Triple Helix

Christian dimensions in healthcare

Should we ever strike?

Ten excuses for not working overseas

In the face of suffering

Once more unto the breach?

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editorial:

'Health for all by the year 2000'

In September 1978 representatives of 134 nations met under the auspices of WHO and UNICEF at Alma Ata in the south east corner of the then Soviet Union, near the Chinese border, and drafted a document which has become known as the Alma Ata Declaration. Its message was 'Health for all by the year 2000'.

The Soviet Union is no more, and, with the deadline just a couple of months away, no more are the expectations the world will achieve that particular goal. There are brave attempts[1] at a realistic resurrection of this hope for health around the world, and there is some good news among the bad, but as we face 2000 inspired to do better with global healthcare, we need to keep asking the fundamental question: 'What is health?' if we are to succeed.

The World Health Organisation definition is: 'Health is a state of complete physical, mental and social well-being, not simply the absence of illness and disease'. While regretting no mention of anything specifically spiritual, Christians would want to support the holistic aspect of that maximalist definition, but must be realistic as well. The definition is impossibly Utopian. We are never going to achieve well-being that complete for one individual on earth, never mind six billion of us.

Ten years ago a group of Christian health professionals and theologians met to consider a more appropriate definition and were attracted to Moltmann's: 'Health . . . is the strength to be human'[2]. It is an empowering definition which avoids any jargon, should engage those of other faiths and ideologies, and leads to the obvious supplementary: 'What do we mean by human?' And now 'the Christian dimensions in healthcare' have their chance, for we can define human-ness (and hence health) in terms of four areas of relationships:

- With God
- With others
- With the environment
- With self

During 2000 *Triple Helix* will be supporting the BMA-inspired 'Millennium Festival of Medicine' which looks back 100 years, to celebrate achievements and to motivate healthcare into the future. *Triple Helix* will look back 2000 years at the achievements of Christians in healthcare as they have followed Jesus Christ, who offers healed relationships with God, with others, with the environment and with ourselves.

Andrew Fergusson

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to strike or not to strike?

Is it right for Christian health professionals to take industrial action or to support it? John Martin looks at some of the issues at stake

A recent British Medical Association survey of junior doctors found that 95% would back industrial action, short of going on strike. This industrial action might include work to rule, refusal to carry out administrative duties, refusal to participate in waiting list initiatives and refusal to act as porters.

The core problem is the hours worked by junior doctors. According to the BMA:

- One in four junior doctors works more than 72 hours a week

- It is not uncommon for some to work 100 hours or more

- Some work shifts as long as 36 hours, with very little rest time

- Whereas in most occupations a premium is paid for out-of-hours work, junior doctors receive half the normal rate for overtime.

- Other health professionals could equally perform a proportion of the tasks done by junior doctors

- The European Commission wants to impose a limit of 48 hours on the working week of junior doctors, but Britain persuaded it to postpone implementation for 13 years

The situation has been in stalemate for some time. 'The government hasn't been listening to us' a BMA spokesperson told *Triple Helix*. She added 'What is important is patient care. Under the present arrangements junior doctors are often tired, not alert, and they miss things.' What that adds up to is that patients do not receive the standard of care junior doctors would like to be able to give.

There are signs that the government is starting to listen. Frank Dobson, Secretary of State for Health, is on record saying that he believes the whole system by which junior doctors are paid is 'very archaic' and he has offered a 'New Deal'. The BMA, for its part, says that some progress has been made. It remains sanguine, however, on whether a full agreement will be reached.

Junior doctors last took industrial action in 1974-75. It didn't paralyse the healthcare system. Accident and emergency patients received treatment. Because consultants saw patients, absence of juniors if anything meant a higher quality of care and death rates did not change noticeably. All this indicates that if precedent is anything to go by, Britain's junior doctors possess very few bargaining chips. But junior doctors are adamant that they have a just cause, so some form of limited industrial action remains a possibility.

So should the health professional consider going on strike? For their part the BMA and the Royal College of Nursing both rule out the proposition of going on strike. 'The RCN has an agreement that nurses can take limited industrial action' a spokesperson said. But she added that the procedures to be followed in getting to that position were 'very complicated'. RCN members have never engaged in authorised industrial action. The RCN, however, does not speak for all nurses or for other health professions. Unison, a major union for other health-care workers, has in the past embarked on various forms of industrial action.

Where, then, should Christians stand?

My submission is that the Christian conscience needs to take into account three biblical 'megathemes' - compassion, justice and grace.

Compassion

The biblical passage that typically sums up the Christian attitude to the sick is Jesus' parable of The Good Samaritan[1]. It is a story of how compassion and mercy towards one's neighbour stand in parallel to the requirement to love God. This parable helped impart a vision that played a huge part in the expansion of Christianity in the first four centuries. When plague swept through Carthage in the second century, pagan households would consign infected people to the streets to die. Christians, led by the local bishop, were seen on the streets caring for them. At great risk to themselves they gave plague sufferers shelter in their own homes. Christians became renowned all over the Roman Empire for their care of widows and orphans in a culture where too often they were left in desperate poverty.

Acts of Christian compassion left an indelible imprint on the Roman Empire. Some time after Christianity was made the official religion of the Roman Empire there arose an emperor who is known today as Julian the Apostate. Julian tried to reinstate paganism. He wrote that for his mission to succeed, pagan apologists would need to show that they and their

adherents cared for people even more than the way Christians cared. Gradually Julian's mission melted away.

But what makes the parable of The Good Samaritan even more potent is how the Samaritan's compassion went beyond the expected. He treated the man's injuries. He put him on his own donkey. He took him to an inn. And when it was time for the Samaritan to move on he made financial arrangements to ensure that the victim's needs would continue to be met.

So, it can be argued, the teaching of Jesus offers the Christian health professional a model of caring that goes beyond the usual norms and limits of care.

Justice

The imperative of justice stands alongside compassion as a golden thread throughout the Bible. But we need to unpack it to appreciate fully its relevance to this issue. In the biblical tradition, justice has different nuances from our contemporary understanding of it. Informed by the principles of Roman Law we tend to see justice as weighing the evidence and agreeing a verdict based it. In the Bible, justice is a much more active process. When the Old Testament, in particular, speaks of God's justice, it speaks of God actively taking the side of the person who has been wronged. Justice was an act which God undertook and it was an imperative of faith to 'do what is just'[2]. I would submit, therefore, that it is a Christian imperative to seek justice, including justice for colleagues who may be being subjected to injustice.

Grace

Beside compassion and justice, the biblical megatheme 'grace' speaks volumes. Grace, in the biblical sense, is 'unmerited favour'. The Bible is a record of God's acts of generosity, lavished on people who have no claim to deserve it. And because God has acted in this way, says the Bible, God's people should act in the same spirit of generosity. 'Freely you have received, freely give'[3].

These megathemes, then, form some of the key values that a Christian would bring to the practice of healthcare. They also inform and underpin the Christian Medical Fellowship's Affirmation *Christian Ethics in Medical Practice*.

While this statement could do with some revision (for example, it could use an inclusive language makeover), it remains one of the most concise and helpful formulations of how the Christian ethic applies in relation to human life, in relation to patients, and in relation to colleagues.

Human Life

Clause 3 of the Human Life subsection speaks of the idea of 'vocation' expressed in service for one another. The same clause also recognises the need for proper rest, which grows out of 'the Creator's rule of one day's rest in seven'. How would this principle apply in the matter of the hours that junior doctors are sometimes required to work?

Patients

Clause 2 of this subsection speaks of serving patients according to their need, 'subordinating personal gain to the interest of the patient' and 'declining to take part in collective action' where this would be harmful to patients. This statement, while not ruling out industrial action in some forms, seems to suggest there would be a limit on its extent.

Colleagues

Clause 1 of the Colleagues subsection speaks of the need for honest relationships with colleagues and of the requirement to fulfil the 'just requirements of the State'. There is a further rider. These requirements must not violate 'basic ethical standards'. Again, while cautioning care, this statement does not appear to rule out industrial action completely. But, I wonder, would doctors be prepared to take action on behalf of other health professionals, and vice-versa?

Conclusions

So, should the Christian health professional go on strike? I would submit that the answer is 'no'. The weight of the combined biblical megathemes of compassion, justice (in its Hebraic understanding) and grace all suggest that a Christian will not turn away from a patient needing care.

Should the Christian health professional take or support more limited industrial action? The weight of the justice megatheme suggests to me that there may indeed be occasions when this is justified.

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2. Micah 6: 8
3. Matthew 10: 8

John Martin is Associate Editor of *Triple Helix*

Postcoital contraception

GP registrar **Mandi Fry** shares some of John Holden's concerns but takes a different line in practice

The rate of unwanted teenage pregnancies in the UK is one of the highest in Europe at 8.2 per 1000, and one of the 'Health of the Nation' targets is to decrease this by 50% by the year 2000[1]. Effective contraceptive services are one way in which the government is seeking to achieve this[2], hence the increased focus on the availability of postcoital, or 'emergency', contraception. However, as pointed out by John Holden in the last issue of *Triple Helix*[3], prescribing postcoital contraception is not without its own ethical considerations.

The sanctity of life argument

Even non-Christians tend to agree that the taking of another human life is wrong and the Bible could not be more clear cut on the issue[4]. However when it comes to abortion, arguments begin to centre upon the definition of when life actually begins. Opinions vary from fertilisation to implantation, to viability, or even to birth itself. Each viewpoint has biblical and ethical frameworks to back it up.

The mode of action of emergency contraception by the Yuzpe (or 'morning after pill') method depends upon its timing in relation to ovulation. Used relatively early in the cycle it may prevent or postpone ovulation, and it also renders the genital tract mucus and uterine fluid hostile to the sperm or blastocyst. Used later in the cycle however, its method relies primarily upon blocking implantation[5]. Consequently for those individuals who see fertilisation as the commencement of life it could indeed be considered abortifacient, despite the Faculty of Family Planning's clear statement to the contrary in its guidelines on emergency contraception[6].

However, if the Yuzpe method is abortifacient then so is the intra-uterine contraceptive device (even when not inserted as emergency contraception) and so, more controversially, is the progestogen-only pill. Both these methods involve an effect on implantation[5], although it is not their primary mode of action, and so logically should not be endorsed by those ethically opposed to postcoital contraception on the grounds of abortion.

Personally I subscribe to John Guillebaud's view[5] of conception as a continuum, commencing with fusion of sperm and ovum but not complete until successful implantation. I admit that, to an extent, this is a pragmatic view which neatly sidesteps some of the issues, but I cannot sustain a position that sees God himself effectively throwing away life when you consider how many unimplanted embryos are lost each month.

The Christian ideal of marriage

Emergency contraception in general is used primarily by those outside a loving, mutually supportive relationship. The majority of requests that I have received have been from teenagers or women involved in extramarital affairs. (There are of course exceptions, such as sexual assault, but these come with their own host of ethical dilemmas and I do not propose to consider them further here.)

The biblical ideal is of one man and one woman, committed to one another for life in matrimony[7]. Society's accepted norm is one of serial monogamy. As Christian healthcare professionals we have an obligation towards educating the public as to the meaning of sex, not as a throwaway gift but as an important, self sacrificing act of love. Even those non-Christian patients who do not uphold biblical principles in this or other aspects of their lives can be encouraged to think about the consequences of their actions.

Some may even go so far as to withhold contraception from the unmarried and whilst I do not endorse this viewpoint personally, I do try to encourage some degree of sexual morality from my patients.

The role of the health professional - advance prescriptions and OTC sales

Recently the British Pregnancy Advisory Service has advocated the prescription of PC4 (the hormone combination) in advance, particularly over the millennium period, in light of the fact that its efficacy is related to the duration of time elapsed since the act of unprotected intercourse[8]. In general this idea has received positive media coverage[9] but raises some interesting questions. For example, can an 'emergency' be foreseen? And if so, should we not be promoting alternative, more efficacious contraceptives particularly if, as seems likely, there may well be several acts of intercourse within the same menstrual cycle? Also the prescription of medication for an event which may happen does not fail within a GP's terms of service[10] (like ciprofloxacin for travellers' diarrhoea), and should thus generate a private prescription. That would naturally incur a charge, perhaps denying access to the very individuals who are most at risk.

Some also see it as the first step towards 'over the counter' sales of emergency contraception as occurs in some other European countries. Certainly PC4 is safer[11] than many of the other med-

ications already available without a prescription in the UK, and OTC sales would certainly solve the availability problem to a large extent. However it would simply shift the ethical and practical considerations (such as potential failure and ongoing contraceptive needs) from one group of healthcare professionals to another; from GPs and other doctors to pharmacists who may not have the time, inclination or training to fulfil this role adequately. It would however be a very public statement of intent from a government publicly committed to reducing the burgeoning teenage pregnancy rate.

Wanting the best - Yuzpe or progestogen-only?

As healthcare professionals and as Christians we should all want the best for our patients. In practice this is often a balance between the most efficacious and the safest treatment options. Where postcoital contraception is concerned there is the added dimension that treatment failure may well, although by no means inevitably, result in abortion of the unwanted pregnancy.

In the UK at present the only licensed hormonal method of postcoital contraception is the Yuzpe regime (Schering PC4). However, there is a growing body of evidence that progestogen-only regimes are more efficacious, and potentially safer, in preventing pregnancy[12]. This has led to some doctors prescribing this option, outside of the product licence on an individual basis. This is being done particularly by those involved in dispensing contraceptive services who are able to obtain single dose 750ug levonorgestrel preparations[13]. For the rest of us, explaining to a woman that she must take 50 Microval tablets has often deterred us from offering the most reliable evidence-based treatment. Perhaps therefore we should be involved in campaigning for the licensing of a suitable preparation[14] in order to achieve the best for our patients.

Conclusion

Any Christian who views postcoital contraception as just another prescription, without any thought of the ethical considerations involved, is like an ostrich with their head in the sand. We owe it to our Lord and Saviour to consider carefully the issues involved so that, when challenged by non-Christian colleagues, we can offer a rational, carefully considered response. The beginning of life is just like the end, fraught with moral dilemmas that are best thought of in advance rather than in the emotional heat of the moment with the patient in front of us.

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(See also Readers' Letters on pages 19-21)

Time for a 'Universal Sabbath'?

At a conference on cloning organised by CORE (Comment on Reproductive Ethics), former Chief Rabbi Lord Jakobovits argued for the 'Universal Sabbath' where scientific advances are scrutinised as the world was after the six days of its creation. Just as God rested, it is now time for the world to rest and consider the moral contraints necessary for scientific advances such as cloning, he said. (Source: *Bulletin of Medical Ethics*, May 1999; p13-16)

Human cloning banned in research

Perhaps somebody in a high place was listening? Three months later there was surprise when the UK government announced a moratorium on using cloning technology for research as well as for reproductive purposes. Public concern about GM foods was probably behind the political caution, and the possible medical benefits of therapeutic cloning will be reassessed. (Source: *The Independent*, 25 June 1999)

IVF pioneer 'preaches' on sin

At the European Society of Human Reproduction and Embryology, Robert Edwards, who led the team behind Britain's first test tube baby, evangelised for social engineering: 'Soon it will be a sin for parents to have a child that carries the heavy burden of genetic disease. We are entering a world where we have to consider the quality of our children.' (Source: *Metro,* 5 July 1999)

A complex about the medical-industrial complex?

The *BME* Editor is even more hard-hitting than usual about a powerful new complex promoted by the US government and European-based pharmaceutical multinationals: 'The reason it is unlikely that the medical-industrial complex adds to human welfare is that this is not its purpose. Its purpose is to make money, by whatever means, including subverting the medical profession and misleading the public.' (Source: *Bulletin of Medical Ethics*, May 1999; p1)

Who's your father?

At least six children were born in the UK in 1998 who had been conceived several years after their fathers died. Will children born to 'fathers from beyond the grave' face psychological difficulties in later life? the survey asks. Some weeks later a headline claims 'A donor is not a "real" dad' as a columnist recalls a student colleague who went off sniggering 'to collect his £15 "money for nothing" fee to fuel his Friday nights in the pub'. (Sources: *The Independent*, 12 July 1999 and 29 July 1999)

Internet sites encourage suicide . . .

Internet sites advising how to commit suicide may discourage people from seeking psychiatric help. There are now more than 100,000 sites about suicide, and 14s-24s, a group likely to use the Net, are also a group likely to consider suicide. One site offering touch key access to an A-Z of suicide techniques blasphemously calls itself 'The Church of Euthanasia' - www.enviroweb.org/coe/ (Source: *British Medical Journal*, 7 August 1999; 319: 337)

. . . and spirochaetes

An outbreak of syphilis in San Francisco was traced to an Internet chat room. Six men with syphilis had used it to find sexual partners. The anonymity of cyberspace makes contact tracing a challenge. (Source: *Minerva* in the *British Medical Journal*, 4 September 1999; 319: 650 quoting *New York Times*, 25 August 1999)

Churches slam 'immoral' curriculum - with effect

The Church of England and the Roman Catholic Church jointly criticised the new national curriculum (compulsory for all children aged 5-16 from September 2000) for neglecting to teach young people spiritual and moral values. Divorce and separation were mentioned but 'we are dismayed that the framework does not contain a single reference to marriage or to the primary responsibility of parents for the education of their children'. In September the government announced substantial improvements. (Sources: *The Independent*, 2 July 1999 and *BBC Radio 4 News*, 9 September 1999)

'No' to medicinal cannabis

After a passionate debate at the ARM of the British Medical Association, doctors voted against legalising cannabis for medicinal use by 125 to 116. They accepted more research was needed on cannabinoids, and also rejected the decriminalisation of cannabis for recreational use. (Source: *BMA News Review*, July 1999; p9)

£1 in every £12 goes on negligence

Eutychus has a love-hate relationship with the output of Ms Polly Toynbee. 50% of the time she talks sense; 50% of the time she doesn't. In the former category was her comment in an analysis of the '£1 in every £12 of the NHS budget wasted on negligence cases' where she wrote: 'The compensation culture is morally corrosive, encouraging greed while implying that life has no risks and someone else is always to blame'. (Source: *BMA News Review*, July 1999; p28)

Freudian slip

Between 1923 and 1939 Sigmund Freud endured 30 surgical procedures for oral cancer. Early, he agreed with his personal physician he would want help with dying, and when he felt his suffering was intolerable he reminded his doctor of this agreement. He went into a terminal coma after two large doses of morphine. (Source: *Archives of Internal Medicine*, 1999; 159: 1521-1525)

Seeking Pharaoh's daughter?

There is historical precedent for trusting babies to baskets among bulrushes, but Hungarian hospitals have responded to the increasing problem of abandoned babies by installing an incubator in reception areas, where babies can be left anonymously. 'Nine babies - that's how many this has saved' said the Schopf-Merei Agost Hospital in Budapest. (Sources: *Exodus* 2: 1-10 and *British Medical Journal*, 24 July 1999; 319: 214)

Eutychus

Among All Nations

Autumn 1999
No. 9

Christian healthcare worldwide

Carers who lead and leaders who care

Pontius Pilate has never attracted much sympathy amongst Christians, for understandable reasons. But there's no disputing he had a difficult job to do - implementing unpopular policies from remote centres of power, trying to accommodate the conflicting demands of local tribal interests, and working with limited resources. Much like health service managers of today.

Around the world, nurses and physios and doctors are genuinely appreciated by their patients for the individual care and attention they give. Christians can offer an additional dimension to that care and have the privilege of ministering to patients' spiritual needs on occasions. A hospital manager rarely has that opportunity. He or she is attempting to do the best not for one individual patient but for every patient in the hospital - and for those waiting to be admitted, and even for those not yet born.

There is an in-built tension in 'the system' between managers and clinicians but they cannot serve their patients effectively without each other's help. Clinicians need managers who genuinely care - not just about balancing the budget (although that might be a measure of good stewardship) but in how staff are treated, how policies are implemented and priorities determined.

Managers need clinicians who are able to think beyond the specific needs of their specialty and their individual patients and can consider how services might be organised in a way which will benefit a much wider community within the limited resources available.

Christians who become involved in determining health policy - whether in a hospital, local community, national government or even at the World Bank - can have as great an effect on wellbeing as thousands of dedicated clinical staff working in clinics and surgeries around the developing world.

We need to pray for more frontline, compassionate carers who are willing to take on leadership roles. But, in the meantime, let's not treat managers as the Pontius Pilates of healthcare. Let's pray instead for more Christian leaders and managers who really care about the health needs of the disadvantaged and are in a position to do something about them.

Howard Lyons

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.

10 good reasons for staying

When God called me back to Africa more than ten years ago for ten more years of overseas service, I had ten good reasons for staying in my comfortable surgical practice in the USA.

1. 'Think of how much I could give if I stayed' I said. But God said 'I own the cattle on a thousand hills. You cannot have two masters.'

2. I said 'It is cruel to make my wife move'. But God said 'All these things shall be added unto you'.

3. I said 'But our home is so nice'. But God said 'There are many homes up here. I am your inheritance.'

4. I said 'Think of all the internationals in the USA'. But God said 'I am sending you'.

5. I asked 'How can I live in a communist country?' But God said 'I will go with you'.

6. Then I said 'No one will go with me because of AIDS, starvation, political unrest, persecution, and suffering'. But God said 'There are windows in heaven'.

7. I said 'How can I find a suitable doctor to take over my practice?' Guess what? God showed me the perfect person for the job within two weeks.

8. But I said 'What is wrong with where I am?' To which He replied 'This is your new assignment'.

9. But I said 'I don't want to beg instead of give'. God said 'I am your great reward. Is my hand short that it cannot save?'

10. I said 'I'm 55 going on 65. You need someone young and strong, without physical limitations.' But God said 'I will do a new thing. Be strong and of a good courage. Fear not, nor be afraid of them. For the Lord thy God, He it is that doth go with thee. He will not fail thee nor forsake thee.'

The full original article by Harold Adolph was published in *Today's Christian Doctor, the Journal* of the Christian Medical & Dental Society of the USA, Volume XXX, No.2, Summer 1999, under the title 'Current Trends in Medical Mission'. The following edited extracts are reprinted with permission.

When I arrived in Ethiopia in 1966, I found the OR table was an old metal examination table with only three legs . . . the OR light hung on a rusting coat hanger from a sagging ceiling . . . the sterilizer blew up during my third month . . . my mentor doctor with whom I had hoped to work for five years left after just six weeks . . . the hospital was in debt . . . the first five patients had all been bitten by various wild animals . . . gourds hung on the walls were filled with goat blood, witch-doctor-recommended for speedy recovery . . . a donkey with four kerosene tins secured water for the hospital from five springs in a nearby valley.

Is it so bad that:

- your children may become missionaries? In God's mercy He blessed us with having both our children return to career missionary service in Africa

- you can have almost all three meals with your family every day? - even if you are the only mission doctor for a 105 bed hospital

- you can have your wife and children actively participate in the ministry as a family? Our daughter started making Sunday rounds on the non-infectious cases when she was seven. She worked as a circulating nurse at the age of ten . . . Our son was fixing the evangelist's gospel recorders at the age of ten. By the time he was 14 he was overseeing hospital maintenance

- your children must attend home school? - where the Bible, memorisation, dedication to Christ, prayer, and The Ten Commandments can be joyfully followed

- your family must enjoy wonderful exotic vacations together? - in Africa, Europe, or the US because you have nine months off night call every three years

What are the trends in medical missions today?

• the sad disappearance of the career medical missionary - only 20% of doctors who have felt the call of God to go as missionary doctors still have that interest when their training is completed and their debts paid off.

• the shortening of the medical missionary career - from the former 30-40 years to less than four years. In some ways the short term service and short term teams have killed long term service . . . One survey found that of a hundred feeling the definite call of God to missions, only 12 completed training for this calling, only two actually went, and only one stayed.

• the actual closure of mission hospitals - because of their expense, the lack of key medical staff, the difficulties in running a mission hospital, and sometimes the lack of vision from mission leadership. At a time when there were l2,000 Americans earning good oil money in a certain near-east country, six medical personnel could not be found for a mission hospital that had worked there for 40 years. The mission hospital was closed despite the pleading of the government to keep it open.

• even though the need for the mission hospital is actually greater now than ever before . . . it is sometimes proposed that this is not so. In Africa only one in twenty women needing a C-section for obstructed labour can get their operation.Only 15% of patients with hernias in Africa can get the operation they need during their lifetime, even if their hernia is strangulated. When you think of the government hospital in a poor country giving their patients a list of items such as gloves, syringes, needles, medicines, and intravenous supplies to pick up from a local pharmacy, you know that the need for mission hospitals is not past.

Because of medical missions, Nepal has over a half million Christians today. 80% of the Christians in India relate their conversion to a mission hospital experience. If you describe a circle with a 50 mile radius around each of the 272 mission hospitals in China, you find that these are the areas of revival today. As much as 90% of the medical needs of some countries are met by mission hospitals.

With the start of the Pan-African College of Christian Surgeons two years ago for the training of African Christian doctors in mission hospitals in Africa, the need for training personnel is even greater than before.

• the acceptance of certain myths of theology such as 'the lost are not really lost'. This myth ignores the Luke 16 story told by Jesus, Himself, where the tormented of hell are even pleading for someone to tell their friends about the good news so that they can avoid the same eternal fate.

Loving and compassionate in-hospital care coupled with the spread of the gospel is still the domain of the mission hospital where the 'Jesus video' can be shown to a thousand people every day. A W Tozer said 'We see the world not as a battleground, but as a playground. We are not here to fight; we are here to frolic. We are not in a foreign land, we are at home. We are not getting ready to live; we are already living. We don't realise that we are in a life and death struggle!'

Thirty-two years later there are more than 700 churches among a tribe of about 5 million people . . . they have sent out 120 missionaries to other tribal groups in Ethiopia. The president of the leading seminary in the country was one of my patients. The current CMO and Chief of Surgery of the hospital was a student among 490 others who were trained in evangelism and as nurse practitioners to work in their own communities. During the revolution many patients came to them even when there were no medicines just to have them pray and lay hands on them.

When you obey Him, He will do great things beyond what you could imagine.

Perhaps God planned for you to reach a tribe and language group with the gospel through the gifts he gave you. But instead you used them for yourself. Now over 100,000 people will be forever lost in the fires of hell.

Love always means sacrifice. Sacrifice always means death. 90% of the Christians in Cambodia lost their lives in the most recent upheavals there. It is estimated that today 17 believers will die as martyrs for the sake of Christ somewhere in the world. Death means death to selfishness. Death means conforming to Christ's image. My father's favourite verse was 'Except a grain of wheat fall into the ground and die it abides alone'.

In the book *Of God and Men* A W Tozer says 'We languish for men who feel themselves expendable in the warfare of the soul, who cannot be frightened by the threats of death because they have already died to the allurements of the world. Such men will be free from the compulsions that control weaker men. They will not be forced to do things by the squeeze of circumstances; their only compulsion will come from within - or from above.'

Harold Adolph MD is an American surgeon who has worked overseas for 27 years. In retirement he and his wife travel the USA speaking and recruiting surgeons for world mission

Refresher

The well-established CMF/MMA annual refresher course for missionary doctors and nurses took place from Monday 21st June-Friday 2nd July at Oakhill College in north London. 22 doctors and 14 nurses attended.

Programme

The first week was mainly spent on medical, nursing and primary health care topics. These included malaria, medical education, fertility and infertility, psychiatry (both community and the psychoses), practical perinatal care, community medicine, a session on the UKCC for nurses, respiratory diseases, tropical medicine, AIDS - both clinical and community aspects, leprosy, sexually transmitted infections, midwifery, dentistry and hospital management.

The second week included surgery and HIV, the acute abdomen, ophthalmology, Information Technology as a missionary tool, wounds, burns and skin grafts, ethics, medical imaging, physiotherapy, gynaecology, dermatology, trauma, tuberculosis, anaesthesia, bone and joint injuries, and ENT.

Other resources used were videos, CD Roms, and apart from handouts by the contributors there were over 100 handouts on topics written by Peter Bewes for the 'In Service Training Programme' in Uganda. Teaching Aids at Low Cost (TALC) had a bookstall from which orders were made and delivered before the end of the course.

The facilities of Oakhill College were largely available to the participants, including the chapel and the lovely grounds.

Some participants comment:

'At any one time a group of about 30 or so missionary doctors and nurses met over 12 days at the end of June for the annual Refresher Course. A few came part time, including a physiotherapist and the disabled occupational therapist husband and baby of one of the doctors. It was quite an intense time. Fitting in 48 hours of lectures in twelve days between 9am and 9pm during Wimbledon fortnight is no mean feat!

Our days began, however, before breakfast with a short worship time, which lecturers and participants took it in turn to lead. We are grateful to the Lord for all of the course. Nevertheless, the morning times and the Sunday rest with services facilitated and led by Rev Robert de Berry were special times of encouragement and drawing close to the Lord. Our days ended in similar tone with one or another bringing an epilogue, usually from the Psalms. We had all come in need of professional update (our 'Martha' need). However, we also needed to commune with our God and to receive encouragement, forgiveness and healing from the Lord Jesus (our 'Mary' need).

We are indebted to the hosts Peter and Hilary Bewes as well as the staff of CMF and MMA for hosting and organising this refreshing course. We are grateful too for over 30 lecturers who kindly gave up their time to come and speak to us. Their current knowledge of medicine, nursing, physiotherapy etc mixed with overseas experience and enthusiasm was invaluable to us. We covered the range of medical and surgical problems and emergencies, we focused too on neonatal care along with obstetrics. There was helpful insight into nursing and midwifery, psychiatry, dentistry, tropical diseases, STDs and HIV as well as the approach to the community. Topics like teaching techniques, management, computing and ethics were also covered along with many other subjects of interest and value.

As colleagues who spend the majority of our time in the 'back of beyond', we are really grateful to be brought up to date as well as helped to see how the 'modern' can be helpful to us. We were glad to share experiences together in three Newsnights of what we have been involved in and what the Lord has done: communities helped, patients saved, churches established,

Photo: Peter Bewes

Hands-on with Professor John Wyatt

Review 1999

Photo: Peter Bewes

Psychiatrist Dr Christine Wright leads a workshop

churches growing and taking responsibility in their area, the strong force for good and for change of national Christian doctors and nurses in developing country health services beset with corruption.

For these times and much more we are very grateful. Neither we nor our mission organisations are very rich. Without Christian Medical Fellowship and its members together with the Medical Missionary Association and a trust fund from the former Nurses Christian Fellowship supporting us on these courses and standing with us in our overseas call, we and other colleagues are not likely to be able to afford to attend further Refresher Courses. We request you all, therefore, to share with us, and to keep subsidising this course which has been so invaluable for us - (our family need).

'. . . according to what what one has . . . Our desire is not that others might be relieved while you are hard pressed, but that there might be equality' (2 Corinthians 8: 12-13).'
Andrew Mitchell
(Doctor, East Africa)

'Please pass on to all at CMF and MMA my thanks and gratitude for another excellent Refresher Course for doctors, nurses and midwives working overseas.

This was the second time I have attended the course and felt it was as good, if not better than the previous course. The mix of lectures on professional topics plus update on current changes in practice and interaction with other course participants was very valuable.

I hope the course will continue into the future as it is currently the only such course available for health professionals working overseas. I look forward to attending again during my next home leave and will recommend the course to other colleagues.'
Diane Norton
(Nurse, working with INF in Nepal)

'. . . fantastic refresher course, many thanks . . . '
Gid Cox
(Doctor, en-route for South Africa)

'It was such a good experience and I am very grateful that I was able to take part with three other colleagues from Germany . . . '
Hans Martin Kilguss
(Doctor working in Pakistan)

'I am a nurse midwife preparing to work under CMS in rural Uganda . . . For those who had returned from overseas it was an encouragement to know others were working in a situation similar to themselves. For people like myself, who are preparing to go, it provided important and relevant information'
Joan Macdonald

'The sessions on primary/community based health care were very useful and there was adequate time for discussion'
Donald Brownlie
(Doctor, Malawi)

'. . . thank you for subsidising the course. The food and accommodation were excellent'
Hazell Newman
(Nurse, working with MECO)

'. . . the discussion on ethics and the introduction of e-mail and the Internet to us was very good . . .'
Iris Schlagehan
(Nurse, home country Germany)

'In addition we learnt much from one another, both about medical matters and about God's work in many different parts of the world and in many situations.

I have written to Crosslinks who paid for me to go to ask them to encourage any missionary medics who are home on leave at the right time to attend future courses.'
Phyll Chesworth
(Doctor, Tanzania)

Refresher Course 2000
Booked for July 10th-21st at London Bible College. The course in 2001 is expected to revert to the earlier dates starting June 18th.

reviews:

Addendum
Red Lights and Green Lizards

This book reviewed in issue 8 is obtainable from the author Dr Elizabeth Anderson, Eastbank, River Road, Taplow, Maidenhead SL6 0BG. Tel. 01628 623139, or from Wayfarer Publishing, PO Box 1627, Maidenhead SL6 0RJ

Handbook of Medicine in Developing Countries

Catherine Wolf and Dennis Palmer. Christian Medical & Dental Society, PO Box 7500, Bristol, TN 37621 USA. 1999. 289pp. $24.95 + $3.50 S&H. Wirebound. ISBN 0 9666809 1 X

Contact CMDS as above or Tel. (423) 844-1000. Fax (423) 844-1005. E-mail gho@christian-doctors.com. Web http://www.cmds.org. Credit card facilities available or if several copies are wanted a bulk order could be made through this office.

The book is intended for the pocket of the short term international health care doctor from the USA. It aims to help specialists at home manage the full range of patients they may meet overseas. It is written by two doctors who have worked in Haiti and Africa, covering the key aspects of clinical evaluation and management of the most common medical, surgical, paediatric and obstetric problems found in their experience in developing countries. It uses basic radiology and diagnostic lab studies and the essential drug formulary, mentioning sophisticated management as secondary information. It provides guidelines, is diagnosis-based rather than problem-based, and assumes a fairly sophisticated medical knowledge. There are 18 chapters each covering a specialty. These give a generalist overview and a second edition might benefit from each of these being reviewed by an appropriate specialist.

I did not find the differences between US and UK practice and spelling a problem. The references are to books more familiar in the USA. Appendices on Mission Organisations and Medicine and Equipment Agencies are for the USA. I would welcome having the book in my pocket, especially in a hospital influenced by US practice. Future editions will benefit if this one is used widely and further suggestions are made to the authors.

David Clegg

request:

Dr Anne Merriman, working with Hospice Uganda, could use copies of the *BMJ* and *Lancet* you have read and can pass on. Contact: Hospice Uganda, PO Box 7757, Kampala, Uganda. E-mail hospug@infocom.co.ug

resources:

Care of the Critically Ill Patient in the Tropics and Subtropics

D Watters, I Wilson, R Leaver & A Bagshawe. Macmillan, 1991. A practical manual for medical staff responsible for the care of critically ill patients in hospitals and clinics. £6.20

TALC are keen to have a second edition but need references to raise funding. If you find this book helpful please tell Ms Indira Benbow at Teaching-Aids at Low Cost, PO Box 49, St Albans, Herts AL1 5TX, UK. Tel. +44 (0) 1727 853869. Fax +44 (0) 1727 846852. E-mail talcuk@btinternet.com

Medical Service Ministries

At their discretion, MSM offer funding and guidance for personal and community health care training for Christian workers. Contact: The Candidates Secretary, MSM, PO Box 35, Hailsham, East Sussex BN27 3XW. Tel/Fax 01323 849047

MSM was established in 1903 as The Missionary School of Medicine, Registered Charity No. 234037. Address for administration and gifts: 41 Marne Avenue, Welling, Kent DA16 2EY. Tel/Fax 0181-303 0465

In His Image

(See 'Vacancies' under Central Asia)
The following extracts are from their brochure:

'Countries in the 10/40 window . . . are open and often enthusiastic toward outside education that will help improve their health care systems. Many desire assistance in introducing primary care health providers into their typically specialty-based systems. This is how God has opened the door for In His Image's (IHI) international medical ministry.

IHI works to fulfil the Great Commission by training Christian family medicine doctors to practise medicine as a ministry to the underserved, abroad and right here at home. IHI began sending teams of doctors, nurses, non-medical spouses and support personnel to conduct overseas medical and spiritual conferences in 1995. As interest continues to grow, so does the need for more committed health care professionals to go . . .

Our colleagues' respect is earned by providing them with current medical information and helpful advice on the training of family practice doctors through lectures, practical workshops and seminars. Fun informal meetings in the evenings give us the chance to know each other as friends and lay the groundwork for sharing the gospel . . . They are able to share what they learn with more people, for a longer term than our short term missionaries ever could . . .

Remember the calling that first led you into medicine? Volunteering to serve in an IHI medical conference can help fulfil your desire to reach others, while renewing your spirit through fellowship and edification. You'll return home overflowing with gratitude, and the knowledge that your gifts helped bring others to Christ.'

vacancies overseas:

Posts often require you to raise your own support (some missions can help with this) and to have support of home church. Longer list of Opportunities of Service mostly through UK-based mission societies available in *Saving Health* (see box).

AFRICA

Urgent: doctors and other health professionals in Benin, Burkina Faso, Niger, Nigeria, Zimbabwe in hospitals associated with SIM-UK. Contact Karen Hutchinson, SIM-UK, Wetheringset Manor, Wetheringset, Stowmarket, Suffolk IP14 5QX. Tel. 01449 766464. Fax 01449 767148. E-mail karenh@sim.co.uk

Nigeria

Doctor for small rural community at Biu. Contact Ron George at World in Need: WIN-UK, PO Box 109, Crowborough, East Sussex TN6 2ZN. Tel. 01892 669834. Fax 01892 669894. E-mail win@pavilion.co.uk

Zambia

School doctor. 6 months or longer. Voluntary, suit recently retired. Part time with backup from nurse practitioners. Remote area of central Zambia, altitude 5000 ft, sub-tropical climate. Details: Dr Malcolm Moffat, 16 Ferguson Drive, Musselburgh, E Lothian, EH21 6XA. Tel. 0131-665 3834. Web http://www.chengelo.sch.zm

ASIA

Central Asia

1-2 week visits with In His Image (see p14). UK doctors could be involved in medical schools - a week of lectures and then as circumstances permit opportunity to share faith in an optional spiritual day. Future trips include: Chimkent, Kazakhstan: October 14-31, Bishkek, Tajikistan: November 4-21. Cost $1500-2000.

Further visits planned. Application packet from Peter Saunders here or Anjanette Spears, 7600 S Lewis, Tulsa, OK 74136 USA. Tel. 918 493 7880. E-mail admin@inhisimage.org. Web www.inhisimage.org

China

Team leader (doctor) 3-5 years: spearhead new programme training village health workers in PHC including MCH. Need obstetric experience; commitment to community development; training experience; strong negotiating, personnel and strategic development skills. Recommended study Mandarin. Contact: International Personnel Administrator, TearFund, 100 Church Road, Teddington, TW11 8QE. Tel. 0181-943 7888. E-mail rns@tearfund. dircon. co.uk

Nepal

Locum doctor (GP or other) for Nepal Leprosy Trust hospital, any period October-December 1999. Contact James Lowther, 15 Duncan Road, Richmond, Surrey, TW9 2JD. Tel. 0181-332 9023. E-mail nlt@dial.pipex.com

Key posts with INF include health professionals (doctors, specialists, dentist, nurse teachers, therapists); technical (appliance, laboratory, equipment, biostatistics, managers) and administration and support services. Contact: Recruitment Officer, INF, 69 Wentworth Road, Harborne, Birmingham B15 9SS. Tel. 0121-427 8833. Fax 0121-428 3110. E-mail jmackay@inf.org.uk

Tibet

Ray Pinniger urgently needs doctors and possibly a midwife, ideally experienced in PHC in developing countries and Tibetan and Chinese languages. Further details here or contact: Director, Primary Health Care Project, KunDe Foundation, Health and Sanitation Bureau, Gesang Rd 8, Zedang, Shannan Prefecture, Tibet, China 865000. E-mail drrayp@bigfoot.com

AUSTRALASIA

Papua New Guinea

Two PHC doctors for rural service, one coastal and one highlands. Emphasis on village health patrols, developing TBA and village health aide and other community based initiatives, working with indigenous health workers to develop diagnostic and treatment skills. Contact: Peter Rookes, National Health Secretary, Anglican Church Health Services, PO Box 673, LAE, Papua New Guinea. Fax +675 472 1851. E-mail acpng@global.net.pg

LATIN AMERICA

Bolivia

Women's 4-bed day clinic in Santa Cruz region requires woman doctor with either GP or gynae experience. Basic knowledge of tropical and poverty/malnutrition diseases advantage, also working knowledge of Latin American Spanish. Contact Gabrielle Grace, Overseas Service Secretary, The Methodist Church, 25 Marylebone Road, London NW1 5JR. Tel. 0171-467 5154. Fax 0171-467 5227. E-mail WCO.personnel@ Methodist Church.org.uk

UK

Medical Adviser to Salvation Army

Doctor to act as Medical Adviser to SA International Headquarters one day a week. Some follow-up phone calls at home. All expenses met. Contact Captain Ian Campbell, International Health Programme Consultant, 101 Queen Victoria Street, London EC4P 4EP. Tel. 0171-332 8080. Fax 0171-489 1410

Director of HealthServe

MMA HealthServe is a new initiative in healthcare mission - a Resource Centre serving Christian churches, organisations and health professionals. Based in central London as part of MMA, activities will include: database; conferences and workshops; research; one-stop website; quarterly newsletter; dialogue with aid agencies.

Candidates, probably aged 30-50, should be evangelical Christians with a heart for mission, have healthcare experience, and be able to demonstrate strong communication skills and ideally computer literacy. Understanding marketing or fundraising in a large charity useful. Salary commensurate with responsibilities of position and experience of successful candidate. Job Description and application pack from Sir Timothy Hoare, Career Plan Limited, 33 John's Mews, London WC1N 2NS. Tel. 0171- 242 5775. Fax 0171-831 7623. E-mail careerplan@btinternet.com

Among All Nations (AAN) is produced by the **Medical Missionary Association** (MMA) and **Christians in Healthcare** (CHC) in partnership with the Christian Medical Fellowship (CMF) as the international section of the CMF publication *Triple Helix*. The MMA also publishes its own magazine *Saving Health* (SH) which is designed for those wishing to know more about, pray for, give to and take part in medical mission. *Saving Health* is currently produced about once a year and a newsletter twice a year. *SH* and/or *AAN* are sent to MMA supporters who donate £5 or more a year (£3 for students and missionaries). MMA is building up a database of those based in the UK wishing to hear of specific types of service opportunities in medical mission and who may be available as locums at short notice. Please ask for a database 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. Websites: www.cmf.org.uk/mma/home.htm and www.healthserve.org

Christians in Health Care
Registered Charity 328018. Director: Mr Howard Lyons MSc FHSM. 11 Grove Road, Northwood, Middlesex HA6 2AP. Tel. 01923 825634. Fax 01923 840562. E-mail howard-lyons@msn.com. Website: www.christian-healthcare.org.uk

the *agony* and the *ecstasy*

Natalie Byles on a difficult delivery during her elective in Papua New Guinea:

'Oh God, please let there be a plane coming' I prayed as I dashed to the radio to find out the latest progress of the rescue plane. I stammered our call signal and the radio crackled into life. 'Please tell me they can evacuate her' I pleaded. 'I'm really sorry Natalie, the plane can't come until tomorrow morning' said the distant doctor. 'You may have to go ahead with the symphysiotomy' and instructions followed. I realised this might be this woman's only chance, so overcame my initial horror and panic to write the directions down.

Photo: Natalie Byles

The day had started with a young mother beginning her first labour in the early hours. By 7am she was fully dilated and pushing. Mid-morning there was still no progress and though we could see baby's head, it would not fit through the pelvis. I had to wait until the noon medical schedule on the radio to alert the nearest hospital and ask advice. I then spent an agonising afternoon in the labour room helplessly watching mother battle with ineffective contractions, surrounded by relatives who blamed her for displeasing the spirits.

It was 6pm when I finally heard the plane was not coming and I might have to try something more radical. I raced down to the labour room only to find baby had just delivered. I was handed the white, limp, flat baby to resuscitate. There was a faint pulse but no breaths so I commenced mouth-to-mouth, but after 20 minutes there had been no change. How long should I keep this up? I was kneeling in meconium and mud, surrounded by the family, and between breaths I was praying for God's help. I'd just about given up hope when his little nostrils flared and he took a breath; he had come to life! He continued to breath for himself whilst I nursed and tube fed him. I returned him to a much healthier mother in the early hours of the morning. As I lay back in bed that night I could hardly believe what I'd been through - the agony and the ecstasy.

The next day he had taken a turn for the worse. His chest sounded horrible and his breaths were becoming laboured. I sucked him out, but then had to decide whether to start positive treatment or leave him without. It was really hard to give him back to his mother and explain it was best to do nothing more and he was going to die. I could hardly get the words out and as the family all began to cry, I did too. The baby did die that day and it left me feeling oddly empty.

On my elective I learnt more because I had sometimes been by myself, and I had to make the effort to get to know people and learn procedures. Some of the experiences I went through were harrowing, but I feel they have helped me grow in confidence and I pray I can transfer the things I have learnt to my life back in England.

Natalie Byles is a medical student in Nottingham. She did her elective with UFM Worldwide at Rumginae Health Centre in Papua New Guinea this year.

RevieWWWs

CyberDoc reviews the Internet on healthcare strikes

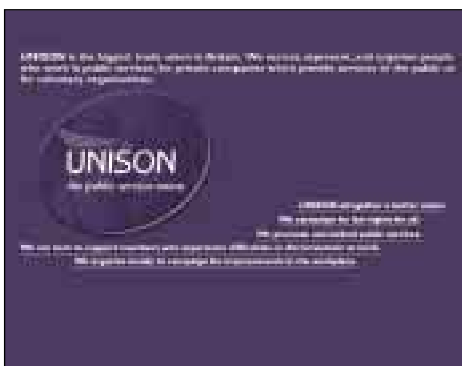
(The blue web-style underlines indicate hyperlinks on CyberDoc's website)

With much publicity having been given recently to the possibility of junior doctors striking, *Triple Helix* reviews what the Web has to say on the subject of health professionals taking industrial action.

The BMA junior doctors site is not surprisingly one of the most useful on this subject on the Internet. The only criticism is that it seems to focus too much on doctor readers and could be more welcoming to non-medical readers. The site has a prominent link from the main BMA pages and it leaves you in no doubt of the serious intent of the BMA. The reasons why doctors are considering striking are clearly described and you are left with a feeling that although this is a last resort for all doctors, it is being considered as the only way to reduce doctors' hours and improve patient care. The site promises to be a useful source of information as the dispute progresses.

According to BMA negotiators, the government is not taking them seriously. Judging from the Department of Health webpage this is the case. There is no mention of doctors at all, let alone information about their working conditions or the current dispute.

As is increasingly the case, my next port of call was the BBC site which is usually a good source of information. In an example of the fluidity of the Internet, previous coverage sympathetic to doctors'



long periods of overtime and rates of pay was no longer easily accessible. One of their background briefings called NHS pay 99 focused on total pay, and seemed to ignore the hours issue. Elsewhere there are stories about doctors' strikes in South Africa and Lebanon. There is also a suggestion that Welsh doctors may benefit from a separately negotiated agreement.

There is a brief mention of the possibility of other health staff also striking. The UNISON website mentions this, but it is not given anything like the same prominence as the BMA site gives its dispute.

There is a perception among UK doctors that conditions in Australia and New Zealand are much better than in the UK. This is attributed, perhaps correctly, to strikes that have occurred in both countries. An article in the *Australian Medical Journal* outlines the unhealthy tradition of long doctors' hours and seems to indicate that the problem is not completely resolved there.

UK junior doctors might argue they have benefited from strike action in other nations. Maybe in the next few months UK strike action will help to establish internationally the principle that doctors should not work excessive overtime as the cheapest form of labour in the hospital.

CyberDoc is Adrian Warnock, an SHO in psychiatry on the Royal London Hospital rotation. Links can be found at http://xtn.org/cyberdoc/strikes/

‘I call you gods’[1]

Fr John Dale reflects on the tensions we can feel in the face of suffering

Is there an affinity between our drive for knowledge and expertise and the feeling of let-down, even of guilt, when, despite one’s best compassionate efforts, someone we have cared for dies? Is there something within the human psyche which desires to be divine and is sometimes cripplingly disappointed when it finds that it isn’t? The early Fathers of the Church were sure that human beings were ‘creatures of God and bidden themselves to be God’ but this century has borne witness to some of the worst depravities that humans can visit upon each other: atrocities committed by people who have usurped God’s unique right to be God.

As health professionals and clerics, we recognise in ourselves many conflicting emotions when faced with the reality of death, especially of someone for whom we have cared and, even for religious people, it can be difficult to generate and recognise a sense of the presence of the being called God. In that situation the absolute can appear very finite and fragile, especially when our faith also seems to be offering an end to suffering and pointing to a new and better life.

There is a two-fold danger here. First, that we separate our professional lives, where it seems God cannot possibly reside in the midst of suffering, from our private lives where God can seem much nearer and manageable. Secondly, having learned to compartmentalise God, it is all too easy to lose or forget him altogether. The one often follows the other because of a lack of authenticity in the place where we most urgently want to be ‘gods’.

We need to be able to move from being sincere to being authentic in our encounter with suffering. We seek a language and context for holding in equilibrium the disparate parts of our life, the gentle and the awkward, the clear and the obscure, the familiar and the frightening: a balance which will enable us to give life to those to whom we relate both professionally and privately.

We know from our experience of intimacy with those whom we love that there is never a time when they are not part of us, present or not; life has been transformed irrevocably by that person. The struggle for intimacy involves difficult and painful self-disclosing conversation where human language can seem quite inadequate. The deepening of that intimacy does not occur while we are waiting for things to get better - there is only the lived reality of love here and now.

Similarly, people of faith need to believe that their lives are changed for ever by the intimate presence of God and that there is no part of their lives from which God is absent. Nor is there a better tomorrow when there will be no suffering, without being prepared to engage with that suffering now and to name it in all its grimness. God is not to be found when things get better. Gandhi named that deception when he said ‘If you don’t find God in the next person you meet, it is a waste of time looking for him further’[2].

Elie Wiesel, survivor of the holocaust, says ‘What happens to us touches God. What happens to Him concerns us. We suffer for the same reasons . . . Does the idea that God also suffers - that He suffers with us and therefore on our account - help us to bear our grief, or does it simply augment its weight? . . . He alone has discretion in the thousands of ways of joining his suffering to ours . . .’ and elsewhere ‘We know that God suffers because he tells us so’.[3]

Can we cope with the notion of God suffering? It does not rest easily in western culture yet is very much at the heart of the scriptural tradition of the people of the book. The Hebrew psalmists’ experience of God leads them to expect of God full, active participation in human concerns, if human beings are to work hand in hand with the God upon whom they are totally dependent[4].

As a Christian, I believe that God has told us most poignantly that he shares suffering with us to the full, in the life and death of Jesus. Why did he do it? Because he had to, because love does such things. But within this image of Jesus giving generously of his love there is also a bitter irony which more than hints at the wastefulness of it all: an irony and waste which is familiar to all who accompany others through the darkness of undeserved suffering and it simply heightens our sense of inadequacy, even of complicity. Yet we still do it. Why? Because we have to, because love does such things.

There is a story from the life of the prophet Mohammed. When one of his companions was groaning in agony, some of the others rebuked him. Mohammed interjected, saying ‘Let him groan, for groaning also is one of the names of God’[5].

References

1. Psalm 82: 6, John 10: 34
2. Nicholl D. Holiness. Darton, Longman & Todd, London. 1996. p25
3. Wiesel E. All Rivers Run to the Sea. HarperCollins, London. 1996. p103-104
4. Psalms 6, 7, 8
5. Nicholl D. Holiness. Darton, Longman & Todd, London. 1996. p131

Fr John Dale is a Roman Catholic priest currently working as a spiritual director in the Northern Regional Seminary. He has worked as a hospital chaplain in Manchester

readers' letters:

Postcoital 'contraception'

*St Helens GP **Mike Clayton** agrees with John Holden's views in the Summer 1999 edition about the morning after pill:*

I do not prescribe hormonal postcoital contraception (PCC) either for reasons similar to those John Holden outlined. Some take a broad definition of 'conception' as not so much a point in time (ie fertilisation) but rather as a period which extends to include successful implantation. Therefore from this definition, PCC is a method of contraception.

Whilst not the only justification for this position, I have never been swayed by the argument that since there is a high loss rate in nature of fertilised embryos (possibly 60% or so) then this somehow downgrades the value, significance and status of the embryo. The observation that something occurs naturally - even frequently - surely does not in itself justify artificial intervention which brings about the same result.

The official view, often stated, that PCC is not an abortifacient is a semantic one based on the legal interpretation that it is not an attempt to procure a miscarriage since no 'carriage' as such has taken place.

So, how I handle such requests in practice is:

1. Establish the facts (sometimes PCC is not indicated - though this is rare as most advice is that even if the risk is very low, it should be given).

2. I explain that I do not give PCC 'for my own reasons' and will usually ring through to one of my other partners or, if I am doing a locum, to one of the partners in the practice (I have always said before I accept locum work that I do not prescribe PCC as I think it only fair to warn in advance). The amount of counselling I give in addition is variable depending on the circumstances - sometimes it is a matter of the other doctor simply picking up where I left off, or ranging to the other extreme, I explain all that is involved and someone else signs the script. (I'm still not convinced about this one.)

3. The other alternatives available are the same as John Holden outlined.

I would estimate that only 20% or so ask me why I take the position I do.

Usually with the help of a quick sketch I explain how PCC is thought to work. My universal finding is that those who want to use PCC appreciate being better informed - only on a few occasions has someone then decided not to proceed once they appreciate the mechanism of action. Just as doctors vary in their ethical positions, so do our patients.

On a practical note, I do not experience difficulties in general from 'burdening' an extra onto another GP (but perhaps I'm not the one to say). It is only polite though to offer to 'swap' extras or return the favour when inevitably something else crops up (eg when allocating visits etc).

Sometimes I wonder whether it is really worth all the bother, given all the other stresses and demands during an average day but I suppose it achieves two things:

1. It makes people think.

2. I want to keep my conscience clear - and although it means inconvenience and anxiety (for both parties!) I cannot simply bury my intellectual conclusions.

***Mark Houghton** is a GP in Sheffield who also takes the same view. He offers 'more pointers to good practice':*

John Holden's article pointed helpfully to the right road in this matter. May I add some more pointers to good practice:

1. The pressure of the 'emergency' nature of the consultation can be reduced by good patient education. All new patients (men as well as women!) need a joining leaflet explaining:
a. The mode of action of PCC. I get repeated complaints from patients who were not told how PCC and other anti-implantation agents work and who wished they had been.
b. That in some doctors' opinion these drugs are unethical and bad for health, with reasons given briefly. Name the doctors in the practice who hold this opinion and promise a caring ear from all irrespective of race, religion, sex etc.
c. That a second opinion is always on offer. Telephone numbers for difficult times like weekends, giving advice and other opinions, can be added so there is no medicolegal comeback and freedom of choice is there.

2. Sexual health literature can indeed extol the benefits of keeping sex for husbands and wives. God has been saying that from the start though it may be better not to mention him at present. But we are duty-bound to point out the serious health consequences of multiple partners, of cohabitation versus marriage, of early first sex and of divorce just as we do for smoking. (Excellent data on this for your waiting room leaflets are in a paper by public health consultant Dr Ted Williams, *Marriage, Cohabitation, Divorce and Children*, June 1999, available from the Maranatha Community, 102 Irlam Road, Flixton, Manchester M41 6JT.)

Yes, this teaching is 'seldom heard' by our society, because it is seldom publicised. Good practice will ensure patients get all the facts from which to decide their own lifestyle before the 'emergency' comes.

*Leicester consultant anaesthetist **Hugh James** however, thinks John Holden ascribes too much value to the early embryo:*

While I respect John Holden's sincerity in his wish to give full value as a human being to a fetus from conception, I think his logic is weak and the scripture he uses is far from conclusive.

At an early stage of development of the embryo it is uncertain whether it will implant and progress, or even whether it will become one person or two, should it form identical twins. Can one really consider it a living human being? At this stage, God knows the future but we do not. Psalm 139 which John Holden quotes proclaims just that, and it emphasises God's role in creation. It says nothing about the stage at which we become 'people'. Indeed Ephesians 1: 4 tells us that God chose us 'before the foundation of the world'. So why is the womb special? And technically of course, many of the embryos never embed in the womb, anyhow. Is it conceivable that a large proportion of those in heaven are conceptuses who never developed beyond ten days?

An embryo is a creation of God and not to be treated lightly. However, that is not to say that it deserves the protection of a fully formed baby. In reality we all give a differing value to a fetus depending on its gestation. In the rare instance that the life of someone's wife is at threat from a pregnancy, who would not sacrifice the life of the fetus for the mother?

For anyone who would want to consider further the concept of a developing value for the fetus, I would strongly recommend Dr Peter May's recent series of articles in the *Church of England Newspaper*.

(See also the article by Mandi Fry on pages 6-7)

Sexual health

*Manchester GP **Sharon Kane** has further practical advice on disseminating the Christian truth about good sexual health:*

As a Christian GP I so often feel helpless before the tide of increasing teenage sexual activity and the attendant problems of unwanted pregnancies, STIs, and the timebomb of female infertility caused by silent chlamydia infection.

I am heartened therefore by the recent publication of three health promotion leaflets intended to educate teenagers about the risks of early sexual activity and to encourage them to say 'no'. They are not preachy or moralising but contain well-substantiated medical facts. They are produced on glossy colourful paper and have catchy titles:

If you think saying 'no' is tough, just wait till you say 'yes'

How to be a better lover

You didn't get pregnant, you didn't get AIDS, so why do you feel so bad?

These leaflets were originally produced by the US Department of Health and Human Services, and are now being published by IMAGE, a Christian group in Cheshire. They are available from them at IMAGE, PO Box 51, Hyde, Cheshire SK14 1PY. Tel. 0161-368 8875.

IMAGE would like to see these leaflets distributed in mainstream health education, to avoid the appearance that this issue is solely the concern of a moralising religious group operating in a little corner. If you have any ideas about how this might be achieved, or if you have the means or connections to make this a reality, they would love to hear from you!

Finally to those who, like me, feel overwhelmed by the tide of evil that seems to be flooding our land, and who sometimes wonder if it has just gone so far that we might as well give up standing for what is right, may I share an encouraging scripture the Lord showed me recently. Isaiah 28: 6 says 'He will be . . . a source of strength to those who turn back the battle at the gate'. I would emphasise those last three words.

Debt relief - but at what cost?

*Retired Sussex GP and former missionary **John Geater** returns after recent encouragements to the question of relief for developing world debt. He argues there's a long way to go yet*

Many *Triple Helix* readers will have signed the Jubilee 2000 petition calling for debt cancellation for the world's poorest countries. We were pleased debt cancellation was high on the agenda at the G8 Conference in Cologne and recognise the major part played in this by our Chancellor, Gordon Brown. Many will have been delighted that debt cancellation of $100 billion was announced in June (not quite as good as it might seem as $50 billion was due to have been written off anyway but still a major step in the right direction). When placed alongside the total developing world debt of over $2 *trillion* however, there is still a long way to go before the poorest nations get out of their economic slavery to the rich.

What many do not realise is that the mechanism whereby debt is remitted is tied to Structural Adjustment Programmes (SAPs) dictated by the International Monetary Fund. These impose stringent conditions on debtor nations, which may force them:

- to privatise state industries, creating profit for richer investing individuals and financial institutions but depriving thousands of people of employment and their only means of support

- to make drastic cuts in government expenditure to free resources for debt repayment. These have almost always resulted in drastically reduced spending on health and education

- to introduce 'cost recovery' mechanisms which can result in the imposition of of heavy charges upon those who are sick and place education beyond the reach of the very poor

- to 'rationalise' the number of civil servants. This often includes laying off doctors and teachers and has a further negative impact on health and education services, particularly for the poorest citizens who cannot afford the private sector

• to devalue currency, rendering their exports and commodities cheaper to the developed world and pushing up the prices of imported goods including medicines

Details of the complicated workings of SAPs can be obtained from the World Development Movement at www.wdm.org.uk or from Christian Aid or the Jubilee 2000 office. The May 1999 edition of *New Internationalist* is also enlightening reading. IMF policies seem to be having the effect of worsening the poverty of the very poorest in the developing world.

Whilst it is not within the remit of Christian health professional organisations to become involved in the wider economic arguments, I would encourage individual Christian health professionals to align themselves with the world's poorest people by writing to their MP and to the Chancellor congratulating the government for what has been done so far but urging that pressure is brought to bear on the IMF to abandon its harsh right wing monetarist policies in favour of an approach that does not harm the poorest people in the poorest countries.

We should all be concerned by the imposition of unaffordable health charges. For instance, as a result of SAPs, state hospitals in Nicaragua now impose an admission charge of $30 - three weeks' salary for the poorest people, and in Tanzania people have to pay what would be the equivalent for the average Briton of about £100 for a clinic visit. Previously they had free medical attention. Whilst we should welcome restrictions on spending on weapons, we should passionately oppose such drastic restrictions on the availability of health care for the poor. We should take up the matter with Gordon Brown and Development Minister Clare Short to prevent debt relief having the effect of depriving the most vulnerable of health care. International subsidies should be applied to medical imports to offset the extra costs to the developing world from IMF-imposed devaluations.

As Christians we cannot walk away from our obligations to the poor, nor as health professionals from our obligations to the sick. We cannot close our eyes to their plight nor walk past on the other side pretending they're not there. Charitable giving helps a few - but if we can change IMF policy we can help the many.

Transplants: are the donors really *really* dead?

***David Hill** replies to those who criticised his views about brainstem death:*

The brainstem tests were introduced in 1976 as prognostic indicators to determine when death will inevitably supervene; it was only in order to obtain organs from beating-heart donors that the 1979 Memorandum regarded the same tests as diagnostic of death. In the first case treatment could be discontinued and the patient allowed to die; in the second treatment is continued and even intensified. David Cranston is correct in writing that ventilators would continue to be switched off even if transplants were not required. The point is that the ventilators are not turned off when organs are required.

His practice is also wrong (as is that of his transplant colleagues) if 'the transplant surgeon has nothing to do with the diagnosis of brainstem death apart from checking the records'. The Code of Practice requires that 'he must have satisfied himself by personal examination of the body that the patient is dead' (Para IX, 35). If death has been determined on the basis of brainstem tests, this can only be by repeating them, which is not done.

John Searle might look again at the Memorandum (II, 7) which justifies the change from prognostic to diagnostic. It claims that 'by then all functions of the brain have permanently and irreversibly ceased'. There is ample evidence, to which Stuart Cunliffe refers, that activity in the cortex, hypothalamus, thalamus, basal ganglia and pituitary may continue, and the permanent irreversibility of other changes is, of course, essentially unprovable. The concept that higher centres of the brain cannot function without the brainstem is long outmoded now that, for example, waking centres have been identified in the higher brain. In addition, the brainstem is incompletely tested.

As a fellow anaesthetist, I cannot agree with him that 'what was then taken to the operating theatre for the removal of organs was a corpse' in any normal use of that word. Both muscle paralysing drugs to prevent movement and some form of anaesthesia to control the hypertension and tachycardia that accompany the trauma of surgery are required - not characteristics of a corpse. Current organ harvesting practice is pragmatic, but neither scientific, logical nor ethical.

Stuart Cunliffe is correct in doubting that this information is ever presented to potential organ donors or their families, thus invalidating their consent.

The Editor welcomes original letters for consideration for publication. They should have both Christian and healthcare content, should not normally exceed 400 words, and if accepted may have to be edited for length.

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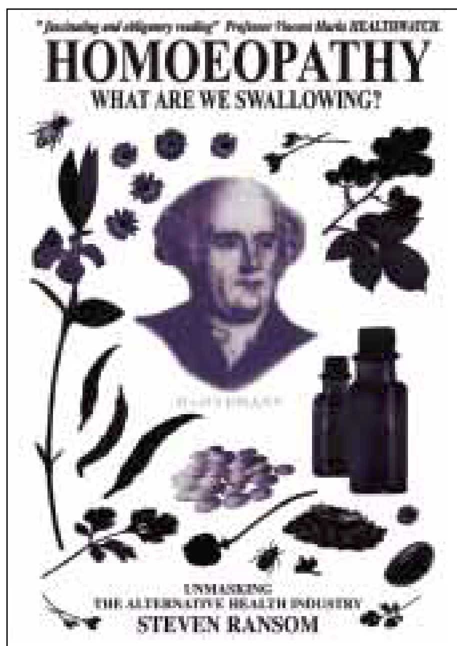
reviews:

Homoeopathy - What Are We Swallowing?

Steven Ransom. Credence Publications, Uckfield. 1999. 124 pp. £6.95 Pb. ISBN 0 9535012 2 1

I get the strong impression that many health professionals are profoundly ignorant about homoeopathy. The popular myth is that this harmless idea believes in the efficacy of weak solutions. Few people seem to realise that the sort of dilutions advocated by homoeopaths would need a volume at least the size of the North Sea, if not the orbit of Venus, to contain a single molecule of the original substance.



Steven Ransom sets out to expose the intrinsic nonsense at the heart of homoeopathy. He starts with the founder, Samuel Hahnemann. He describes his historical context in the 18th century, his childhood, student days, involvement with freemasonry, occultism and blatant quackery. Hahnemann claimed for instance to have a cure for scarlet fever which was causing appalling epidemics among children at that time. For financial gain, he kept selling his remedy but refused to divulge its secrets. It eventually came to light that it consisted of tiny amounts of belladonna dissolved in '2.4 million drops of water'. This useless substance was then administered with very complicated instructions, which had to be followed precisely for it to be effective. It was therefore always the parents' fault and not his if their child died.

Hahnemann was prosecuted in cities across Europe, before being allowed to settle in Paris. His crackpot theories are described in detail before Steven Ransom reviews the current state of play.

There has been an enormous promotion of homoeopathy in the last 40 years. It is now sold by pharmacists with chain stores such as Boots training their staff in it. As it sweeps all before it (taught in universities, promoted by BUPA, served up in outpatient clinics) it has become politically incorrect to challenge it. However, it remains the case that not a single, well constructed trial of homoeopathy with positive findings has ever been successfully repeated by other workers. Theoretically absurd, it has no sound evidence to show that it works. Hopefully this urgently needed little corrective will open a few blind eyes.

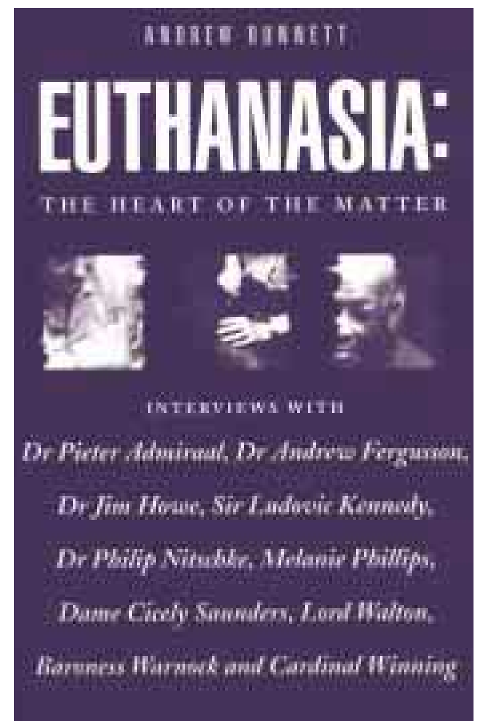
Peter May
(GP, Southampton)

Euthanasia: the Heart of the Matter

Andrew Dunnett. Hodder & Stoughton, London.1999. 207pp. £6.99 Pb. ISBN 0 340 69486 6

Another book on euthanasia? Yes, but a different one. The press release describes it as 'a collection of interviews with ten well-known people who are helping to shape the debate surrounding the practice of euthanasia in this country'. There is a wide range from all sides, including Ludovic Kennedy (president of the Voluntary Euthanasia Society), Jim Howe (Tony Bland's doctor), Cicely Saunders (founder of the UK hospice movement) and *Triple Helix* editor Andrew Fergusson.

For those seriously interested in the euthanasia debate this book is quite indispensable. Its biggest strength is that proponents of all views have their say. The reader doesn't have to settle for second-hand tirades against the pro-euthanasia lobby, or vice versa, because all sides are represented first hand. The interviews are



not long and the question-and-answer format means you can flick around quickly to find a certain person's view on a particular issue. Some of the material is not to be found elsewhere (for instance, Jim Howe's first major interview since the Bland case).

There are two caveats worth mentioning. First, it is not a book of 'how Christians should view euthanasia'. Only three contributors appear to hold Christian convictions. For 'the Christian view' there are other books available. This is a source book that gives a bigger picture than just one viewpoint. Information is presented for the reader to evaluate and this is done well.

Secondly, contributors are limited both by space and the interviewer's questions. You will not get their views on all matters relating to euthanasia fully laid out; more an introduction. It is perhaps a pity that little guidance is given for further research. However, there are a few mentions of other published work in the biographical details beginning each interview.

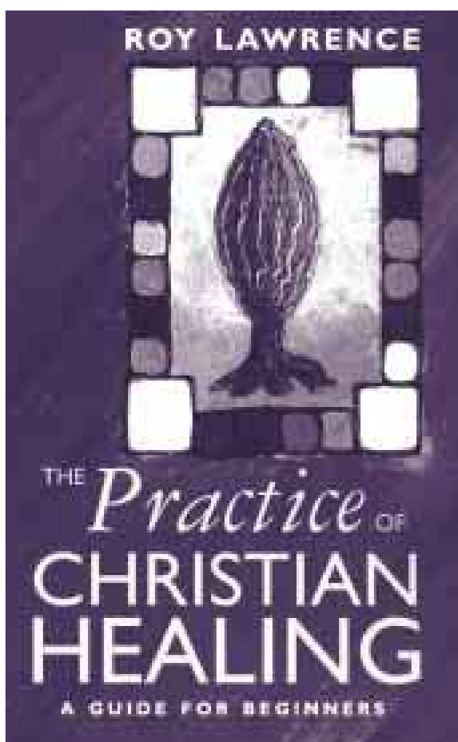
Both these considerations mostly reflect the nature of the book, not any real faults. As long as they are borne in mind it is a unique and vital contribution to the euthanasia debate. I highly recommend it as a valuable means of gaining a more balanced view of this crucial topic.

Mark Pickering
(Medical House Officer, London)

The Practice of Christian Healing

Roy Lawrence. Triangle (SPCK), London. 1998. 117pp. £5.99 Pb. ISBN 0 281 051852

In this book Roy Lawrence sets out to de-mystify Christian healing. By a combination of 'scripture, logic and experience', he endeavours to make a case for the practice of Christian healing to be the norm within every church congregation and possible for every Christian. Although acknowledging that some may have a special gift in healing, the author is more concerned in encouraging the ministry of Christian healing to grow throughout the Body of Christ.



The book is simply written in 13 short chapters. It takes the reader through many different practices of Christian healing in a down-to-earth, practical manner, rather than in an in-depth theological exposition on the subject. Each chapter is referenced to scripture as well as the writer's own experience. The book is full of anecdotes from his own ministry which makes the narrative live. At one point I was concerned that the picture given was too rosy and simple, but chapters 12 and 13 do look briefly at the question of suffering, as well as problems, difficulties and failures (although even the failures turn into ultimate blessings).

Roy Lawrence devotes one chapter to what Christian healing isn't, and goes on to define it as 'quite simply the difference Jesus Christ makes in body, mind, spirit and lifestyle for those who take Him seriously'. But what is the place of the health professional in this ministry, as distinct from just happening to be involved in the healing ministry of their own church? The proposition of doctor/clergy groups to enable cross referrals and a working together is touched upon, and the example of where clergy have been an equal part of the interdisciplinary team in complex cases gives an indication of the way forward.

If you are wanting to be more involved in the ministry of Christian healing and want to find ways of bringing that ministry into your practice, then this book is a good starting point.

Paul Worthley
(Senior Physician, Burrswood Christian Centre for Healthcare & Ministry)

The Journey - a road to post-abortion recovery

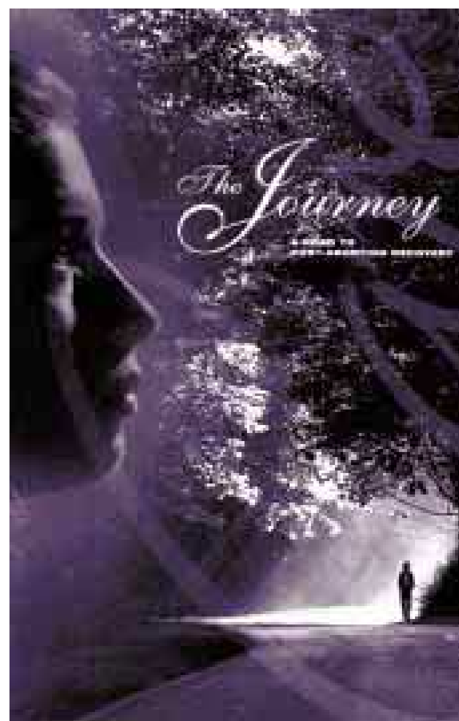
CARE for Life. CARE, London. 1998. 220pp A4 Manual. Available from CARE, 53 Romney Street, London SW1P 3RF for £30 plus a donation for p&p invited. No ISBN given

'Can you keep a secret? Years ago I had an abortion and never recovered.' *The Journey* states it takes at least ten years to move out of denial and seek help after choosing abortion. The effects of post-abortion syndrome (PAS) are devastating but in this manual from CARE for Life we have a training package to treat it.

The heart of the manual is a ten step 'journey' from first seeking help (step 1) through anger and grief to the way ahead (step 10). It is bound in an A4 clip file and well laid out with simple headings and diagrams.

The first section covers underlying principles such as the consequences of the 1967 Abortion Act, the pressures women undergo and the psychological effects that follow. Helping men and helping Muslims is covered well, but sadly not the other faiths.

The ethos is distinctly Christian but the cross cultural bridges into post-modern thought are made brilliantly while facing the hard issues step by step. I would feel comfortable to refer anyone to seek help from a counsellor using *The Journey*. The goal is to help women recover from abortion and while salvation will come to some during the programme, this is not the main aim. A catchphrase throughout is 'We cannot change the past, we do not know the future, but we can change the way we think'.



Here is a great toolkit for those in contact with PAS - counsellors, churches, GPs, pregnancy crisis centres - who want in-depth training. However, the price of £30 is going to put some off, and foreign markets like Africa will be excluded. A compact edition could be an idea so as to have the maximum sales for a growing problem. I would love to see this manual equip those called to a costly but crucial ministry.

Mark Houghton
(GP, Sheffield)

When he saw him . . .

. . . he had compassion on him