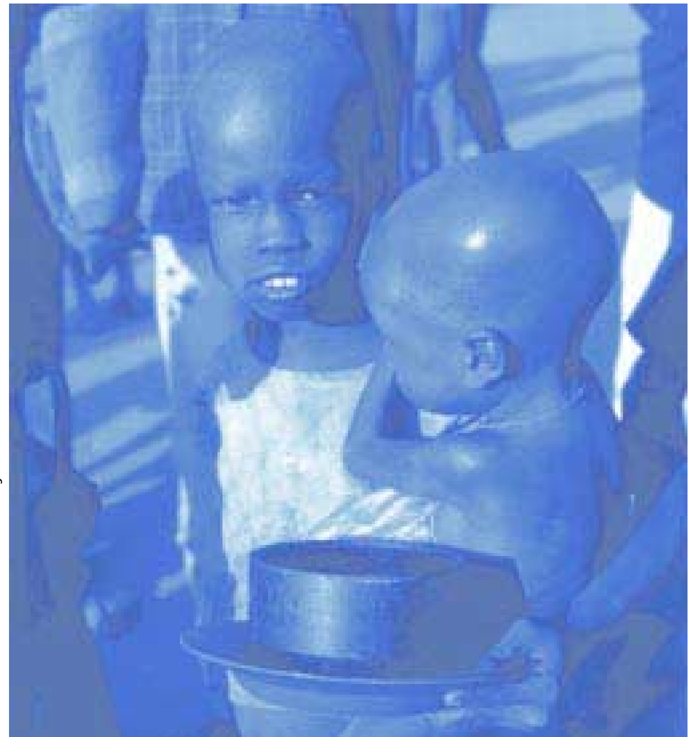


Photo: Church Mission Society

of a cross, seated 1,000 people and was full. They wanted us to preach and teach immediately and listened through translators. They killed several chickens and a goat for us to eat. The next morning I tried to hold a clinic but had to give up because there was a risk of it causing a riot.

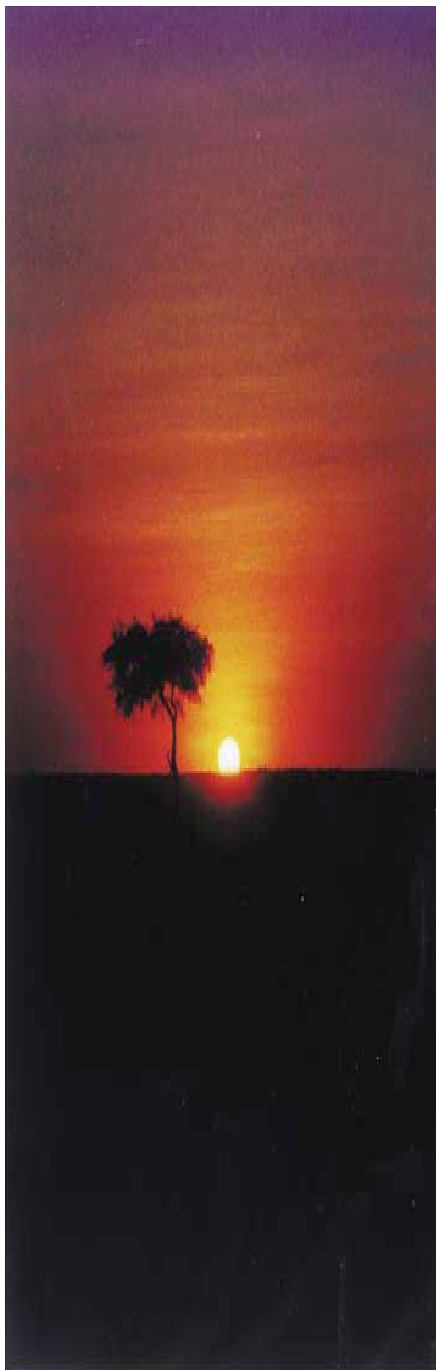
Since then I have paid two more visits to southern Sudan. It was lovely to meet old friends and they were overjoyed to see us. I organised the immunisation of 2,500 children and saw many sick people. There were many surgical and medical conditions including river blindness, guinea worm, bilharzia and tuberculosis, but malaria was the most common. The afternoons were too hot to work or even to sleep. The International Red Cross is hoping to establish centres for primary health care and have already begun a vaccination programme.

During all my visits I saw despair, but also hope. The church of Jesus Christ is being built in a way I have never experienced before. In one area I visited it has grown from 11 to 17 churches of over 1,000 people. 'The wind blows wherever it pleases' (John 3:8).

Dr Raymond Givan works for the Africa Inland Mission

Medicine, Mission a

Sunset o



David Clegg believes the opportunities for healthcare with mission have never been greater, and reflects on three key components of Christian care

As we enter the next millennium, is medical mission over? Is the sun setting on a golden era?

Many with experience in developing countries believe the scope for Christian healthcare with mission has never been greater. There are more sick, poor and hurting people in the world today than ever before. God loves the world and still desires that his 'saving health'should go 'among all nations'.

Perhaps then it is just the language for which the sun is setting? The word 'missionary' conjures up an old-fashioned image of colonialism and paternalism, and words such as ''partner'' may become more appropriate.

Jesus clearly left his church with the command to mission, and while the way we relate to others has changed, our way of life should still demonstrate Christlikeness in three areas.

1. Intensity of care: For those we go to

The word 'love' may also have some new interpretations, but the commands to love God and to love one's neighbour are not old fashioned. We can be kept aware of the health situation among the nations by listening to the BBC World Service, by reading professional journals, and by taking mission magazines.

If we are called to go ourselves, we will take our professional help into a world where some health indicators are getting better and some are getting worse, but scientific answers alone are not enough to combat the AIDS pandemic, broken marriages, and child abuse. Teaching the Christian truths of Jesus' death and resurrection in the power of his Spirit can halt these disasters and meet many needs of those who suffer their consequences.

Intensity of care: For those we send

Perhaps we know health professionals working overseas and support them in prayer and in practical ways. We can make them our representatives. To do this properly will make many demands on us but will add a valuable new dimension to our lives.

2. Purity of motive

Hope in a kingdom that does not belong to this world should not be seen as a colonialist threat by those who are concerned with the kingdoms of this world, but unfortunately, meeting the needs of the poor may be seen thus and conflict may sometimes be unavoidable.

What are the needs of the poor? I do not think Jesus sees needs as divided into 'physical, mental and spiritual'. Nor do I believe that he sees healing as a tool for preaching the gospel. His motives were pure. To him, suffering - whatever its cause and whatever its nature - was suffering.

True healing leads to wholeness. Healthcare in the affluent world has lost

nd the Millennium:

r Dawn?

its way because it has lost that vision, but the Christian mission hospital still has the opportunity to share it. The Christian health professional does not need to be an evangelist, the mission hospital does not need to favour Christians nor those who might become Christians, and it does not need to promote any denomination or culture. It will probably have been founded by a foreign culture, and may well work within the context of a denomination, but the only requirement is that the mission staff should be servants of Christ.

The hospital's mission is Christian service. Where Christians with a heart for mission live and work together, there will be worship and study of the Word, which others can join in. The healing ministry should become a holistic ministry to the community, leading not to dependence but to freedom.

3. Humility of method

Serving Christ is an act of faith, dependent on his grace and not our ability. It cannot be paternalistic. Grace does not, however, invalidate skills acquired by training and hard work, but enhances them.

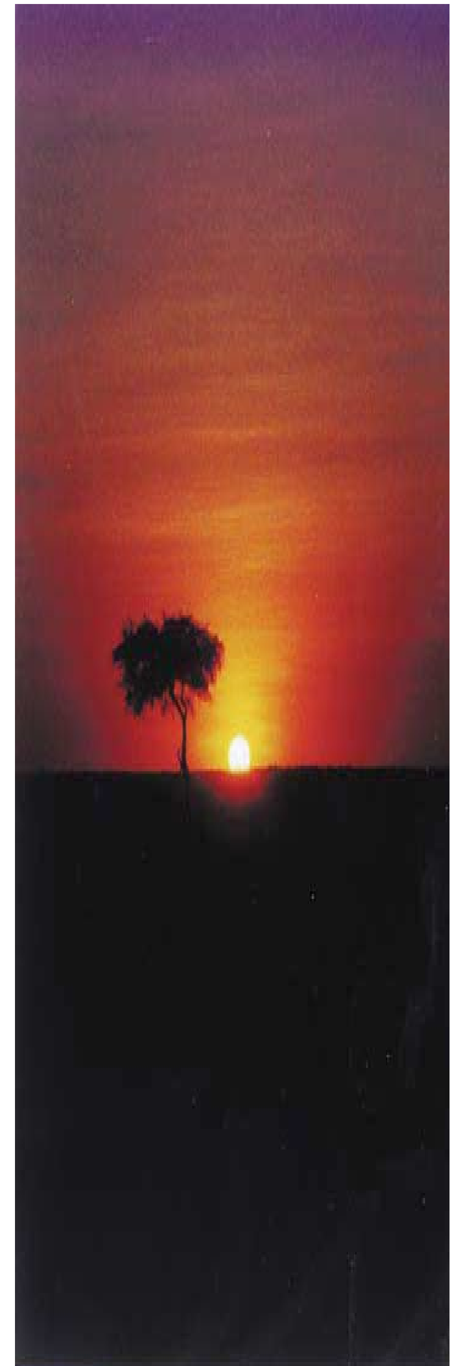
The clinical tools potentially available to healthcare today are very powerful compared with those of a hundred years ago, let alone two millennia. Sadly, widespread poverty often means they are not available. Whether the tools are available or not, we remain dependent on God. Healthcare would never usher in his Kingdom even if it were to find the secret of biological immortality. We may have no more than our shirt to bind a Samaritan's wounds, or we may have a district hospital with reaonable supplies. We may have the technology to eradicate yaws, smallpox, polio, guinea worm, Chaga's disease and leprosy, but other diseases will take their place. Human behaviour and the power of evil will still produce problems like AIDS, resurgent tuberculosis, famine and violence.

Conclusion

Intense care, pure motives, and humble methods - or, in the words of 1 Corinthians 13, love, hope and faith? Like the words 'medical mission', these words may be perceived by changing cultures with different meanings, and may produce different emotional responses, but they define Christ's way of living and working.

They are not utilitarian tools to be used with political skill and a hidden agenda, but concepts to inspire service which openly represents the master who, according to Albert Schweitzer, 'sets us to the tasks he would perform in our time'.

David Clegg is an obstetrician and gynaecologist who has worked in southern Africa for 25 years. He is now the Overseas Support Secretary of the Christian Medical Fellowship and the General Secretary of the Medical Missionary Association.



Healthcare Services for those Working Overseas

Are you thinking about working overseas? Are you experiencing health problems during an overseas elective or posting, or as a result of one? Here are some sources of specialist help and ongoing advice:

InterHealth

Director: Dr Ted Lankester. 157 Waterloo Road, London SE1 8US. Tel. +44 (0) 171 902 9000. Fax +44 (0) 171 928 0927. E-mail: 100636.1271@compuserve.com

Services: travel clinic, medicals, psychological assessment, personal debriefing, counselling, referrals, careers and vocational guidance, travel insurance, medical advisorship. Free information sheets for aid workers, volunteers, mission partners. Can advise by e-mail clients who have since gone overseas.

Care for Mission

Director: Dr Michael Jones. Ellem Lodge, Duns, Berwickshire TD11 3SG. Tel. +44 (0) 1361 890677. Fax +44 (0) 1361 890329. E-mail 100633.2065@compuserve. com

Services: medical examinations, travel advice, immunisations, debriefing, counselling, short term accommodation, consultancy for missions, education.

Equip

Manager: Tony Horsfell. Bawtry Hall, Bawtry, Doncaster DN10 6JH. Tel. +44 (0) 1302 710020. Fax +44 (0) 1302 710027. E-mail: 101325.516@compuserve.com

Equip run a series of weekend and short courses for preparing and equipping Christians for service, for example, 'Parenting and Mission' held July 7-9. They produce an information pack 'What Next?' for those returning to resettle in the UK, price £3.

Wellsprings

Project co-ordinator: Marjorie Salmon MBE (formerly of Nurses Christian Fellowship). Address as for *Equip* but e-mail 106341.2266@compuserve.com

Residential accommodation for missionary personnel needing time to recover from demanding ministries. Costs: 24 hours £24.00, weekly £150.00, deposit £30.00.

Booklets

The Christian Medical Fellowship and the Medical Missionary Association have jointly produced booklets for doctors and medical students wishing to work abroad in mission and church-related hospitals and health projects.

Short-Term Christian Medical Service Overseas (1994 - being updated). £2.00.

Medical Elective Opportunities (April 1997) and *Preparing for an Elective Overseas* (April 1997). Both free to medical students.

Voluntary Agency Medical Advisors (VAMA)

Chairman: Dr Hedley Missen
VAMA is an association of advisors providing health care for missionaries and volunteers in the developing world. Meetings are held twice yearly in London, with invited lecturers and with in-house workshops on the selection and healthcare of voluntary agency personnel.

Members receive the twice yearly *VAMA Newsletter* and advance notice of meetings. Annual subscription £10. Subscriptions to Treasurer, Dr David Clegg, Christian Medical Fellowship, 157 Waterloo Road, London SE1 8XN.

The 21st Century Missionary

Care for Mission have published the papers of their 1996 conference 'Caring for the Missionary into the 21st Century - II'.

A paper by Elizabeth Jones includes an analysis of comparative satisfaction and frustration by age. 'In general women express lower satisfaction than men, the least satisfied being the married woman, particularly those whose prime role is perceived to be "in the home" or who have an undefined role.'

Copies (£4 including p&p in the UK) from Care for Mission, Ellem Lodge, Duns, Berwickshire TD11 3SG. Tel. +44 (0) 1361 890677. Fax +44 (0) 1361 890329. E-mail 100633.2065@compuserve.com

MMA Travelling Secretary

The Council of the Medical Missionary Association (MMA) plans to appoint a doctor as a full-time Travelling Secretary. To be based in an office close to the present joint office of the MMA and the Christian Medical Fellowship. Christian medical experience in a developing world country is essential.

The work will include promoting medical mission, maintaining computer databases, visiting health professionals at study and at work, and relating to other organisations involved in medical mission and Christian healthcare in developing countries.

Further details and job description available from:
Dr David Clegg, General Secretary MMA, 157 Waterloo Road, London SE1 8XN. Tel. 0171-928 4694. Fax 0171-620 2453.
E-mail 106333.673@compuserve.com

vacancies overseas:

(Please note that medical mission posts often require you to raise your own financial support, though help is given with this.)

AFRICA

Angola

Ophthalmologist. Enquiries: Crosslinks, 251 Lewisham Way, London SE4 1XF. Tel. 0181-691 6111

Cameroon

Married couple, doctor and nurse, for remote primary healthcare project run by the Cameroon Baptist Convention's Life Abundant Project (LAP). Enquiries: Dr David Clegg, MMA or Geoff and Pat Mitchell, PO Box 9, Kumbo, NW Province, Cameroon, West Africa. Tel. 00 237 481399. Fax 00 237 481161. E-mail gmitchell@cam.healthnet.org

Gambia

Midwives. Enquiries: WEC International, Bulstrode, Oxford Road, Gerrards Cross, Bucks SL9 8SZ. Tel. 01753 884631

Ghana

Midwife/Community Nurse. Enquiries: Qua Iboe Fellowship, 30 Mattersley Close, Bessacar, Doncaster DN4 7QZ. Tel/Fax 01302 532690

Kenya

Physician (especially August 1997-February 1998), able to take part in training interns.
Hospital engineer. Presbyterian Hospital of East Africa, Chogoria. Job description for engineer from Dr David Clegg, MMA or contact Dr Gordon McFarlane. E-mail GAMcFarlane@compuserve.com

Kapsowar Hospital. Surgeon. Long-term post. Enquiries: Peter Williams c/o MMA or Africa Inland Mission International, 2 Vorley Road, Archway, London N19 5HE. Local information from Richard Cook. Tel. 0151-427 7206

Madagascar

Medical laboratory technician. To cover missionary leave September 1997 for 6-9 months. E-mail Africa Evangelical Fellowship, Mandritsara 100254.2057@compuserve.com or contact Africa Evangelical Fellowship, 6 Station Approach, Borough Green, Sevenoaks, Kent TN15 8AD. Tel. 01732 885590

Nigeria

Surgeon. Two hospital doctors, one to do leprosy work. Enquiries: Qua Iboe Fellowship, a/a
Egbe Hospital. Mission doctor. Opening has been made more urgent by the death of 'a very capable and spiritually alive Nigerian doctor'. Enquiries: SIM-UK. Ullswater Crescent, Coulsdon, Surrey CR5 2HR. Tel. 0181-660 7778

Tanzania

District Health Services, Kigoma Region. Doctor: previous overseas experience in district services essential, experience in obstetrics and surgery preferred. Enquiries: Mrs Kay Bugg, Christian Outreach, 1 New Street, Leamington Spa, Warwicks CV31 1HP. Tel. 01926 315301. Fax 01926 885786

Dodoma. Pharmacist. Enquiries: Crosslinks, a/a

Uganda

Woman doctor for MCH work. Enquiries: Crosslinks, a/a

Zambia

Mukinge (rural hospital). Doctor with some surgical experience needed for one year.
Nurse for Tutor post. Pharmacist to establish computerised pharmacy system. Enquiries: Africa Evangelical Fellowship, a/a

ASIA

Japan

Medical Adviser to Overseas Missionary Fellowship. To replace Dr Bill Baird who is returning from missionary service. Job description from OMF Japan, Tel. 0081473 24 3213, or Dr David Clegg, MMA

Thailand

Doctor. Leadership role in small hospital. A post for someone who can work in a sensitive cultural and political situation. Enquiries: Mr Silvan Dupertuis, SME 335 Route des Lausanne, Bellevue, Geneva 1293, Switzerland. Tel. 00 41 22 77 41043

MIDDLE EAST

General

Doctors. Midwives. Enquiries: WEC International, a/a

Egypt

Nurse tutors. Nurses. Nurse teachers. Occupational Therapist. Physiotherapist. Enquiries: Interserve, 325 Kennington Road, London SE11 4QH. Tel. 0171-735 8227/8. Fax 0171-587 5362

Lebanon

Workers with handicapped children. Enquiries: Interserve, a/a

North Africa

Dentist. General Practitioner. Health Educator. Midwives. Nurse/Health Educator. Obstetrician/Gynaecologist. Occupational Therapist. Paediatrician. Physiotherapist. Nutritionist. Rehabilitation Superviser. Enquiries: Interserve, a/a

SOUTH AMERICA

Brazil

Doctor for leprosy work. This is a secular placement, with costs and living allowance. Two years minimum. Enquiries: UNAIS 01904 647799

Among All Nations is produced in partnership with the Medical Missionary Association and Christians in Health Care as the international section of *Triple Helix.*

They also produce *Saving Health* which has more material on healthcare with mission, and a more comprehensive list of multidisciplinary opportunities for service. This is currently produced two to three times a year, and is available for a minimum donation of £5 per annum (£3 students, missionaries and retired).

MMA has a database of people who would like to be contacted when a suitable opening in a mission or church hospital is notified. Please contact for a form.

Medical Missionary Association
Registered Charity 224636
General Secretary: Dr David Clegg. 157 Waterloo Road, London SE1 8XN. Tel. 0171-928 4694. Fax 0171-620 2453. E-mail 106333.673@compuserve.com

Website:
http://www.interdart.co.uk/ mma

Christians in Health Care
Registered Charity 328018
Director: Howard Lyons MSc FHSM. 11 Grove Road, Northwood, Middlesex HA6 2AP. Tel. 01923 825634. Fax 01923 840562. E-mail howardlyons@msn.com

Website:
http://christian-healthcare.org.uk

a world of *opportunity*

Obstetrician and gynaecologist Gordon Mackay shares his experience of short-term service overseas.

My wife and I planned early retirement with the hope that we would spend time abroad helping or teaching in a mission hospital. Because of elderly relatives we decided we could not leave for longer than six weeks at a time, but even so, discovered many openings. Here are four of them:

Uganda - Kisiizi Hospital

I spent six weeks at Kisiizi. Having sent my CV to the Ugandan Protestant Medical Bureau, three hospitals contacted me and I soon found myself sitting in the bus in Kampala, waiting to start the 7-8 hour journey to Kisiizi. It was wonderful to be able to stay with a Ugandan family. At least once I even managed to eat the *matoke*! There were several areas where I found I could help:

Practical gynaecology

There had never been a gynaecologist there before. We were swamped with infertility problems. A number of unusual operations were necessary. Several vesico-vaginal fistulae (VVF) presented, and I was able to teach a method of tackling these. Sadly, there were some difficult VVFs beyond even my experience. Additionally I found myself helping in the arduous on-call rota. The work involved meeting patients with eclampsia and neglected labour, rare in the UK. I could have done other clinical work, but felt it was not right to start doing things like orthopaedics at my age.

Teaching obstetrics and gynaecology

This was relevant so that a Ugandan doctor who had recently joined the unit could work independently, particularly for emergencies. I also demonstrated the use of obstetric ultrasound to general duty doctors, midwives and nurses.

Ministry

This included speaking in chapel: in morning prayers, the Sunday service and small groups. One should not impose oneself but simply be willing if asked.

India

I reviewed a project in Bombay of which I am a trustee in the UK (the Thana Trust). It involved a four-week visit to evaluate a self-sustaining clinical service for the underprivileged. A second visit to India is in prospect.

Nigeria - St Luke's Hospital, Anua, Uyo

I was invited by the consultants in Anua and partly sponsored by the British Council. I had spent a few weeks there two years before improving my surgical expertise in the repair of VVF. This time it was a three-week teaching visit. The work had four aspects:

- Regular theoretical and practical instruction in the use of obstetric ultrasound.
- Systematic teaching of obstetrics and gynaecology through talks, seminars, instruction in exam technique and mock exams.
- Inspection for the Royal College of Obstetrics and Gynaecology to report on the hospital’s suitability for training for Membership.
- Christian contact with Nigerian doctors whom I had known previously, and with the local Graduates' Fellowship.

Gibraltar

I did a locum in Gibraltar for a gynaecologist who with his wife also ministers to people working with mission organisations. As he is the only gynaecologist on the island he needs a pool of those willing to do locums. This is a paid post and can help to subsidise the other work done on a voluntary basis.

Making contact

My contacts in Uganda and Gibraltar were made through the CMF. It is necessary to finance travel, insurance and a contribution towards the cost of hospitality.

What can you take?

Ask the hospital contact if there is anything you can take with you. You may go with a full case and return with an empty one, or even leave the case! Suture material is nearly always welcome and is light to carry, but there are unlimited possibilities.

Your spouse

We decided that unless my wife also has a role to play or knows the people involved, it is better for me to go alone for short visits. It is unfair for her to leave home and our local community where she is heavily involved, to go where she will have nothing to do while I'm busy from morning till night. We decided she would not go to Uganda or Nigeria, but she did come to India where she knew some people. There she was able to speak to groups of women, including church leaders' wives.

No hidden agendas

It is important not to have any hidden agendas. This is not an ego trip. The visitor must adapt to the local situation and be a servant for Jesus' sake. The end result should be encouragement both to the expatriate workers and to the local staff.

More than likely you will come away strengthened in the faith and motivated to go again.

Gordon Mackay is retired and lives in Sunderland

Entertaining phrases from research ethics. Dr Martyn Evans gives a long list of thought-provoking and amusing definitions. Examples: 'Data - little blob-like thingies on a chart. Initial data - blobs through which no curve could remotely be plotted. Revised data - blobs through which a curve is plotted faultlessly. Ethics committee meeting - a four-hour paralysis of all clinical services within a District Health Authority.' (Source: Bulletin of Medical Ethics, February 1997; p21.)

Cars and Centenaries. Britain's first recorded drunk driving case was on 10th September 1897 when 25-year-old cabdriver George Smith drove into the front of 165 Bond Street, the home of actor Sir Henry Irving. 'The prisoner admitted having had two or three glasses of beer' and was fined 20 shillings. Thirteen days later, the first child killed on the British highway was 9-year-old Stephen Kempton who fell while riding on the back of a taxi. (Source: Catholic Roadwatch, PO Box 1580, London W7 3ZP.)

European Parliament calls for ban on human cloning. A resolution on 12th March 1997: ' . . . 2. Calls for an explicit worldwide ban on the cloning of human beings; 3. Urges the Member States to ban the cloning of human beings at all stages of formation and development, regardless of the method used, and to provide for penal sanctions to deal with any violation.' The resolution also calls for strict controls on animal cloning. (Source: Bulletin of Medical Ethics, May 1997; p10-11.)

Chaplains on transplant teams increase organ donation. Consultant urologist Grant Williams imported from Boston the practice of having the chaplain present when seeing the grieving relatives of brain damaged potential donors. At Charing Cross Hospital, donation of organs was never refused when the chaplain participated in the discussion. He thinks the relatives 'felt that the chaplain was on their side rather than mine'. (Source: British Medical Journal, 21 June 1997; 314: 1831.)

Homoeopathy fails evidence base test. Lambeth, Southwark and Lewisham Health Authority has stopped paying for homoeopathic treatment because there is not enough evidence to support its use. It had previously been referring more than 500 patients a year to the Royal Homoeopathic Hospital in London, but public health doctors took the decision after a literature review under their policy of purchasing only evidence based medicine. (Source: British Medical Journal, 17 May 1997; 314: 1574.)

Cannabis on prescription? Representatives at the British Medical Association's annual meeting called for the legalisation for medicinal use of drugs derived from cannabis. Only two derivatives are currently licensed but enthusiasts claim that other cannabinoids may have medical benefits, and those listing side effects lost the day. If legalised, consumption would be oral, by aerosol, or by injection, and not by smoking. (Source: Jeremy Laurance, The Independent, 3 July 1997, p8.)

Religion and 'inappropriate' treatment. Because of religious beliefs, American patients or their families are making more requests for treatment which their physicians consider inappropriate. After examining one Muslim and three Christian cases, an ethics paper offers some helpful guidance and concludes 'that most persistent requests for "inappropriate" treatment should be honoured'. (Source: Journal of Medical Ethics 1997; 23: 142-147.)

First synthetic human chromosome. Researchers in Ohio have constructed the first artificial human chromosome. Disguised in a fatty coating, the fake chromosome penetrated the cell walls of human cancer cells, which organised the DNA as if it came from a naturally occurring cell, and the information was inherited by the next generation of the cell culture. Whilst perhaps presaging techniques to introduce 'therapeutic' DNA into the body, there is a *Brave New World* feel here. (Source: The Splice of Life, June 1997; Vol 3 No 6 p13.)

Calls to ChildLine. 90,000 calls a year to this 10-year-old UK helpline for children means about 250 a day are received. 82% are from girls. Family relationships, bullying, physical abuse, sexual abuse and pregnancy are the most common reasons for calling. The magic number is 0800 1111. (Source: Quadrant, May 1997.)

SHO life more satisfying than PRHO life. In a survey of junior doctors' job satisfaction and health, 'respondents reported significantly higher scores for satisfaction with the job itself and with the achievement value and growth aspect of job satisfaction in 1994 (as SHOs) than in 1993 as PRHOs'. Perhaps CMF is right to target its pastoral care at the most recently qualified? (Source: Health Trends 1997; 28: 132-134.)

Consumerism can be objectionable. In a paper on consumerism and the internal market, philosopher Tom Sorell writes 'moral criticism of recent NHS reforms may stop short of calling consumerism into question. This, however, would be a mistake: consumerism can be objectionable both within and beyond the health care market.' (Source: Journal of Medical Ethics 1997; 23: 71-76.)

Atheist's tribute to Christian patient. The JME isn't all philosophy. Italian neurologist Claudio Crisci describes his relationship with his patient Louise, dying from central neurofibromatosis. 'As I am an atheist and Louise was religious, we avoided the religious issue in our talks: time was too precious to her to spend it in philosophical discussions. I never asked her how she could believe in a God who played with her and her family this way, because I already knew the answer, absurd to me: "blessed are they who suffer, for they will be comforted" (Matthew 5:4) . . . When I think of Louise, I envy her her "absurd" faith and moral strength, her hunger of life.' (Source: Journal of Medical Ethics 1997; 23: 18.)

Eutychus

off with the old
on with the new

What are the issues at stake in revising the Hippocratic Oath?

Historians know little about the origin of what we now call the 'Hippocratic Oath', and little about its use in antiquity. It came from Greece around 400 BC, and was probably associated with the 'school' of Hippocrates rather than with one physician alone.

The general public today believes mistakenly that all doctors swear the Oath on graduation, and are bound by high ideals ever afterwards. In fact, while few swear it, perhaps rather more swear by it. The Hippocratic tradition has been popular and has undoubtedly been a conservative yardstick for medical ethics.

There are different forms of the Oath around in modern use. Ludwig Edelstein's translation[1] reads:

> *I swear by Apollo Physician and Asclepius and Hygeia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgment this oath and this covenant:*
>
> *To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art - if they desire to learn it - without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.*
>
> *I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.*
>
> *I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guide my life and my art.*
>
> *I will not use the knife, not even on sufferers from stone, but will withdraw in favour of such men as are engaged in this work.*
>
> *Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.*
>
> *What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.*
>
> *If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honoured with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.*

'In purity and holiness I will guide my life and my art.'

1. Supplements to the Bulletin of the History of Medicine, No. 1. Baltimore, Johns Hopkins Press, 1943, p6

At its Annual Representative Meeting in 1995, the British Medical Association called for an updated version of the Hippocratic Oath for all doctors to take on graduation, to ensure that ethical standards were maintained in a rapidly changing world with many new pressures.

A 'Draft Revision of the Hippocratic Oath', the text below, was published by the BMA this spring. Their plan is for a final version to be accepted by the World Medical Association in 1998, so this could potentially affect healthcare all around the world.

The practice of medicine is a privilege which carries important responsibilities. All doctors should observe the core values of the profession which centre on the duty to help sick people and to avoid harm. I promise that my medical knowledge will be used to benefit people's health. They are my first concern. I will listen to them and provide the best care I can. I will be honest, respectful and compassionate towards patients. In emergencies, I will do my best to help anyone in medical need.

I will make every effort to ensure that the rights of all patients are respected, including vulnerable groups who lack means of making their needs known, be it through immaturity, mental incapacity, imprisonment or detention or other circumstance.

My professional judgment will be exercised as independently as possible and not be influenced by political pressures nor by factors such as the social standing of the patient. I will not put personal profit or advancement above my duty to patients.

I recognise the special value of human life but I also know that the prolongation of human life is not the only aim of health care. Where abortion is permitted, I agree that it should take place only within an ethical and legal framework. I will not provide treatments which are pointless or harmful or which an informed and competent patient refuses.

I will ensure patients receive the information and support they want to make decisions about disease prevention and improvement of their health. I will answer as truthfully as I can and respect patients' decisions unless that puts others at risk of harm. If I cannot agree with their requests, I will explain why.

If my patients have limited mental awareness, I will still encourage them to participate in decisions as much as they feel able and willing to do so.

I will do my best to maintain confidentiality about all patients. If there are overriding reasons which prevent my keeping a patient's confidentiality I will explain them.

'All doctors should observe the core values of the profession.'

I will recognise the limits of my knowledge and seek advice from colleagues when necessary. I will acknowledge my mistakes. I will do my best to keep myself and colleagues informed of new developments and ensure that poor standards or bad practices are exposed to those who can improve them.

I will show respect for all those with whom I work and be ready to share my knowledge by teaching others what I know.

I will use my training and professional standing to improve the community in which I work. I will treat patients equitably and support a fair and humane distribution of health resources. I will try to influence positively authorities whose policies harm public health. I will oppose policies which breach internationally accepted standards of human rights. I will strive to change laws which are contrary to patients' interests or to my professional ethics.

This draft has been praised for being a religion-free, non culture-specific, contemporary statement of ethics which includes community and international considerations. It has also been criticised: it is not an Oath, it is ambiguous, it mixes principles with guidelines for practice, it is dangerously weak on 'pro-life' issues, it no longer explicitly prohibits sexual relations with patients . . .

In a back-to-back comparison, what do you think?

What oath, if any, would you support?

Write and let us know:

Triple Helix
157 Waterloo Road
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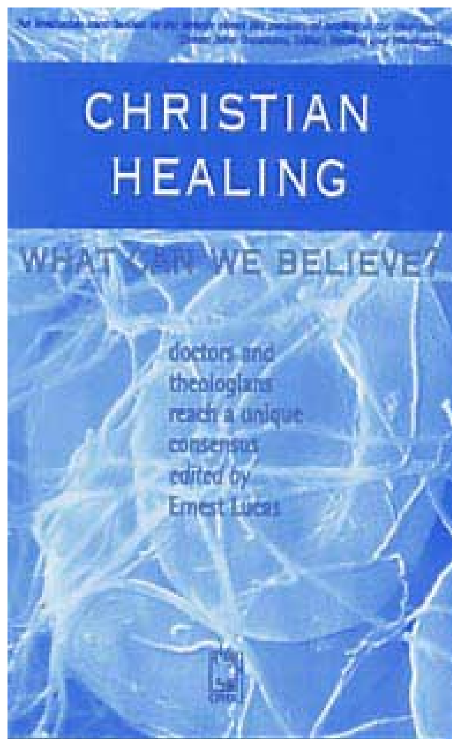
reviews:



Christian Healing - What Can We Believe?

Ed Ernest Lucas. SPCK, London. 1997. 202pp. £12.99 Pb.

There are many books on Christian healing. Most, alas, are superficial and unbalanced but this is more profound than most and addresses the fundamentals. It arose from meetings between Christian health professionals, pastoral workers, theologians and ethicists, coming from different traditions of the healing ministry.

Each chapter is written jointly by a doctor and a theologian and the headings give an idea of the book's scope: How are people healed to-day? - The relationship between the 'medical' and the 'spiritual' in healing. The Church's ministry of healing today. What is health? - Towards a Christian understanding. The significance of Jesus' healing ministry. Suffering. Psychiatry and religion. Growing old and dying.

In 'a Christian understanding' the authors emphasise that health is the gift of God and appropriate medical intervention, whether by drugs, surgery, vaccination or radiotherapy, simply improves the conditions for natural healing to occur. Several contributors deal with the important pastoral question: How should we pray for those who are ill? Services for prayer and healing are considered fully and helpfully.

The psychiatrist acknowledges the common Christian mistrust of psychiatry, and traces this to earlier psychiatrists' misunderstanding of religion, but gives evidence that the situation is improving. He does not believe Christians should insist on seeing a Christian psychiatrist, and thinks any good psychiatrist should respect a patient's central religious belief.

Co-operation between health professionals and hospital chaplains is discussed, and in general, chaplains seem more open to it. The final chapter, on growing old and dying, is written jointly by a nurse who lectures in palliative care and a hospice chaplain, and expresses deep concern over the growing secularisation of care for the dying.

David Short
(Emeritus Professor of Clinical Medicine, Aberdeen University)

Treasures of Darkness - Facing the Problems of Personal Suffering

Jane Grayshon. Hodder and Stoughton, London. 1996. 150pp. £6.99 Pb.

'But what can I say? He has spoken to me, and he himself has done this. I will walk humbly all my years because of this anguish of my soul' (Isaiah 38: 15). So speaks King Hezekiah after recovering from a near fatal illness over 2,500 years ago, and it seems Jane Grayshon's experience has been much the same. Following a ruptured appendix, she has since suffered repeated bouts of near fatal peritonitis, requiring numerous surgical interventions and several spells in ITU. She is a committed Christian, and like Hezekiah has had to face the truth that faith does not mean God will protect us from times of difficulty and pain. Often we speak of suffering as God's megaphone alerting unbelievers to his existence and their need of him. This book shows God using it to bring Christians to greater maturity, understanding and dependence on him.

Like Hezekiah, Jane can report that God 'has spoken to me' through experiences. Through poems, vivid descriptions of objects such as Epstein's sculpture of Jacob wrestling with the angel, and details from stories, she endeavours to share some of her insights. Being stripped of her independence by life-threatening illness left her with no option but to depend completely on God, clinging desperately to the truths that God is good, sovereign, and completely in control, even when circumstances would seem to scream the contrary. This has taught her to 'walk humbly' before the Lord, but she makes no attempts to glamorise the 'grim darkness' of her journey.

If you want something rigorous and scholarly on suffering, this is not the book for you. Nor would I recommend it to anyone unsure of the biblical truths of God's goodness and sovereignty, as Jane assumes belief in these. However, it does contain 'treasures' of illumination, both for Christians confronting suffering and for those who wish to avoid giving them glib answers.

Gill Matthews
(is a nurse and was a Cornhill Training Student at the time of writing this review)

Counselling in the Community - A Guide for the Local Church

Roger Altman, Kingsway Publications, Eastbourne. 1996. 126pp. £6.99 Pb.

The author has worked in Social Services and in residential care for teenagers, setting up a residential retreat centre and latterly developing courses for training in Christian counselling. This extensive experience gives him ample authority to write this book.

It is informative and practical, with a list of do's and don't's and helpful examples of forms and processes. It is a must for anybody wishing to set up a Christian counselling centre or residential retreat - it is sobering that very few Christian groups who start with faith and vision are still going three years later with a good reputation within the church and the professions.

Chapters cover caring and counselling within the pastoral church setting and in the community, residential care, supervision, training, accreditation (including the role of the Association of Christian Counsellors), law and ethics, policies and procedures, and the place of feasibility studies and consultancies before projects begin. The book ends with a short summary and detailed appendices.

This is a very helpful tool for those wanting to set up counselling services in either pastoral or community settings. Although simple in its approach and fairly superficial, it gives a comprehensive grasp of what is involved. A good read which is easy to follow.

Mervyn Suffield
(Former GP, past Chairman of the Association of Christian Counsellors, and now Director of Trinity Care plc)

The Puzzle of Ethics

Peter Vardy & Paul Grosch. Fount paperbacks, London. 1994. 220pp. £7.99 Pb.

To attempt an overview of ethical puzzles in a short book is a major challenge. To encourage people to think for themselves, and understand and apply philosophical approaches to ethical decision-making is a greater challenge. The authors face these challenges and seek to involve people from the beginning with ethical statements that require justification, ranging from 'Sex before marriage is wrong' to 'Multinational companies that exploit tropical rain forests are evil'.

Asking Pilate's question 'What is truth?' they guide the reader through many different ethical answers, from Plato through Aquinas, Kant and Bentham to Macintyre. After briefly considering Buddhist ethics, they apply ethics to fields such as abortion, war and the environment. Each chapter encourages thought and ends with perceptive discussion questions.

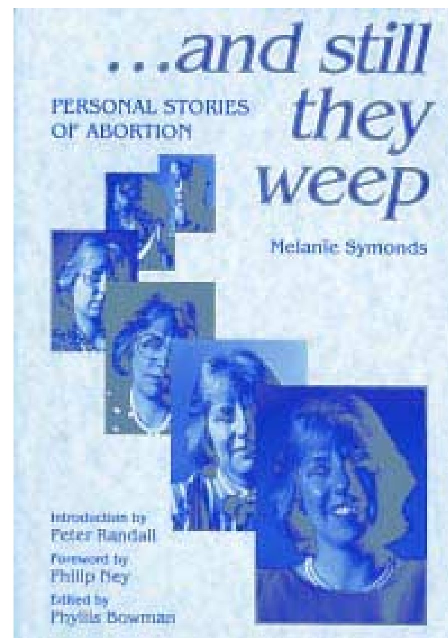
The authors understand their field well, and are particularly good at exploring the views of Aquinas and at bringing to the fore the ideas of Alasdair Macintyre, but this reviewer felt unsatisfied at the end. Perhaps this was the publisher's fault - expectations are raised inappropriately by statements on the back cover. Perhaps the chapters on different philosophers seemed to lack the coherence and development of other recent books. Perhaps it was because one is left asking why, of all approaches outside the Western tradition, Buddhism was chosen for special consideration: why not Islamic ethics or Hindu ethics?

But perhaps most of all it was because of the apparent disjunction between theory and application. The 'theoretical' chapters do not really explore applications to specific issues, although there may be hints in the questions. The 'applied' chapters make some mention of earlier views but do not always tease out application or contrasts.

Health professionals in particular will be frustrated by the limited discussion of major medical issues, although the chapter on abortion does emphasise the 'personhood' debate.

The authors quote Macintyre that 'man (sic) is a teller of stories that aspire to truth'. Perhaps there is insufficient story-telling in this valiant attempt to get people thinking.

Carl Whitehouse
(Professor of Teaching Medicine in the Community, Manchester University)



'...and still they weep'

Melanie Symonds. SPUC Educational, London. 1996. 166pp. £8.99. Pb.

This powerful and moving book examines the effect that abortion can have on women and their families. Using 20 personal stories, it highlights some of the reasons women choose abortion, the psychological and physical consequences

of abortion, and possible effects on the lives of others. After 30 years of legalised abortion in the UK, women are beginning to speak out about the pain and emotional trauma that may have been hidden for a long time.

The personal stories are accompanied by poems and reflections written by the women themselves and there is a commentary on each situation from Philip Ney, a professor of psychiatry in Canada. He himself has concluded that 'abortion is the most deeply damaging trauma that can happen to any human'.

This book introduces us to 'Post Abortion Syndrome', and reveals the extent of the pain and distress experienced by post-abortion women from a variety of backgrounds and very different circumstances. A recent study published in the British Journal of Psychiatry estimated that 10% of women having abortions suffer PAS, and as we read these stories, a clear picture emerges of the huge emotional cost of abortion.

The book also outlines the painful process that 1eads to recovery and may be helpful therefore for those counselling post-abortion women. Whether closely involved or not, it is impossible not to be deeply moved by the stories in this book and it is difficult to disagree with the conclusion of Philip Ney.

Philip Clarke
(is a GP in Southampton and is active in CARE for Life)

Where do we go from here? The case for life beyond death

David Winter. Hodder & Stoughton, London. 1996. 112pp. £4.99 Pb.

This is my sort of book, not a theological or academic thesis, littered with footnotes or Bible references (though there are appendices), but undemanding, a book to be read rather than studied. Assuming some Christian knowledge, it is clearly developed, Bible based, and thought provoking.

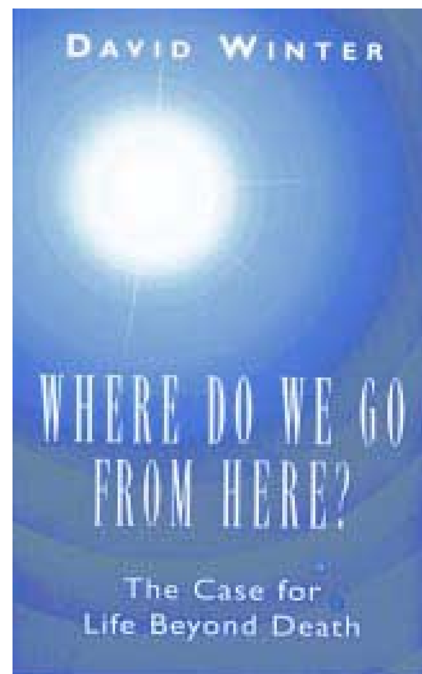
How many of us can say we welcome death? As Christians we believe that in heaven there will be no more pain or suffering or tears, and we will be constantly in the presence of God. But there remains uneasiness, perhaps to do with fears of how we die and of bereavement, as well as with change and the unknown. Read this book. There is more evidence than you might have realised, and the prospect of heaven gets quite exciting!

Why do we exist? Is death the end? What is the soul? What about the resurrection of the body? There are the inevitable analogies with computer technology - hardware wearing out or becoming outdated, yet software going on forever - but helpfully blended with biblical truth and real life experiences. Scientific evidence may be lacking, but experience cannot be ignored. Bravely, Spiritualist experiences are mentioned (though seeking them is not encouraged), as are 'near-death' phenomena. A whole chapter is then devoted to the evidence for Christ's resurrection.

Who will get to heaven? Most religions believe the answer depends on divine choice and moral behaviour. For the Christian the key is our forgiveness through Christ's death on the cross. Only here did I find the author a little lenient, or maybe not . . .

What kind of body do we receive for our next existence? What is heaven like? No one knows, but 'the resurrection life has everything good from this earthly life, but without the things that make it earthbound, limited, and frustrating'. See you there!

Jean Maxwell
(Consultant in Palliative Medicine, St Francis Hospice, Romford)



readers' letters:

We intend all subsequent editions of *Triple Helix* to contain lively correspondence columns, and therefore welcome original letters for consideration for publication. They should have both Christian and healthcare content, should not normally exceed 250 words, and if accepted may have to be edited for length.

Write to:
Triple Helix
157 Waterloo Road
London SE1 8XN
Fax: 0171 - 620 2453

headline review:

Prayer on Trial

A controlled trial of prayer in three groups of USA patients awaiting heart surgery is underway. Two groups will be told they may be prayed for: one will be, one won't. The third will know they're being prayed for and will be assessed for psychosomatic effects of that knowledge. Comments the coordinator: 'God's got a will of His own and might decide not to co-operate'.

Abortion Pill Abandoned

In April French pharmaceutical company Roussel-Uclaf decided to abandon production and distribution of mifepristone (RU 486), the 'abortion pill'. They blamed pressure from American anti-abortion activists, whose threatened boycotts in the US would have unacceptable commercial consequences.

Ministry to the Gender Confused

Parakaleo Ministry (meaning 'gentle appeal') is a new Christian group seeking to help those with gender identity problems, including transsexuals and transvestites. 25-page booklet available from Parakaleo Ministry, c/o Courage, PO Box 338, Watford WD1 4BQ. Tel. 0181-421 3411

First Cadaver Kidney Transplant at CMC Ludhiana

In January the first cadaver kidney transplant in the Punjab was performed at the Christian Medical College and Hospital in Ludhiana, the donor being an 18-year-old farmer on artificial ventilation for a week after a head injury. More than 60 transplants from live related donors had been done over the previous five years.

Overwhelming Votes Against Euthanasia

In a landmark decision on 26th June the US Supreme Court ruled unanimously (9-0) that terminally ill Americans do not have a constitutional right to doctor assisted suicide. On 3rd July representatives at the British Medical Association's annual meeting 'overwhelmingly' opposed any change in the law to allow euthanasia or physician assisted suicide.

Doctors Admit Killing 200 Patients

Despite, or because of, the above, in late July two British doctors admitted having intentionally shortened the lives of patients. Michael Irwin, Chairman of the Voluntary Euthanasia Society, may have 'helped' some 50 patients and David Moor, a Newcastle GP, put his count at about 150. Whether their actions were technically illegal and whether charges will be brought remains to be seen.

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network diary dates:

Health Care Sunday - October 19

Churches are asked to pray for professional and voluntary carers, as well as for health issues in general. Focus this year on two key anniversaries - the 30th Anniversary of the Abortion Act and the 50th Anniversary of the Nuremberg Trial verdicts. Literature and details from Healthcare Christian Fellowship, 349 Beersbridge Road, Belfast BT5 5DS. Tel. 01232 453595

Palliative Care Conference - November 14

'Palliative care: the way forward' is to be held at the Hospital of St John and St Elizabeth, London. Speakers include Dame Cicely Saunders. Cost £50 (students £20). Details from Centre for Bioethics and Public Policy, 58 Hanover Gardens, London SE11 5TN. Tel. 0171-587 0595

Autumn Conferences for Doctors and their Families

Christian Medical Fellowship has regional conferences in Northern Ireland (October 10-12), the North (October 17-19), Ireland (October 17-19), Oxford (October 18), Scotland (November 7-9), the Midlands (November 8), and the South East (November 14-16). Details from CMF, 157 Waterloo Road, London SE1 8XN. Tel. 0171-928 4694

Christians in Caring Professions

Contact this multidisciplinary group for details of local events and autumn activities: CiCP, King's House, 175 Wokingham Road, Reading RG6 1LU. Tel. 01734 660515

Matters of Life and Death

On four consecutive Monday evenings in November, consultant neonatal paediatrician Dr John Wyatt is giving the Institute for Contemporary Christianity's London Lectures. 6.30-8pm, Brunei Gallery, School of Oriental and African Studies, Russell Square, London WC1H 0XG. Cost £20 inc. course materials for series (students £7.50). November 3 - Opening Pandora's box. November 10 - Brave new world. November 17 - A good death? November 24 - Ancient values for a new century. Details from London Lectures in Contemporary Christianity, St Peter's Church, Vere Street, London WC1E 6JJ. Tel. 0171-629 3615

Student Nurses' Conference

January 30-February 1 1998

The Quinta, Shropshire. Cost £29. Details from Annie Leggett, UCCF Nurses Staffworker, 157 Waterloo Road, London SE1 8XN. Tel. 0171-928 4694

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http://www.cmf.org.uk

Christian Medical Fellowship announces launch of its unique Home Page on the World Wide Web.

A must for anyone needing to keep a finger on the pulse of the key personal, professional, and ethical issues affecting the world of medicine.

Take some time to visit the site and tell us what you think

http://www.cmf.org.uk

Doctors, Drink and Drugs

Misuse of alcohol and other drugs is a growing problem in the health professions. Christians are not necessarily exempt.

This short booklet reviews the evidence, looks at some causes, describes the professional help available, and points to the potential for freedom from addiction and for abundant life in Christ.

Single copies (in the UK) £3.00 including p&p. Please enquire about bulk orders.

Available from: Christian Medical Fellowship, 157 Waterloo Road, London SE1 8XN. Tel. 0171-928 4694. Fax 0171-620 2453.