TRIPLE HELIX

Spring 2002

For today's Christian doctor

STEM CELL STITCH UP

CHRONIC FATIGUE SYNDROME

GOOD NEWS IN THE SURGERY

GAY ADOPTIONS

ICMDA

RUSSIAN ORPHANS

CARING FOR REFUGEES

DEVELOPING WORLD DRUGS

SPIRITUALITY OF THE CONSULTATION

OVERSEAS OPPORTUNITIES

ISSN 1460-2253

Triple Helix is the quarterly journal of the
Christian Medical Fellowship
157 Waterloo Road
London SE1 8XN

Tel 020 7928 4694
Fax 020 7620 2453

Email admin@cmf.org.uk
Website www.cmf.org.uk

A Registered charity no 1039823

Subscriptions
Triple Helix is sent to all members of CMF as part of the benefits of membership, but individual subscriptions are available to non-members at £2.95 a copy including postage (UK only).

For special offers see the coupon enclosed.
Enquiries: Tel 020 8559 1180 (Monday-Friday, 9am-5pm).

Contributions
The editor welcomes original contributions which have both a Christian and medical content. Advice for preparation is available on request.

Authors have reasonable freedom of expression of opinion in so far as their material is consonant with the Christian faith as revealed in the Bible. Views expressed are not necessarily those of the publishers.

Design S2 Design 020 8404 7470

Cover Cloning by nuclear transfer. Nucleus being injected into enucleated egg. Wellcome Photo Library

CONTENTS

NO. 19. SPRING 2002

EDITORIALS

The Lords' Report on Stem Cells

Selective with the truth

There is no doubt that stem cell technology holds great promise for sufferers of degenerative conditions like diabetes, Alzheimer's and Parkinson's disease, but the main issue addressed by the Lords' Select Committee on Stem Cell Research was whether research on cloned human embryos was still necessary, given recent advances in the ethically acceptable alternative use of adult stem cells.

The Donaldson report, tabled in June 2000, on which the newly passed law is based, took what the Lords now acknowledge to be an overly pessimistic view of the properties of adult stem cells. Two years is a long time in science, and subsequent research has confirmed their amazing versatility in treating a wide variety of conditions in both humans and other mammals (*www.stemcellresearch.org*)

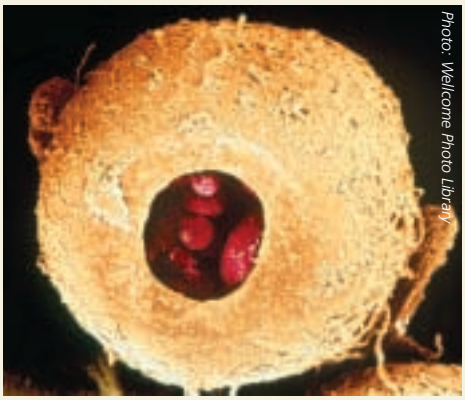


Photo: Wellcome Photo Library

Human embryo perforated for harvest of cell for genetic testing.

The very latest research from the University of Minnesota (reported in the *New Scientist*, 23 January) reports discovery of a new variety of adult stem cell (dubbed the multipotent adult progenitor cell or MAPC) which is easy to isolate and culture, and has been shown, given the right conditions, to have the same versatility as the embryo stem cell, but without the risks of immune rejection, uncontrolled growth or cancer.

Given the considerable technical and ethical problems of cloning human embryos, growing international opposition to the practice and the danger that reproductive cloning will follow, it is outrageous that the Lords' committee have not only authorised it, but have misled the British public, and especially vulnerable patient groups, into believing that their best hope lies in this direction.

Goldenhar Syndrome

A tragic breakdown in communication

A high profile disagreement between doctors and the parents of a baby with a rare facial disorder was finally resolved after a seven hour High Court hearing in Leeds, when the parents agreed to an urgent tracheotomy (*BBC News*, 7 March).

Twelve week old Maria Aziz Al-Rafi, the only survivor of triplets born in Saudi Arabia, has oculoauriculovertebral dysplasia (Goldenhar syndrome), a rare condition affecting only one in 500,000 babies, and has no right eye or ear, and only half a nose and jaw. She will require 18 years of surgery to correct abnormalities, and doctors at Royal Victoria Infirmary in Newcastle-upon-Tyne had wanted to perform a preliminary tracheotomy to secure her airway and assess the anatomy.

But the parents, who had already started a public appeal to raise £500,000 for private reconstructive surgery in the US, threatened to withdraw their child from the intensive care ward after the mother clashed with a consultant over proposed treatment. They were worried about losing their daughter during surgery, and also about 'medical staff experimenting and trying different procedures'.

Lord Fenwick, of the Newcastle Hospitals Trust, in taking the case to court said, 'The hospital was obligated to act in the best interest of the child'.

Legally, the balance of power over a child is weighted in the parents' favour, on the assumption that parents will look after a child better than the State. But these rights do not extend to letting a child die or suffer by refusing necessary medical treatment.

But it is tragic that what began as a breakdown of communication between doctors and parents should escalate into a full-blown media circus and court proceeding. It is a reminder that good medicine involves far more than technical expertise. It is as much about understanding anxieties, addressing fears, patiently answering questions and giving information, and communicating empathy in a way that gains trust. The doctor/patient relationship, is a relationship, not a contract.

HFEA Decision on Designer babies

An unethical and dangerous precedent

A Leeds couple, Shahana and Raj Hashmi, have been given permission to create a baby to act as a bone marrow donor for their son Zain, who suffers from thalassemia. No compatible donor has been found. The couple will undergo IVF treatment with the resulting embryos being screened for both thalassemia and tissue compatibility. Any resulting baby will donate umbilical stem cells after birth.

In defending the judgement, Michael Nazir Ali, Bishop of Rochester, who chairs the Human Fertilisation and Embryology Authority's ethics committee said, 'We are minimising harm and maximising good…this is not a liberty hall for the child to be created as some sort of spare parts factory'.

The use of umbilical cord stem cells in bone marrow transplants is an exciting scientific advance, which if successful, offers the chance of a cure for otherwise fatal inherited blood disorders, with minimal risk to the donor.

But in allowing preimplantation diagnosis and embryo selection in order to ensure the birth of tissue-matched donor babies, the HFEA have set an unethical and dangerous precedent.

It is unethical because the approved procedure involves destroying embryos that fail to fulfil the selection criteria. Whilst it is true that in very rare circumstances, the only way of ensuring that a tissue-matched donor is born, is to use this kind of 'search and destroy' technology, the end of saving a human life never justifies such means. This ruling moves the goalposts even further than before as embryos, which are of the wrong tissue type, but otherwise normal, are to be discarded in order to treat a condition which is not necessarily fatal.

The precedent is also dangerous because, despite the HFEA's assurance that the procedure will be used only in 'very rare circumstances and under strict controls', the ruling is likely to lead to a slippery slope whereby designer embryos and fetuses can be created and destroyed for more and more trivial reasons. It also cannot be in the best interests of any donor child, however much they are subsequently loved, to be created for the primary purpose of providing transplant material for somebody else. And if the umbilical cord transplant fails to work, for whatever reason, then pressure may well be on the resulting child to provide stem cells via more invasive harvesting procedures.

Peter Saunders is Managing Editor of Triple Helix

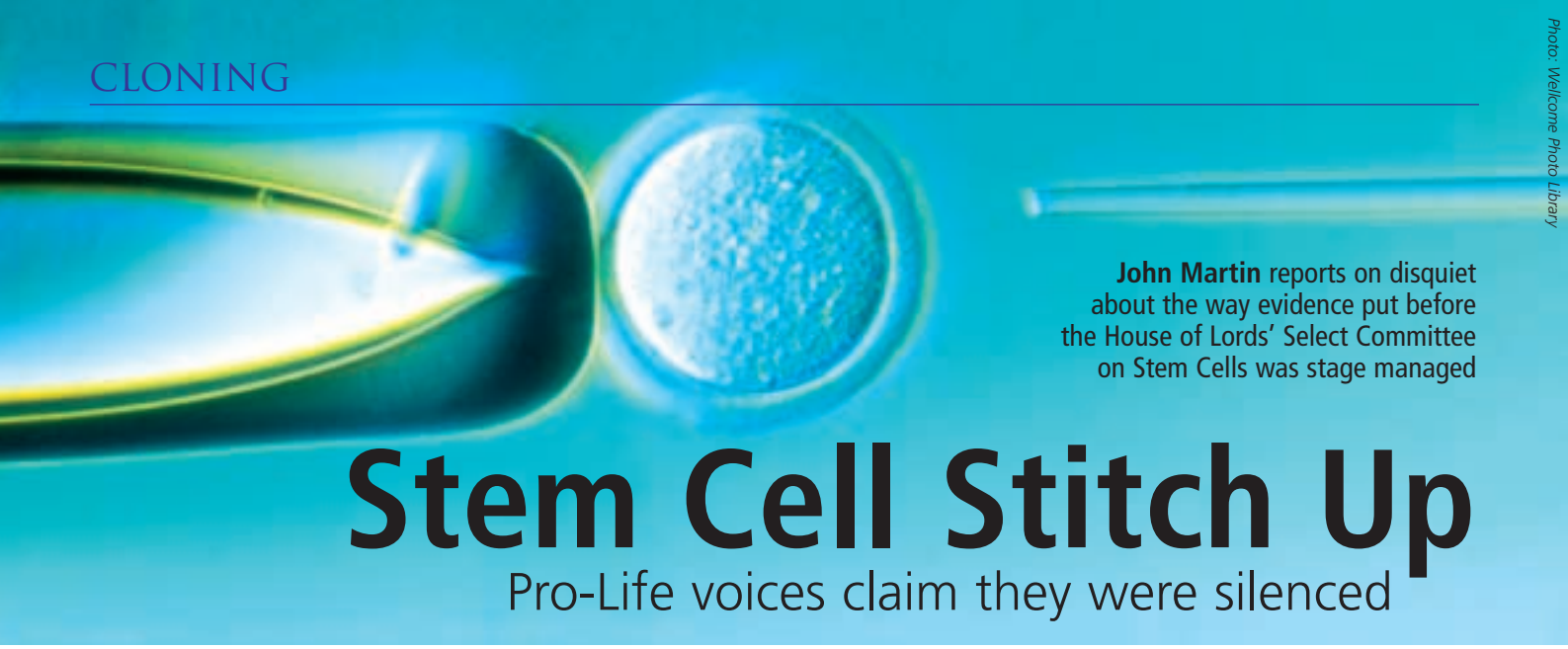


Photo: Wellcome Photo Library

John Martin reports on disquiet about the way evidence put before the House of Lords' Select Committee on Stem Cells was stage managed

Stem Cell Stitch Up

Pro-Life voices claim they were silenced

The religious press predictably headlined it 'Church backs cloning decision'[1] but the reality is more complex than that. What the headline boils down to is that the Board for Social Responsibility (BSR) of the Church of England threw its weight behind the recommendations of the House of Lords' Select Committee on Stem Cells. The BSR is mandated to advise the Church on matters of public policy. But there are thousands of Anglican churchgoers who have never even heard of the BSR and would not feel themselves bound one way or the other by its views. But this is just one small part of what looks very much like a 'stitch-up'. The Select Committee, chaired by the Bishop of Oxford, the Rt Rev Richard Harries, silenced voices that believed that stem cell research on human embryos was unethical and dismissed without giving a hearing voices wishing to put the case for an alternative - adult stem cell research.

The Committee's remit was to 'examine the ethical, legal, scientific, medical and commercial issues surrounding the Regulations as they stand'. There was a mountain of written evidence. The Committee heard addresses from over 43 persons with oral evidence from ethical, scientific and medical perspectives and the BioIndustry Association, but according to Pro-Life activists scientists who hold that adult stem cell research is superior to research on embryos were excluded and did not get a hearing. Pro-Life agencies also criticised what they see as failure to take into account legal issues raised by the recent Judicial Review sponsored by the Pro-Life Alliance.

The critics also pointed out an imbalance of representation of religious communities in the oral evidence. Only Church of England voices were heard from the Christian community. They claim that Muslim input was 'minimal' while no witnesses were called on behalf of the Sikhs and Hindus.

Lord Alton of Liverpool described the Committee's findings as 'disappointingly predictable, bereft of any new insights, ethically compromised, and already eclipsed by exciting new scientific developments in adult stem cells research'.[2]

He said the inquiry had been 'one-sided'. The appointment of a senior cleric (the Bishop of Oxford) to chair the enquiry had added to 'the general sense of cynicism' and was designed 'to give a cloak of respectability to a process that diminishes humanity and wantonly destroys life'.

He was critical, too, of the way scientific evidence was marshalled. 'The further appointment of an "impartial" scientific adviser to the Committee, who is himself a leading protagonist and practitioner, adds general contempt and cynicism about this risible process.'

The Committee, he said, had not only failed to give proper consideration to the case for adult stem cell research. It had 'failed to investigate the significant commercial interests driving the cloning agenda'.

Lord Alton said that Britain would now 'need to look to Europe and the USA to uphold the sanctity of human life and to demonstrate that the pursuit of scientific excellence does not have to involved the destruction of early human life'.

If Pro-Life campaigners are right and the selection of who would supply oral evidence to the Committee was relentlessly weighted towards those who argue for the benefits of cell nuclear replacement and embryonic stem cell replacement (CNR), stem cell research has a serious credibility problem. Such a stitch-up does no good for Parliament in a climate where more and more people are cynical about its relevance.

There are reputable scientific journals who at least voice disquiet about CNR. Meanwhile advances are taking place all the time in adult stem cell research. We have to hope and pray that truth will out.

Christian divisions

This turn of events makes absolutely clear what has been known for some time. There is a gulf between the Pro Life Movement and the Church of England (at least the Board for Social Responsibility at Church House and the Bishops in the House of Lords for whom it acts as a Civil Service). There is fault on both sides and the situation has not been helped by divisions among Pro-Lifers and the extreme tactics used by some of their allies in the USA.

More importantly it indicates a serious division between Anglicans and the Catholic Church over what is a defining issue in moral theology. As reported in the last issue of *Triple Helix*[3] a heavyweight brigade of theologians and ethicists, many of them Catholics, reject the arguments marshalled by the Bishop of Oxford in support of the use of embryos in stem cell research.

Indeed but for the interventions of the Catholic Church, in particular by Pope John-Paul II, few members of the general public would even have been aware of adult stem cell research as an option. So what price ecumenical advance now?

John Martin is Associate Editor of Triple Helix

References

1. *Church of England Newspaper*, 8 March, 2002.
2. Statement issued 27 February 2002.
3. Martin J. Cloning advocate under heavy fire. *Triple Helix* 2002; Winter:5,6

Peter May reports on clashes between consumers and scientists

Chronic Fatigue Syndrome

A report to the Chief Medical Officer by an independent working party has considered best practice in managing Chronic Fatigue.[1] But the working party's conclusions caused six resignations from its committee. The four medical specialists who resigned constituted the majority of the expert medical members. The working party had used a 'trident' approach to evaluating the medical evidence: trying to find consensus from research findings, considered clinical opinion and patients' anecdotal stories.

What is in a name?

The report adopts the name CFS/ME as an interim title for the condition, while an international USA-based group is currently looking for a more acceptable title. The term 'fatigue', according to the report, provokes 'strong loathing' from sufferers, who do not consider it to be their main problem. Many consider it demeaning yet it is the *sine qua non* of the illness. 'Myalgic' is inappropriate, as muscle pain is not a significant feature for many patients. 'Encephalomyelitis', implying inflammation of the brain and spinal cord, is plainly incorrect. There is no evidence for it. An acceptable title would remove unnecessary conflict that is present at the beginning of the important doctor/patient relationship.

Approaches to management

The working party identified three successful approaches to modifying the condition that are offered on equal terms. These are Cognitive Behavioural Therapy (CBT), Graded Exercise Programmes and Pacing. There is now good documented trial evidence for the first two but none at all for the third.[2,3] A number of clinicians advocate pacing as part of a 'common sense' approach to fatigue. Patients and patient self-help groups also advocate it strongly.

Cognitive Behavioural Therapy (CBT)

Evidence is accumulating that CBT helps most patients. The core components of this approach to CFS/ME include energy/activity management, establishing a sleep routine, goal setting and psychological support. Three out of four randomised, controlled trials found positive benefits. Few patients felt worse though only a few reported complete recovery. However, some patients refuse what they see to be a psychological treatment for what they perceive to be a physical illness. They need to be encouraged to take a holistic view of their illness, open to both physical and psychological interventions. The lack of general availability of CBT is a cause for concern.

Graded Exercise

Based on the belief that CFS/ME is maintained, though not caused, by inactivity, graded exercise seeks to offer a structured and supervised programme of gradual and increasing aerobic activities such as swimming or walking. This is initially based on the patient's current physical capacity. All three randomised controlled trials published so far have found varying degrees of improvement. Very few participants reported feeling worse, though patient surveys revealed more negative feedback for this than any other form of treatment, including drug treatments.

Pacing

The principles and practice of pacing are described in the 1994 task force report.[4] While some clinicians advocate pacing within a framework of graded exercise, there lies within this approach an internal contradiction. The theory behind pacing holds that the sufferer only has a certain amount of available energy (physical, mental and emotional) that is limited and finite. There is held to be a 'glass ceiling' that the patient cannot go beyond. Therefore, energy expenditure must be kept within budget throughout the day, maintaining a careful balance between expenditure and rest.

Critics maintain that if the patient is encouraged to believe that there is only so much energy available, there is no scope for increasing the amount of exercise. Bound by the conviction that their illness is essentially a physical condition, patients with strongly held beliefs about pacing are trapped into a lifestyle of persisting inactivity; this itself perpetuates the fatigue.

Inactivity is held by many clinicians to be a root cause of continued symptoms. Physical deconditioning has physiological consequences: muscle wasting, sleep disturbance, balance problems, autonomic dysfunction and loss of confidence may all result from it.

The Expert Patient?

Underlying the philosophy of the report is the view that patients should be encouraged to be experts in their own right and should become key decision makers in their own care.[5] Patients' fixed beliefs, not open to evidence or discussion, are not addressed in the report. However worthy it is, the approach of regarding the patient as an expert clearly would have limited usefulness in various other conditions. Patients are not always in the best position to evaluate treatments objectively.

The report advocates the various ME self-help groups without drawing attention to the dangers of prejudice and fixed beliefs propagated by some of these organisations; not least in denying psychological factors, denigrating psychotropic medications and promoting a rigid view of pacing.[6]

Christians will welcome the working party's approach of getting alongside and listening to a group of patients who often feel alienated from orthodox medical care and is vulnerable to alternative therapists' claims. They will be less welcoming of recommendations that are not soundly based in objective evidence, are undergirded by a new 'political correctness' and may leave patients trapped in their illness by their own false perceptions.

Peter May is a General Practitioner in Southampton

References

1. CFS/ME Working Group. *Report to the Chief Medical Officer of an independent working group*. London: Department of Health, 2001 *www.doh.gov.uk.cmo/cBound by fsmereport/index.htm.*
2. Bagnall AM, Whiting P, Sowden A, Wright K. *Systematic review on the effectiveness of interventions used in the treatment and management of chronic fatigue syndrome/myalgic encephalomyelitis (ME) among adults and children*. University of York: The NHS Centre for Reviews and Dissemination, 2001 *http://www.york.ac.uk/inst/crd/cfs.htm*.
3. Whiting P, Bagnall AM, Sowden AJ, Cornell JE, Mulrow CD, Ramirez G. Interventions for the treatment and management of chronic fatigue syndrome. *JAMA* 2001; 286(11):1360-68.
4. *National Task Force on Chronic Fatigue Syndrome, Post Viral Fatigue Syndrome, Myalgic Encephalomyelitis*. Bristol: Westcare, 1994.
5. *The Expert Patient – A new approach to chronic disease management for the 21st Century*. London: Department of Health, 2001
6. CFS/ME Working Group. *Op cit*: section 4.3.2

Evangelism is too important to leave to others, argues **Richard Scott**

Good news in the Surgery

We have greater access to non-Christians in a congenial environment than most fulltime ministers.

Christian GPs are aware that health includes a spiritual component. But to what extent should we take some responsibility for our patients' spiritual welfare? In particular, is it 'OK' to talk to our patients in surgery about Jesus? The Bible is quite clear about evangelism. We are told about the lost sheep, how the harvest is plentiful but the workers are few[1] and Jesus' great commission to go and make disciples of all nations.[2] Paul takes up the theme: 'how can they believe in the one of whom they have not heard? And how can they hear without someone preaching to them?'[3] If the exhortations to preach the Gospel are clear in Scripture, what reasons might there be for reluctance to do so in the surgery?

Not my job

Firstly, the surgery is not a church. Evangelism is primarily the job of the minister and a few others to whom special gifts have been given. The Bible fuels this view: 'It was he who gave some to be apostles, some to be prophets, some to be evangelists'.[4] Clearly, some Christians (eg. Apostle Paul and Billy Graham) have been given special gifts (and the time!) to be 'professional' evangelists. Does this let the rest of us off the hook? If we look at other Scriptures, it is pretty clear that it doesn't. Paul said, 'Since, then, we know what it is to fear the Lord, we try to persuade men'.[5] There is a hint of urgency here, which he further emphasised by saying 'for I am compelled to preach. Woe to me if I do not preach the gospel'.[6] Whilst he is clearly talking about himself here, the lesson for us is clear - and reflects what Jesus said himself: 'If anyone is ashamed of me and my words in this adulterous and sinful generation, the Son of Man will be ashamed of him when he comes in his Father's glory'.[7]

Peter goes further and makes a general comment: 'Always be prepared to give an answer to everyone who asks you to give the reason for the hope that you have'.[8]

His words teach that evangelism is a job for all Christians, at all times and in all places, including the surgery.

An abuse of trust

A second common objection is that we are abusing our position of trust as doctors by forcing our views on patients. Evangelism is therefore rather naughty, underhand, best kept secret and all right only as long as nothing goes 'wrong'. Wouldn't it simply be easier and less risky to preach the gospel elsewhere and leave our patients alone?

But to whom or what do we owe our allegiance? Is it to politically correct behaviour, our colleagues attitudes or to Jesus himself? Jesus memorably said, 'Give to Caesar what is Caesar's, and to God what is God's'.[9] Evangelism doesn't alter our service commitment and thus Caesar should have no cause for complaint. But Jesus also said: 'All authority in heaven and on earth has been given to me'.[10] We preach under his authority, at his command and with the very best interests of our patients as our goal. Rather than being underhand or somehow ashamed of evangelism, let us be bold for Christ in surgery, remembering that Peter teaches us to do so with gentleness and respect.[11] This is essential.

No time

A third objection to evangelism in the surgery is lack of time. Preaching the gospel, even to a couple of patients per surgery would surely lengthen the working day. I'd like to answer this point from two angles - firstly by looking at how we work and secondly by considering job satisfaction.

Certainly, if evangelism is merely added onto existing work patterns, it will increase consultation times. My own practice is to deal with simple complaints (eg. tonsillitis) relatively quickly, thus allowing myself more time for situations in which the gospel might reasonably be introduced (eg. depression). You may also wish to give some patients more time by altering your working practices. This limits the risk of burnout and allows us to give to God what is due him. How does evangelism in clinic affect the evangelist? Just as 'faith comes from hearing the message', [12] so our own faith increases as we speak the Word of God. Paul encouraged Philemon to share his faith, so that he would have a fuller understanding of Christ. [13] And it's fun! God's will is good and perfect but also pleasing [14] - evangelism isn't a chore, it's tremendously exciting and uplifting.

Getting practical

Does evangelism in the surgery work? Isaiah was clear that the words of God's mouth would not return to him empty [15] and we can be confident that fruit will develop. In 1996, Palmer reported sadly that only 5/30 Christian doctors in one seminar felt that it was right to use their position as doctors to evangelise. Unsurprisingly, when asked later how many of them had led others to Christ it was this same cohort of five. [16] We can expect God to reward our efforts similarly.

How, practically, can we introduce God into consultations? In my experience, having prayed for discernment and his words at the beginning of clinic, God speaks to us quietly about whom to present the gospel. My own particular focus is on depressed patients and anyone wearing a cross. The latter are often lapsed Christians who carry much guilt and welcome the chance to discuss their faith - truly fertile ground. The Christian notice board in the waiting room and glossy posters in my room act as talking points. Only last week a six-year boy read the words from John 8:32 on a poster and professed his belief in Christ. I was able to give him a Bible the next day.

Practically, having spoken to a patient about Jesus and gained his/her interest, what do we do next? Clearly, we can pray there and then if it seems right, give out a 'Knowing God Personally' or a gospel, but what then? This is where the Church comes in - I refer everyone to the local Alpha course and there is a fair take-up. I'm involved in the course and it's tremendously gratifying to see my patients attending and making commitments to Christ. Here are brief testimonies from two of my patients who attended the last Alpha course:

JC - a recovering alcoholic - 'I thank God for now I know he walks with me, hand in hand'.

JN - an elderly lady with cancer who died soon after the Alpha course - 'I have a greater understanding of my beliefs (and) have gained peace'.

We must ask ourselves, the question - why has God placed us with access to thousands of lost sheep? The parable of the prodigal son shows not only how pleased God is when people return to him but how desperate their plight is if they don't. People are dying for the lack of the gospel message; eternal separation from God in Hell is their future. It has been said that bringing someone to Christ is the greatest service that one man can render another. It is as if we are sitting in a lifeboat with the lifebelt in our hands. Our patients are floundering in the water and our lifebelt maybe their only chance for survival.

We are in a position second to none to reach the lost in our local area. We certainly have a greater access to non-Christians in a congenial environment than most fulltime ministers. Liz Croton, in a previous issue, talked about hospitals as funny, unique mission fields. [17] Jabez cried out to the God of Israel, 'Oh, that you would bless me and enlarge my territory'. [18] Our territory, our peculiar mission field, is our patients. If we ask God for the opportunity, he'll answer our prayer as he did Jabez. Evangelism is far too important a job to leave to others.

Richard Scott is a part-time GP in Cliftonville, Kent and formerly a medical missionary in Tanzania

References

1. Matthew 9:36-37
2. Matthew 28:19
3. Romans 10:14-15
4. Ephesians 4:11
5. 2 Corinthians 5:11
6. 1 Corinthians 9:16
7. Mark 8:38
8. 1 Peter 3:15
9. Matthew 22:21
10. Matthew 28:18
11. 1 Peter 3:15
12. Romans 10:17
13. Philemon 6
14. Romans 12:2
15. Isaiah 55:11
16. Palmer B. Should doctors evangelise? *Nucleus* 1996; October: 2-12
17. Croton C. Sharing Christ with Patients. *Triple Helix* 2001; Summer:16-17
18. 1 Chronicles 4:10

Evangelism is a job for all Christians, at all times and in all places, and Christian GPs are in a unique position to reach the lost in their local area. Sharing the gospel with patients is not an abuse of trust because God himself gives us the authority and salvation is their greatest need. We need to allow time for consultations in which the gospel might reasonably be introduced; but with prayer, discernment, selection and a sensible approach with good follow up evangelism ceases to be a chore and becomes tremendously exciting and uplifting.

Seyi Hotonu takes issue with new government proposals

Gay adoption

KEY POINTS

British adoption law is based on Judeo-Christian ethics, which make the welfare of the child paramount. But new government proposals, in an effort to increase adoptions, may extend the right to adopt to unmarried couples: both homosexual and heterosexual. The assumption that homosexuals will make good adoptive parents has its roots in contemporary postmodern ideology rather than evidence-based research. By contrast, an overwhelming weight of evidence shows that children with married parents fare best in life, having fewer behaviour and psychiatric problems and less anti-social behaviour. Whilst adoption is a Christian concept which is echoed in God's adoption of us into his family through Christ's death on the cross, homosexual adoption runs counter to Christian concepts of sexuality, family and child development.

Adoption is not a modern idea. Roman Civil law legislated adoption in order to provide a male heir for the estate. This sentiment is reflected in the adoption laws of various European and Latin American countries.[1] In contrast, British law is based on Judeo-Christian beliefs. Here adoption has always been used primarily to safeguard and promote the child's welfare.[2]

Concern for the welfare of the child is also the main impetus for the Government's current proposals on adoption fuelled by the increase in child abuse in children's homes. For currently there are about 55,300 children in care who are eligible for adoption.[3] In 1970 the number of adoptions nationwide was around 20,000 per year, but by 1999 it had fallen to 4,100. (This fall also reflects the growing incidence of abortion and the removal of stigma against having a child outside marriage.)

Under current adoption law children may only be adopted by married couples or a single person. Ninety-five per cent of adoptions are by married couples.[4] There are fears that an amendment to the Adoption and Children Bill may extend the right to adopt to unmarried couples: both homosexual and heterosexual.[5]

Homosexual parents per se are not a new phenomenon. Many children raised by homosexuals are born within marriage[6] but after their birth their father or mother declares same-sex preferences. The offspring of lesbians whose mothers have opted for self-insemination using donor sperm from either a sympathetic male[7] or a sperm bank[8] are fewer in number. Yet it is the emergence of this new type of family that has evoked support from social scientists. There have been many attempts to dismiss the adverse effects of this kind of relationship while claiming they provide all the benefits (and more) of two married parents.

This propaganda has had a dangerously misleading effect, and public policy has been influenced to the extent that homosexual adoption is seen as a viable option for children. The assumption that homosexual parents will make good adoptive parents has arisen despite a complete lack of data on the comparative effects of homosexual foster care or adoption, and the questionable interpretation of the available information about the effects of homosexual parenting.

Families with homosexual parent(s) are relatively uncommon and therefore recruitment is difficult. Consequently sample sizes are small, for example one often-quoted study that looked at gay fathers and their children interviewed only 40 men.[9] Similarly one of the most eminent studies, which followed up the children of single mothers, both lesbian and heterosexual, over 15 years, had 27 mothers and 39 children in each group at the beginning. However by the end of the study although 51 mothers were traced, only 25 children from the lesbian families and 21 children from the heterosexual families were willing to participate.[10] In many homosexual parenting studies, anecdotal evidence or personal opinion is repeatedly presented as fact. For example, one study, which created headline news reporting that gay dads make better fathers, was based on the opinion of about 100 men, some of whom were not even fathers but hoped to be in the future.[11]

Despite their flaws, these studies still show that between eight per cent[12] and 33 per cent[13] of children with homosexual parents subsequently adopt a homosexual lifestyle as adults. This consequence is explained by describing 'same-gender sexual attraction' as a positive trait derived from open-mindedness and acceptance of homosexuality.[14] Yet many adolescents are often afraid or too embarrassed to tell their peers about their home circumstances[15] and young children suffer from gender confusion. Thus 40 per cent of the sons of lesbian mothers displayed mainly feminine qualities whilst 50 per cent of their daughters showed mainly masculine qualities. By contrast, among the children of

What does the research show?

- Children born to cohabiting couples are twice as likely to experience a family break up compared to children born within a marriage. [18]
- The incidence of child abuse was 20 times higher for children living with their cohabiting parents compared to those living with their married parents. [19]
- Children in single parent households had maths and reading levels that were 11% and 10% lower than those of children with married parents. [20]
- Compared with children of married parents, children with unmarried parents were six times as likely to exhibit violent misbehaviour in school. [21]
- 87% of children with married parents graduated from high school, compared to 68% with a single parent at home. [22]
- Children in single parent households had risks of injury that were 20% to 30% higher than for children who lived with their married parents. [23]
- Boys raised outside of an intact marriage are, on average more than twice as likely as other boys to go to jail. [24]
- Being with a stepfamily or with a single mother at the age of ten more than doubled the chances of a boy being arrested eventually compared with the son of married parents. [25]
- Under 16s were three times more likely to run away from step-families, and twice as likely to run away from a lone-parent, than were children living with both birth parents. [26]
- Young men were 1.5 times more likely to be out of school and not working if their parents were not married. [27]
- Women who spent time with a single parent were 111% more likely to have teenage births, 164 per cent more likely to have premarital births and 92 per cent more likely to have failed marriages than daughters who grew up in two-parent homes. [28]
- When wives experienced parental divorce, the odds of divorce increased by half and when both spouses experienced parental divorce, the odds nearly tripled. [29]

heterosexual mothers, none of the boys had predominantly feminine characteristics or the girls predominantly masculine characteristics. [16] As the fifth commandment implies, children need a mother *and* a father as a role model with each parent providing a complementary but different perspective. Even lone- and lesbian-parenting manuals acknowledge this and often encourage the creation of an 'extended' family consisting of friends and past partners. [17]

The further away you move from the traditional family structure, the poorer the outcomes for children (see box). The largest study to compare children of married, cohabiting and homosexual parents, [30] even though it was carried out by someone with gay rights sympathies, showed that children of gay couples performed the worst in school followed by the children of cohabiting couples whilst the children of married couples performed the best.

Homosexual adoption is radically opposed to the Judaeo-Christian family ethic which views marriage as the only right context for sexual relations, procreation and childrearing. [31] Christian involvement in adoption and fostering is rooted in some central Christian beliefs. Paul argues that all Christian believers are adopted into God's family and have the full rights as sons. [32] This adoption is made possible only by Christ's sacrifice of himself on the cross in our place, as the substitute for our sins. As Christ said: 'Greater love hath no man than this, that a man lay down his life for his friends'. [33] Christians are to show this same love towards their neighbours because they themselves are beneficiaries of God's love in being adopted as sons. This is a very strong motivation to care for children in need, particularly for those who have no parents.

Dr Oluseyi Hotonu, worked with Patricia Morgan on her new book 'Children as trophies?' which reviews the research evidence on same-sex parenting. Copies are available for £8 (inc p&p) from The Christian Institute on 0191 281 5664 or www.christian.org.uk

References

1. *Macmillan Encyclopaedia* 2001
2. Hart C et al. *Children as trophies?* The Christian Institute 2002;11-13
3. *Adoption, Prime Minister's Review - http://www.cabinet-office.gov.uk/innovation/2000/adoption/html/02.htm*
4. *Surveying Adoption* 1998-1999, BAAF 2000;88
5. *The Independent,* 23 January, 2002
6. Bailey J et al. *Developmental Psychology* 1995; 31(1):124-129
7. *The Daily Telegraph*, 31 July, 1998
8. Chan R et al. *Child Development* 1998;69(2):443-457
9. Miller B. *The Family Coordinator* 1979;28:544-552
10. Tasker F. *American Journal of Orthopsychiatry* 1995; 65(2):203-215
11. Dunne G. The Different Dimensions of Gay Fatherhood. LSE Disc Paper Series 2000;4
12. Miller B. *Op cit*:546-547
13. In Bozett F *Homosexuality and Family Relations*, Haworth Press, New York, 1990:183
14. Tasker F. *Op cit*:212
15. Javaid G. *Child Psychiatry and Human Development* 1993;23(4):243
16. Hoeffer B. *American Journal of Orthopsychiatry* 1981;51:536-543; Hoeffer B. cited in Belcastro P et al. *Journal of Divorce and Remarriage* 1993;20(1/2):111-112
17. Morgan P. *Op cit*:108-109
18. Andersson G. Paper presented for the XXIVth IUSSP Gen Pop Conf in Salvador, Brazil. 18-24 August 2001
19. Whelan R. *Broken Homes and Battered Children*. London: FET 1993
20. Pong S. *Journal of Marriage and the Family* 1997;59:734-746
21. Sheline J et al. *American Journal of Public Health* 1994; 84:661-663
22. McLanahan S. Cambridge: Harvard University Press, 1994
23. Dawson D. *Journal of Marriage and the Family* 1991;53:573-584
24. McLanahan S and Harper C. Center for Research on Child Wellbeing Working Paper #99-03:25-26,40, 1998
25. Coughlin C and Vuchinich S. *Journal of Marriage and the Family* 1996;58:491-501
26. Rees G and Rutherford C. Homerun: *Families and Young Runaways*. The Children's Society, Briefing Paper, 2001:1
27. McLanahan S and Sandefur G. Growing Up with a Single Parent. Cambridge: Harvard University Press, 1994
28. McLanahan S and Bumpass L. *American Journal of Sociology* 1988; 94(1):130-152
29. Amato P. *Journal of Marriage and the Family* 1996;58:628-640
30. Sarantakos S. *Children Australia* 1996;21(3):23-31
31. See Leviticus 18:22; Romans 1:26-27; Matthew 5:27-28; 1 Corinthians 6:9
32. See Galatians 4:4-6
33. John 15:13 (AV)

Peter Pattisson gives an international update.

ICMDA

New frontiers

Warurua Mugo, Peter Pattisson, Ralph Sinn, Ricardo Zandrino.

What's happening on the international scene? Peter Saunders (PS) talks to Peter Pattisson (PP) on recent developments at the International Christian Medical and Dental Association (ICMDA).

PS: Peter, we hear that ICMDA has just appointed a new General Secretary to follow on from you. Can you tell us a little about him?

PP: *Ralph Sinn and his wife Barbara both graduated from the University of Alberta Medical School, Canada, in 1984. Ralph is a family physician practising in Edmonton, Alberta, with a special interest in general practice psychiatry. They have four children aged 7 to 13 and Barbara works two half days a week in general practice. Ralph attended the ICMDA's Executive Committee meetings in April last year and from that time the Lord began to lay on his heart a calling to work with ICMDA. The appointment was confirmed in February and Ralph expects to take up the position on 1 October. It has been agreed that ICMDA's international office will move from Cambridge to Edmonton, Alberta.*

PS: That certainly is a major move. ICMDA has always been based in UK. What implications do you see for CMF UK's role in ICMDA?

PP: *ICMDA's office at one time was within CMF's offices in Partnership House. ICMDA's office relocated to Cambridge ten years ago, in part to dispel the perception that ICMDA was simply the international arm of CMF UK. The move to Canada is a further step in internationalisation and will raise ICMDA's profile in North America. CMDS Canada already has heavy involvement in international programmes and is well placed to provide local support for the ICMDA office.*

PS: Canada – Yes. But isn't Edmonton a bit 'out in the sticks'?

PP: *In one sense, but in today's world of modern communications the actual office location is a secondary matter. As it is, we have almost no personal visitors to the office in Cambridge. We looked carefully at other options but Canada is as good a choice as any.*

PS: What about Europe? With so much happening in Europe at present, and so much need, do you think this will lead to a dilution of ICMDA's contribution in Europe?

PP: *No, part of ICMDA's strategy over the last two years has been to develop effective regional committees supporting and guiding adequately funded regional secretaries across the world and I have agreed to take up a role as Regional Secretary for Europe for up to two years while we develop the structures and look for a younger person for a substantive appointment. The next ICMDA European Regional Conference is in Germany in September 2004. I hope that by that time I will be handing over an effective ongoing programme.*

PS: Tell us a little about recent encouragements in ICMDA.

PP: *With over 50 affiliated national movements now ICMDA continues to grow. Dr Warurua Mugo in East Africa and Dr Ricardo Zandrino in South America as regional secretaries are both experienced in the work and widely respected. Last year we established committees in East Africa and South America to support them. As well as Europe, this year we hope to establish an effective committee in East Asia.*

The other area that is enormously encouraging is the student work. New groups among medical and dental students seem to be springing up all over the world. Mark Pickering has made a tremendous contribution in this area as ICMDA's Student Secretary. Over the next couple of years he too will be looking for his successor. Over Easter East African students are meeting for a retreat in Mombasa. ICMDA was able to make a grant to their travel expenses. In Zambia a large group of students from Lusaka is hoping to attend the Taiwan Congress, raising approximately £1,000 each toward their expenses from local sponsorship and support.

PS: You mention Taiwan and some of us are already coming to that World Congress in July. How are the preparations going?

PP: *Very well and we are looking forward to a great conference. The programme of plenary sessions and seminars is now tied up and the President of Taiwan will address the welcome dinner.*

When the bursary allocation committee met in February we had £65,000 to allocate, from the generosity of donors around the world. We expect to help around 150 people. Each delegate will contribute something, and many have been challenged to ask in faith for more than they initially indicated that they could contribute. We are particularly praying that there will be representatives from every country in East Asia as well as across the world. We know that these conferences have played a pivotal role in establishing and strengthening new national movements in the past.

PS: I'm a great ICMDA enthusiast. How can CMF support ICMDA more?

PP: *First I'd like to say a big 'thank you' to CMF and its members for all they are already doing through support, prayers, encouragement and financial generosity.*

I am particularly keen to establish ICMDA's development fund on a firmer financial basis. CMF members have contributed significantly to this and I hope that this will continue. Perhaps the move to Canada will help to internationalise our prayer and funding support. A number of CMF members are already checked in for Taiwan but there's plenty of room for more. Please come to encourage others and to be encouraged. Thank you CMF and let's have more of the same.

How Christ's love is touching children in Moscow. **Janet Goodall** reports

To Russia *with* love

A short visit to Russia last autumn took me to join Moscow's Christian Medical Mission (CMM) under the directorship of Dr Olga Polezhaeva. We visited two city orphanages and another in Tula district, near Tolstoy's old home. Each held about 50 orphaned or abused children, aged 5-16 years. Throughout Russia and the old USSR there are thousands of orphans, many even younger. Their care varies and I probably saw the best, with children as physically well cared for as $5 per head per month allows, plus $5 more a *year* allocated for health needs. Despite a few staff psychologists, many orphans must have deep emotional wounds. One young teenager had lost his natural parents and was then adopted by a couple who later died of alcoholism. In a few years time, he will either be alone in a State flat or a young soldier.

The team aims to examine and, if possible, treat the children and to share with them the practical love of Christ. Open evangelism could risk closed doors. The Russian Christian doctors currently have official permission to visit, with overseas doctors as their guests. 'Protestantism' is seen to be distinct from (and less desirable than) Russian orthodoxy, so it is love in action which gives entry and sometimes prompts further questions. Our trendy young psychologist went down well, with talks about saying 'No to drugs, tobacco and casual sex', but some children told him, 'We hate being in an orphanage - we want families, but nobody wants bigger children.' We left them a few educational videos with a Christian flavour, along with Bibles, small gifts, sweets and toothbrushes. At Yasnia Polyana, young church members from Tula performed Christian songs and sketches.

In the medical room, various pieces of equipment, sent to CMM as aid, allowed routine electrocardiography and abdominal and thyroid ultrasound for all. Gall-bladder disease was reported in 15% of orphans, so far with no control series. A new Russian laser beam therapy was in use for chest infections. This all indicated the shortage of more customary therapies which, apart from their expense, can be limited by import regulations banning any medication from certain drug companies and all narcotic drugs. Antibiotics and dental amalgam are costly or scarce so there is great reliance on overseas aid. More clinical teaching would be welcomed, too.

Church life of various kinds is active, but poverty can limit vision. My Christian interpreter, who had not visited an orphanage before, promptly took along a hairdresser friend to cut the children's neglected hair. Better still, as he told his church of the experience, a few Christian women asked if they could visit the children. This was a real thrill, as most orphans have little experience of home life. One of the directors, herself a resident, told me, 'I now believe that orphanages are prisons. Children need families.' There is a Christian project in Moscow which aims to link orphans with foster parents and soundings are now going on about reduplicating this facility, but it will need more cash. How lovely it would be if orphaned children could meet with Jesus as they are welcomed into loving Christian homes.

Members of the Christian Medical Association in Moscow share in CMM's ministry and try to meet weekly for prayer and Bible study. They are hard-pressed and wearied by trying so lovingly to care for so many, yet with minimal supplies. Even so, I was touched by their warm and generous welcome (and lovely singing!). They badly need practical help and supplies, but they also covet our support in prayer.

Janet Goodall is retired Pediatrician in Stoke-on-Trent

Orphans in Russia

The term 'orphan' includes approx. 90% social orphans, held in orphanages because of abuse or social deprivation, as well as children whose parents have died. Accurate figures are hard to come by. One estimate (circa 1990) suggested that 19,000 children were held in orphanages in St Petersburg alone, with 10,000 more abandoned or living rough in that city.[1] Rising levels of unemployment and alcoholism since then must have sent even more children into institutional care.

Many such children are too readily labelled 'oligophrenic' (mentally retarded) but without adequate evaluation, little or no special education and rare review. One independent study found that 66% of 82 children from 10 institutions were within the normal range on non-verbal developmental and IQ testing.[2] It is hoped that interventions by Baroness Cox and others will gradually improve matters, but as ever, there is inadequate funding even for existing levels of care.

References

1. *Trajectories of despair: misdiagnosis and maltreatment of Soviet orphans.* Ed Caroline Cox, Christian Solidarity International (CSI) ISBN 3 9520345 3 3
2. *Scientific results of tests carried out by the CSI group in September 1991.* (ibid p35).

Three GPs give their perspective on asylum seekers.

Caring for refugees

KEY POINTS

People seek refuge in another country to escape natural disasters, poverty, famine, war and persecution; and many asylum seekers have genuine tragic stories to tell. But even if they overcome the difficulties and dangers of travel, the administrative, financial, psychological and cultural hurdles of adapting to their new home are considerable. God has a heart for the poor and vulnerable, and many of the key players in salvation history, including Jesus Christ himself, have been refugees. Christian doctors therefore have a huge role to play and, if we are willing to make ourselves available, there are good ways to overcome language barriers and offer effective treatments, even to victims of torture.

Asylum seekers are frequently portrayed as bogus or economic migrants who enter the country illegally and should be locked up and sent back where they came from. One of these statements is true: if you are forced to flee your country there are few ways of doing it legally. Many have tragic stories and very genuine grounds for claiming asylum but inevitably there are some who have less than honourable motives.

The 1951 Geneva Convention defines a refugee as: 'One who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country'.

At the beginning of 2000, there were more than 22 million displaced people worldwide. 75% were seeking refuge in another region of their own country or in the developing world. Only four percent were seeking asylum in Europe with less than one percent in the UK.[1] There are various reasons for seeking asylum in another country, mostly unchanged over the centuries. Natural disasters, poverty and famine still compel their victims to move to a place of safety. War and civil war uproot innocent people from their homes en masse in fear for their lives. Alternatively individuals or specific groups find themselves the targets of violence. Governments may persecute various religions as well as cultural, ethnic and political groups. Ineffectual or corrupt government causes situations of lawlessness and political instability. Individual refugees may be strong idealists, active in politics and aware of possible recrimination, or unfortunates, born in the wrong place at the wrong time to families on the wrong side of the conflict.

The UK situation

Refugees come to the UK as single men or women, couples, unaccompanied children, single parents with children or whole families. Their reasons for seeking asylum may include persecution, imprisonment, torture or rape. The journey out of their home environment may have been hazardous and uncomfortable. Many have stayed in basic conditions at a refugee camp and travelled in cramped lorries or walked long distances. Human traffickers are often the only option for a successful journey and they charge huge fees, requiring refugees to sell all their possessions.

On arrival in the UK they are met with a whole series of new challenges. Escape had been a dream: their Utopian destination often fails to meet expectations. They are confronted by the Home Office and NASS (National Asylum Support Service) and a confusing asylum system: it is easy to stumble at various hurdles and so be refused asylum on grounds of non-compliance. The housing is usually in the poorest of areas. The subsistence living allowance consists largely of vouchers, instantly identifying the bearer as an asylum seeker. Racist attacks and attitudes are not uncommon. Communication is often a struggle increasing their isolation. The asylum seeker's life is a perpetual waiting exercise involving intense anxiety, boredom, frustration and loss of status.

Top seven countries of origin of refugees arriving in UK

- Afghanistan
- Somalia
- Iraq
- Sri Lanka
- Turkey
- Iran
- Former Yugoslavia

Since April 2000, asylum seekers arriving in the UK have been dispersed around the country while awaiting the government's decision on their claim to be recognised as refugees. Over this time their

Runaways: fear of reprisal

- Moses - murdered an Egyptian - Exodus 2:15
- Jacob - took Esau's birthright and blessing - Genesis 27:43
- Onesimus - runaway slave - Philemon 10-17

Economic migrants

- Abraham - escaped famine to Egypt and lied to protect his life - Genesis 12:10-20
- Naomi's family - escaped famine to Moab - Ruth 1:1-2

Escaping danger

- Elijah - stood against an evil regime - 1 Kings 17:2-3, 19:2-4
- Jesus with Mary and Joesph - escaped King Herod's wrath - Matthew 2:13-14
- Church in Jerusalem - scattered following Stephen's martyrdom - Acts 8:1-3

Driven out

- Joseph - sold into slavery - Genesis 37:28
- Israel - exiled into Assyria - 2 Kings 17:23b, 25:21b
- Judah - exiled into Babylon - 2 Kings 25:21b
- Priscilla and Aquila - Jews ordered out of Rome - Acts 18:2
- John - exiled to Patmos - Rev 1:9

presence has become a prominent political issue. As Christians and as doctors we are more likely than ever before to come into contact with these individuals in our communities, surgeries, clinics and wards.

A biblical perspective

The Bible makes it clear that God is sovereign over all peoples: his plans and purposes will prevail.[2] He is compassionate and just, concerned for the poor and vulnerable from every nation.[3] He wants everyone to know the truth and experience his saving grace.[4]

In a world rife with conflict, displacement and terror, the prophet Micah gives a vision of hope: nations looking to the Lord for his truth and justice, resulting in freedom from fear, every person safe in his own home and land.[5]

Refugees in the Bible

In apparently unlikely circumstances, godly refugees influenced the destiny of their host nations: consider Joseph in Egypt, Daniel in Babylon and Esther in Persia. Jesus made it clear that his disciples would be hated by the nations and would flee from their homes.[6] So, the scattered church spread the good news of Jesus wherever they went.[7]

The Bible acknowledges the psychological impact of being forced to leave one's beloved country.[8] The Old Testament is insistent concerning the responsibility of God's people towards foreigners.[9]

Translation and Torture

GPs working with refugees and asylum seekers face several specific challenges, two of which are communication using interpreters and dealing with patients who have experience of torture.

A while ago a hospital colleague told me that his department had opted out of providing interpreters as it was too much hassle. This is obviously nonsense. There must be full understanding between doctor and patient before prescribing a medicine or performing an operation. If not, why practise medicine instead of veterinary science? Working with an interpreter is not easy. It takes great effort to speak normally, using eye contact and the second grammatical sense, whilst your patient looks at you blankly, waits for the interpreter to say his bit. Nevertheless, if you are motivated and have a motivated interpreter, the effort will be worthwhile. Suddenly the consultation seems to 'gel' with both patient and doctor almost unaware of the interpreter.

Some fascinating research shows that doctors and nurses tend to avoid ward patients who are terminally ill. Sexual abuse victims often complain that no one appeared interested when they wanted to talk. Torture victims equally find themselves ignored and sidelined by health professionals. This can be an expression of doctors' own fears of death, impotence or shattered illusions. However, giving in to our fears means denying care to those who need it most.

How should we provide adequate care for survivors of torture?[10,11] Firstly, make yourself available to these patients. Their stories are hard to listen to but many survivors find relief in simply being heard by someone without being rejected. It can be the first and most important step to recovery. Secondly, there are many forms of helpful therapy: physiotherapy can have almost miraculous results, cognitive behavioural therapy may be beneficial and medication is sometimes necessary. However, unless we listen in the first place, patients may not return to benefit from these therapies.

Opportunities

There are many medical opportunities to become involved with refugees.[12] There are several medical organisations with concerns for asylum seekers and torture victims.[12,13] Many churches are also leading by example in providing drop-in centres where second-hand clothes and other articles can be obtained. Opportunities abound for offering friendship.

We are reminded of Jesus' words: 'I was a stranger and you invited me in…Whatever you did for one of the least of these brothers of mine, you did for me'.[15]

Rebecca MacFarlane, Katherine McKenzie and Peter von Kaehne are salaried GPs caring for asylum seekers and refugees.

God is compassionate and just, concerned for the poor and vulnerable from every nation.

References

1. Scottish Refugee Council Briefing Paper. UNHCR, January 2001
2. Isaiah 14:24-27; Psalm 33:10-11
3. Psalm 140:12; Acts 10:34-35
4. 1 Timothy 2:3-4
5. Micah 4:1-5
6. Matthew 10:22-23, 24:9
7. Acts 8:4
8. Psalm 137
9. Exodus 22:21, 23:9; Leviticus 19:33, 24:22, 25:35; Deuteronomy 24:14,17; Psalm 146:9
10. Burnett A, Peel M. Health needs of asylum seekers and refugees. *BMJ* 2001; 322 (7285):544-7 (3 March)
11. Burnett A, Peel M. Asylum seekers and refugees in Britain. The health of survivors of torture and organised violence. *BMJ* 2001; 322:606-609 (10 March)
12. Von Kaehne P. Working with refugees and asylum seekers. *BMJ* 2001; 322:S2-7287 (17 March)
13. Physicians for Human Rights. Examining asylum seekers – a physician's guide to medical and psychological evaluations or torture. *www.phrusa.org/publications/asylum_report.html*
14. Medical Foundation for Care of Victims of Torture. *www.torturecare.org.uk*
15. Matthew 25:35,45

John Griffin revisits north/south drug inequalities.

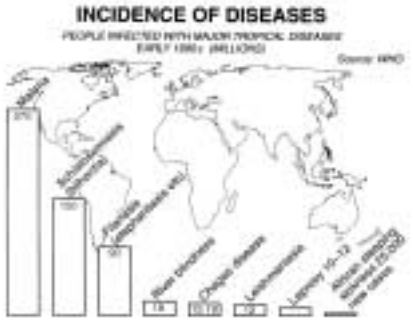
Developing World Drugs

THE BULK OF NEW CHEMICAL ENTITIES LICENSED HAVE BEEN LIMITED TO... CONDITIONS WHICH ARE LARGELY CHRONIC AND OCCUR PRINCIPALLY IN THE AFFLUENT WESTERN COUNTRIES.

The recent publication by *Medicines sans Frontiers* entitled 'Fatal imbalance: the crisis in research and development for drugs for neglected diseases' has caused considerable interest in the press.[1] The report describes the research and development activities of eleven major pharmaceutical companies, representing combined sales of nearly $117bn (£78bn). In the last financial year, eight of the eleven companies spent nothing on research and development into sleeping sickness, leishmaniasis or Chagas' disease. One company did not answer the question. Two reported spending on malaria and five reported spending on tuberculosis, but seven reported spending less than 1% of their research and development budget on any of the five diseases highlighted. The authors commented, 'Drugs are not developed according to public health need but according to profitability'.

In fact, not much has changed in the last twenty years. In 1979 Prof Franz Gross wrote, 'the concentration of research efforts on a relatively small number of fields, which look promising from a commercial point of view, has had the consequence of a crowding in some areas of research and a neglect of others'.[2] Similar views were expressed in 1981 by Griffin and Diggle[3] who wrote, 'The bulk of new chemical entities licensed have been limited to a relatively small number of therapeutic groups...in fact conditions which are largely chronic and occur principally in the affluent Western Society. Innovation is therefore directed towards commercial returns rather than therapeutic need. The pharmaceutical industry like any other major industry is of necessity motivated by the need to be profitable'. Diana Melrose of Oxfam[4] reported in 1983 that only one to three per cent of the international pharmaceutical industry's total research and development allocations is devoted specifically to tropical diseases.

One has to be careful of taking these comments as an outright condemnation of the research based pharmaceutical industry - this would be naive.



Incidence of diseases. People infected with major tropical diseases (millions). World Health Organization.

Type	Orphan	Definition
I	diseases	rare diseases for which treatment would be very expensive to research
II	medicines	medicines that are not developed as their target populations are too poor to afford them
III	patients	Patients who are too poor or isolated to afford existing treatments

Taylor and Griffin[5] writing on the subject of '*Orphan Diseases, Orphan Medicines and Orphan Patients*' in 1985 dissected the issue into three categories of orphan. First, those cases in which the condition to be treated is prevalent only in a very small section of the global population. Type I orphans suffer from rare diseases. In such instances, the ratio of the costs of research, development and production against projected market earnings and the overall levels of welfare to be generated may be so high as to discourage investment in the area.

The second group, type II orphans, describes the category where medicines likely to benefit very large numbers of people are not being developed because the people who suffer from these diseases are very poor and are not usually served by adequate health care systems. Here the conditions most likely to be involved are tropical diseases. In

In Rwanda only 500 patients are receiving AIDs drugs because the cost of $140 per month is half the average yearly income.[7]

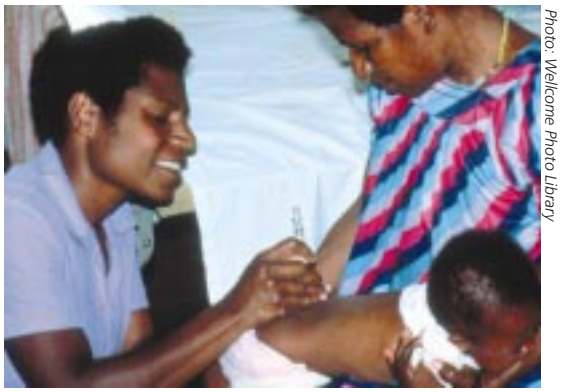


Photo: Wellcome Photo Library

some environments, type III therapeutic orphans exist where effective remedies are freely available on the world market, but for economic or other distribution reasons they are simply not available to those who need them.

Dealing with type I and type II orphans requires considerable research and development expenditure. The development of a new chemical entity costs between £500 - £800 million. Pharmaceutical companies cannot invest sums of money of this magnitude without any possibility of recouping these costs. It has been calculated that in the current economic climate only one out of five new chemical entities recoup their research costs so 'block-buster products' fund the companies' overall research and development expenditures.

In the developed world, type I orphan drugs which are able to exploit American, European and other 'orphan drug' provisions can fund their research and development costs by charging health authorities a premium price for such products. However, no such opportunity exists for type II orphans. Pharmaceutical companies have a responsibility to their shareholders to provide return on investment. If there is an inadequate return on investment, a company's share price falls and this could be catastrophic for the future of the company, and any research and development it might undertake; this would inevitably lead to job losses.

The suggestion by *Medicines sans Frontiers* that governments should become involved in tackling the problem of type II orphans is not new and was advanced by Taylor and Griffin who stated: 'Governments should be encouraged to support ongoing initiatives like UNDP/World Bank and WHO special programme'. However, it has to be remembered that several western governments including that of the UK have reduced their funding of academic tropical research, and some nations have been slow in paying their contributions to the UNDP/World Bank/WHO programme. *Medicines sans Frontiers* also makes recommendations for technology transfer and increased research and development in developing countries, a proposal similar to that made by Sir John Vane (Nobel Prize Winner) as long ago as 1985.[6]

Future circumstances are likely to change. The re-emergence of tuberculosis in the western world and the appearance of malaria outside areas conventionally regarded as malarial risk areas, are serving as stimuli to increase government sponsored research in these areas. The increased resistance of the malarial parasite to existing anti-malarial agents, and increased travel for military, business and pleasure are also raising the demand for new anti-malarials and other treatments for tropical diseases. These demands by the developed world will have consequent beneficial effects for the citizens of developing countries.

In theory, the problem of type III orphans should be easier to deal with given good will. In recent months, a number of pharmaceutical companies have made considerable price reductions for their products for HIV/AIDs treatment, albeit under pressure. They have done this despite understanding from past experience that such dual pricing can lead to the re-export of low priced products back from recipient developing world countries into the markets of the developed world by unscrupulous governments or wholesale dealers seeking windfall profits. Furthermore, for nearly two decades, Merck Sharp & Dohme have provided generous and unlimited free supplies of ivermectin for the treatment of onchocerciasis in Africa, but this altruism of pharmaceutical companies is frequently ignored by activist groups. Attempts by developing countries to import from other developing countries products that do not conform to the patent agreements of TRIPS (trade related aspects of intellectual property rights) has resulted in the supply of defective rather than cheap drugs.

For many countries even cheaply priced HIV/AIDs treatment is not an option since they cannot afford to buy any treatment at all. For these type III orphans the only chance is free medicines and they will benefit from UN Secretary General Kofi Annan's initiative in setting up a Global AIDs and Health Fund with a $1.4 billion capital and a target spend of $7-10 billion per annum.

In conclusion, the situation as identified by Medicines sans Frontiers is neither satisfactory nor new. Realistic solutions have to be sought, but it has to be tackled by governments, the UN and WHO, not by charity from individual pharmaceutical companies. The developed countries must be made to realise that they are stewards but not the owners of the resources they have, and that these should be used responsibly.

John Griffin is an Independent Consultant to the Pharmaceutical Industry

KEY POINTS

A recent report on 'neglected diseases' by Medicines Sans Frontiers has concluded that 'drugs are not developed according to public health need but according to profitability'. Orphan diseases, orphan medicines and orphan patients still exist. Developed countries are stewards, not owners of their resources and, whilst there have been some encouraging developments, there is still much to be done which will require Western governments, the UN, WHO and pharmaceutical companies to work together.

References

1. *www.doctorswithoutborders.org/publications/reports/2001/fatal_imbalance_short.pdf*
2. Gross F. Constraints of drug regulations on the development of new drugs. *Arch Toxicol* 1979; 43:9-17
3. Griffin JP, Diggle GEA. Survey of Products Licensed in the United Kingdom from 1971-1981. *Br J Clin Pharma* 1981; 12:453-463
4. Melrose D. Better Pills. Oxford: Oxfam 1983
5. Taylor DG, Griffin JP. Orphan Diseases, Orphan Medicines and Orphan Patients. *Medicines: Research Regulation and Risk 2nd Ed*. Belfast Press: 421-430. (Paper first presented 1985 at a Conference on Orphan Drugs at Leeds Castle)
6. Vane J, Gutteridge W. *World Health*. May 1985: 21-23.
7. Scrip 29th August, 2001 p 23

Huw Morgan focuses on how to deepen the doctor-patient relationship.

Spirituality of the Consultation

I have learned
To look on nature, not as in the hour
Of thoughtless youth; but hearing often-times
The still, sad music of humanity,
Nor harsh, nor grating, though of ample power
To chasten or subdue. And I have felt
A presence that disturbs me with the joy
Of elevated thoughts; a sense sublime
Of something far more deeply interfused,
Whose dwelling is the light of setting suns,
And the round ocean and the living air,
And the blue sky, and in the mind of man[1]

Spirituality is a rather fashionable word these days. All kinds of human endeavours are described as having a spirituality. It would be easy to dismiss this as woolly minded sentiment, which perhaps sometimes it is, but I believe that there is merit in looking beyond our instinctive prejudices to examine one fundamental aspect of medical practice that above all lends itself to spirituality. The consultation between the doctor and the patient, that cornerstone of medical activity, has been subject to much analysis but little has been written about the spiritual aspects of it.

MEDICAL PRACTICE IS FREQUENTLY BUSY, TIRING, FRUSTRATING, AND STRESSFUL, BUT ALSO OFFERS THE POSSIBILITY OF SPIRITUAL CONTACT BETWEEN DOCTOR AND PATIENT WHICH TRANSCENDS THE PRESSURES AND STRAINS.

I will attempt to define spirituality and then consider how it might be recognised in the consultation. A brief but illuminating definition of spirituality is given in Ewert Cousin's book on 'Christian Spirituality: Origins to the Twelfth Century'[2] where it is described as that which 'focuses on that inner dimension of the person called by certain traditions the spirit. This spiritual core is the deepest centre of the person. It is here that the person is open to the transcendent dimensions; it is here that the person experiences ultimate reality'. Many encounters with patients involve that deepest centre of the person, whether the doctor's or the patient's or both. There is that sense of 'something far more deeply interfused' that Wordsworth describes above, the sense that we are standing on holy ground.

Few authors attempt to discuss the spirituality of the consultation. One exception is Toon[3] who touches on it in his treatise of the virtuous practitioner. He argues that medical practice can and should be based on the virtues categorised in the western Christian tradition, such as fortitude, faith, temperance, charity and hope. These will encourage the doctor to act with compassion, humility and responsibility. The virtues Toon describes are ultimately spiritual, even though he regards them as the traditional precepts of secular

moral thinking. I will attempt to summarise the factors that seem to me necessary for the spirituality of the consultation to emerge.

Being There

Firstly, there is the all-important matter of being there for the patient. This means much more than simple availability, although that is a necessary prerequisite. It involves the deliberate focussing of attention on the patient and their problems to the extent that they perceive that the doctor is truly concerned about them. With time and practice, it is possible to give the *impression* of focussed concern by means of the appropriate use of communication skills, and no doubt all doctors do this from time to time when under pressure. This is not the ideal, however, and whilst good communication skills are necessary to establish rapport with the patient, to truly be there for them requires an effort of heart (I can think of no better phrase) which goes beyond techniques of communication and that the patient is likely to discern and appreciate. It is hard to define exactly what this is, but probably both the patient and the doctor know, in some intuitive way, when it has occurred. The result is a deepening of the doctor-patient relationship in a way that leads to more rewarding consultations and increases the likelihood of the patient being healed; in other words, becoming whole rather than just recovering from sickness.

Meaning

Secondly, there is the issue of meaning within the consultation. I believe that spirituality tends to emerge in consultations that are highly charged with meaning for the patient or even the doctor. The patient who is concerned about the meaning of their symptoms or trying to come to terms with the meaning of an established illness or who is revealing to the doctor the meaning that they perceive, is demonstrating an openness of heart and soul that may stir the depths of the doctor who is trying to be there with them. Whilst this happens more commonly with serious and long term illness, it can also occur in brief but intensive fashion when a patient is concerned about a symptom that they fear could portend major disease. To understand the meaning of the illness as perceived by the patient is therefore one of the most important tasks in the consultation so to fail here will leave the patient unsatisfied. For example, all GPs are familiar with the healthy person who consults with unremarkable headaches who, when given time and space, reveals that a friend has just had a stroke or died of a brain tumour. Once the meaning is understood by the doctor, and the patient knows that the doctor understands, the spirituality of the consultation can emerge.

Compassion

Thirdly, there is the matter of the heart being moved. This is not the same as the effort of the heart to be there for the patient which I describe above, but is a spontaneous 'gut reaction' which cannot be produced at will or manufactured. It occurs in response to the giving of time and understanding to the patient. When the doctor understands the meaning of their illness to the patient, he may find that his heart goes out to them as he experiences a genuine sense of empathy with them. Perhaps the word compassion describes this, and although compassion is more commonly thought of as a virtue, what I am describing here is something that arises without any moral effort on the part of the doctor. It is in being there and seeking to understand that the moral effort occurs; compassion may or may not follow. When it does, it seems to add a further dimension to the healing quality of the consultation, as though the patient senses the doctor's compassion for them and this helps them to return to wholeness. They are likely also to respond with gratitude and appreciation to the doctor as their own heart perceives the spiritual contact that has occurred between them and their doctor.

Conclusion

Once all these elements are present, the doctor and the patient together may be aware that they are hearing 'the still, sad music of humanity…of ample power to chasten and subdue…A presence that disturbs…with the joy of elevated thoughts… Whose dwelling is…in the mind of man'.

To be unaware of this transcendent aspect of the consultation seems to me to be blind to part of the fundamental reality of being human, for surely all of us have experienced that sense of the whole being greater than the sum of the parts which occurs when we truly communicate with the other person. Here we touch, in some mysterious way, the ultimate reality that surrounds us all as we encounter within each other God in whose image we are made. Jesus said: 'Whatever you did for one of the least of these brothers of mine, you did for me'.[4]

Medical practice is frequently busy, tiring, frustrating and stressful, but whilst it continues to give a central place to the doctor being there for the patient to come to with their problems through the many ups and downs and perhaps long years of life, it will continue also to offer the possibility of that spiritual contact between doctor and patient which transcends the pressures and strains. As such, it will remain essentially an enjoyable privilege to be a doctor and to spend one's working life encountering the deepest realities of the human condition.

Huw Morgan is a General Practitioner in Bristol

The consultation between doctor and patient is a 'spiritual encounter'. To let the spirituality of the consultation emerge, we must first 'be there' for the patient. This requires an effort of the heart which goes far beyond just having good communication skills. Next we must understand the true meaning of the illness for the patient, from the patient's perspective. Finally, as we give our time and attention we will find our hearts being genuinely moved in empathy and compassion. As we encounter the deepest realities of the human condition in our patients, this spiritual contact in turn will help us to face the stresses and strains, and medicine will continue to be an enjoyable privilege.

References

1. Wordsworth W. *Tintern Abbey* 1978
2. Cousins E. *Christian Spirituality: Origins to the Twelfth Century*. Routledge and Keegan P 1986
3. Toon P. *Towards a Philosophy of General Practice: a study of the virtuous practitioner*. London: Royal College of General Practitioners 1999
4. Matthew 25:40

EUTYCHUS

Dilly-Dally Dolly

Dolly the cloned sheep has arthritis, further evidence that she is 'old before her time'. Certainly her telomeres - end-chromosomal DNA fragments which shorten with each cell division - are shorter than would be expected for a sheep of her age. And we do know that cloned animals are ten times more likely to die in utero and three times more likely to die shortly after birth. And yet still the Lords' Committee on Stem Cell Research remains confident that embryos produced by the 'Dolly method' of cell nuclear replacement (CNR), hold our best hope for the treatment of degenerative conditions like Parkinson's disease. Have I missed something here?

Damned if we don't

A new French law forbids disabled children from seeking damages simply for being born. But parents can still seek compensation if their child's condition has been missed in prenatal examination through doctor error. Doctors, fearing higher insurance costs, are outraged by the decision which they feel will condemn them for not diagnosing malformations with 100% certainty. And yet the malformations are being sought only to allow the option of abortion. The Hippocratic Oath condemns doctors who kill. But this new law condemns doctors who don't search and destroy with perfect precision.

(*BMJ* 2001;323:1384, *BMJ* 2002;324:129)

Hope for Superman?

Will research on cloned human embryos really help Christopher Reeve's quadriplegia? The nervous system is notoriously complicated, and attempts to replace lost cells have so far met with disaster (eg. use of cells from aborted foetuses put into the substantia nigra to treat Parkinson's disease, resulting in excess dopamine and irreversible side-effects). Superman might look to adult stem cell research, which has shown promise in nerve regeneration in rats, but perhaps he first needs to look towards the creator.

Speciesism?

Sir David Steel was the prime mover for the 1967 Abortion Act and was also, ironically, the parliamentary presiding officer when the Protection of Wild Mammals (Scotland) Bill was recently debated in the Scottish Parliament. The subsequent vote banned fox hunting. Foxes have a gestation of seven to eight weeks, so a baby (born) fox is a little younger than ten weeks, the average gestational age of the180,000 (human) babies aborted each year by doctors in the UK.

(*Guardian* 2002; 13 February)

Misappropriated funds

The latest financial accounts for the high-profile charity Comic Relief show that, in the twelve months to June 2000, £51,953 was paid to abortion provider Marie Stopes for projects in Africa. SPUC national director John Smeaton commented: 'Anyone with a conscience would not support Comic Relief if they knew their money was being used to kill unborn children'.

(*Catholic Herald, SPUC News Digest*; 8 February).

Chinese clones?

Chinese scientists claimed on 6 March to have cloned 'dozens' of human embryos in the last two years. They told the *Wall Street Journal* they were working to create their own unlimited stem cell line and had already tried producing stem cells by fusing human tissue into a rabbit egg. The aims await independent verification.

(*Metro* 2002; 7 March)

Alzheimer's breakthrough?

A Chicago woman due to develop early onset Alzheimer's disease has given birth to a baby free of the mutation which causes the affliction. The baby was produced from an embryo after preimplantation genetic diagnosis. Embryos carrying the same 'defect' as the mother were discarded.

(*The Times* 2002;1, 27 February).

Conjoined conundrum

The mother of twin girls, conjoined at the heart and due to be born in April, has signalled her intention to have them separated. The operation, scheduled to take place at Great Ormond Street in London, will result in the stronger twin Natasha getting the heart. The weaker twin Courtney will die. Tina May, the 23 year old Catholic mother, who refused abortion on religious grounds, is quoted as saying: 'I am proud of my religion and it is important to me, but I won't let it come between me and my family's happiness'. If not separated, both babies are likely to live, possibly indefinitely .

(*The Tablet* 2002;46, 9 February)

Reproductive complications

Infants conceived with use of intracytoplasmic sperm injection or in vitro fertilization have twice as high a risk of a major birth defect as naturally conceived infants, according to a Western Australia study.

(*New England Journal of Medicine* 2002;346:725-730, 7 March)

Copycat

The birth of the world's first successfully cloned cat has been announced by US scientists. The kitten named 'cc', the first to be born alive out of 87 cloned cat embryos transplanted into eight cats, was born on 22 December 2001 at Texas University.

(*Guardian* 2002; 15 February)

New role for TV soaps?

TV soaps should show more teenagers getting sexually transmitted diseases (STIs), in order to add a touch of realism to the portrayal of relationships, according to *the British Medical Association*. STIs, taken together, increased by nearly 300,000 between 1995 and 2000. Vivienne Nathanson, head of Science and Ethics at the BMA blamed the rise on poor sex education in schools, a 'desperate' lack of clinics and people not remembering the 1980s Aids campaigns. What about parental responsibility?

(*The Times* 2002;9, 27 February)

OPPORTUNITIES ABROAD

Specific Vacancies by Continent and Country

Posts often require you to be **UK based** with your own **financial** and **prayer support**. The contact details given are to enable you to start researching possibilities. For many other posts see previous issues of *Triple Helix* and recent issues of ***HealthServe***. (Contact them at Barker House, First Floor, 106-110 Watney Street, London E1W 2BR Tel: 020 7790 1336 Email: info@mmahealthserve.org.uk www.mmahealthserve.org.uk)

AFRICA

Cameroon

Meskine Hospital needs a **physician/GP** willing to include simple on call surgical cover, a surgeon willing to include medical cover, an ophthalmologist and other health professionals. Need flexible attitude, basic French (training available), short tropical medicine course. Community relations excellent. Family environment with school on site. **Contact** Dr Mark Houghton (Action Partners Ministries), 45 Crimicar Drive, Sheffield S10 4EF Tel: 0114 230 2162 Email: mhoughton@doctors.org.uk

Chad

Action Partners require **GP** to work in Ndjamena among English-speaking families. Referral options limited. Air ambulance involved occasionally. French and some tropical medicine required and readiness to develop links with other health providers, local and expatriate. **Contact**: Dr Mark Houghton (see above)

Malawi

Livingstonia Hospital requires a replacement **Medical Officer** for Donald Brownlie who is due to retire. Livingstonia is a 100 bed hospital with a strong community health programme and is under the control of the Livingstonia Synod, CCAP.

Contact: Donald Brownlie, PO Box 5, Livingstonia, Malawi, Tel: 00 265 368 207, or Rev Terry McMullan, Overseas Board, Presbyterian Church in Ireland, Fisherwick Place, Belfast BT1 6DW. Tel: 028 9032 2284 or Sheila Ballantyne, Church of Scotland Board of World Mission, Tel: 0131 225 5722

Mozambique

Male Doctor required to work in Mozambique. Needs an interest in public health and ability to be speak Portuguese fluently (or be willing to learn the language to a high standard). **Contact:** Vanessa Lillingston-Price (Personnel Officer), The Leprosy Mission International, 80 Windmill Road, Brentford, Middlesex, TW8 0QH Tel: 020 8569 7292 Email: vanessal@tlmint.org

Nigeria

Action Partners has vacancies for a number of doctors to work as GMOs in a rural health centre, leprosy & rehab. centre, church run hospital and an AIDS unit. Willing to be involved in teaching and upgrading local medical workers, nursing and midwifery staff. **Contact:** Personnel Department, Action Partners Ministries (as above)

ASIA

Specialists in General Surgery, Community Health and Paediatrics required in a hospital in South Asia on four year contracts, commencing in July 2002. **GMO** also required for one year with involvement in emergency obstetrics. The hospital serves a community of some 20,000 people. **Contact:** Su East, 6 Rutland Gardens, Croydon, Surrey, CR0 5ST Tel:020 8680 8598 Email: info@pse.co.uk

Anaesthetist required by TLM India to train staff 'in the art of anaesthesia, willing to provide simplified training in CPR and advanced life support systems'. **Contact:** Vanessa Lillingston-Price, The Leprosy Mission International, 80 Windmill Road, Brentford, Middlesex TW8 0QH. Tel: 020 8569 7292 Email: vanessal@tlmint.org

Nepal

Surgeon, United Mission Hospital,Tansen (United Mission to Nepal). UMHT is located in a pleasant hill town and has a very active surgical unit. Surgeons are needed to share a busy and varied practice of clinics and emergency and routine operations. An advanced qualification and ability to work independently in general surgery is essential. A sub specialty might be useful, but the emphasis is on general surgery, including the surgery of trauma.
Enquiries to: Dr John Dickinson at Email: John.Dickinson@umn.org.np

Physician, Patan Hospital (United Mission to Nepal)

Patan Hospital is in Patan Municipality in the Kathmandu Valley. It provides in-patient and out-patient services to a large population. A general physician is required to be Chief of the Medical Service and manage a broad range of medical conditions including emergencies and a good deal of infectious disease. The physician should also be willing to teach junior doctors in the medical team.
Enquiries to: Dr John Dickinson at Email: John.Dickinson@umn.org.np

Pakistan

Kunhar Christian Hospital. Needs a **female doctor** and a **midwife** from April 2002 – someone who already knows the language and has experience of midwifery in Pakistan. **Other doctors and nurses** also needed. Short-term help can be useful. **Contact:** Dr Haroon and Miriam Lal Din at KCH, PO Box Garhi Habibulla, Distt Mansehra, 21240 Pakistan, Tel: 92 985 450350 Email: kcc@atd.hazara.net.pk

EVENTS

Overseas Update, Residential Refresher Course 2002

To be held at Oak Hill College North London from 24 June - 5 July.

Programme and brochure now available from Peter Armon at the CMF Office

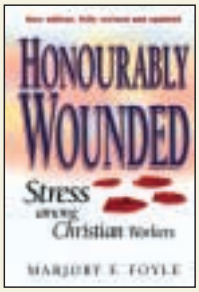
Programmes for Missionary Kids

Re-konnect - A summer re-entry holiday programme for **MKs aged 6-12 years** involving lots of fun and games and other activities. Held in Slack Top Centre, Heptonstall, West Yorkshire. 29 July to 2 August. Cost - £50 per child. **Contact:** Janet Brown at Global Connections. 186 Kennington Park Road, London SE11 4BT Email: info@globalconnections.co.uk

MK Re-konnect – Another programme designed for **16-24 yr old MKs** who have recently returned to complete their education in the UK. To be held at Oak Hill from 17-24 August 2002. Cost - £100 per person. 'An action packed programme – designed to equip and prepare for the next strategic phase of their lives'. **Contact:** Marion Knell also at Global Connections (Email as above).

BOOKS

Honourably wounded - stress among Christian Workers



Marjory F Foyle
Monarch, London and Grand Rapids 2001
£7.99 Pb 288pp
ISBN 1 85424 543 0

Marjory Foyle was a general medical missionary in South Asia and experienced her own fair share of stressor exposure before training in psychiatry and returning to India. When she reached 60 years of age she embarked on a global travelling ministry conducting counselling and carefully noted psychiatric assessments. Her ground-breaking research, first presented in 1984, caused initial discomfort to some in missionary agencies but they were largely won over after the publication of the first edition of this book in 1987. The title was significant, restoring self-esteem to those who were genuine casualties but had been misunderstood, and I am very glad that the original title has been retained.

The first edition was a classic, and required reading for anyone involved in overseas mission. This edition casts its net more widely, including those who travel across international boundaries but continue to live in their home country, and those working with immigrants. Fourteen chapters encompass the changing face of missions, understanding stress, dealing with depression and discouragement, adjustment and culture shock, occupational stress, interpersonal relationships, parental and home country stress, stress and singleness, missionary marriages, stress and children, special forms of stress, re-entry, caring for missionaries and God's model of missionary care.

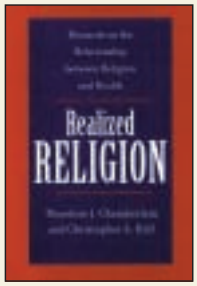
Every chapter is important and well written, in touch with the current realities of overseas service, brim full with realism, wisdom, insight, and hope informed by a love for Christ, but the author does not gloss over the ways in which mission partners may manufacture their own problems. All the chapters can be described as outstanding.

Is this still a book for this first decade of the 21st Century? Definitely yes. Her references are up to date and demonstrate an impressive breadth of research. Have I any criticisms? Yes, but only two very minor ones. Occasionally the style is more like a scientific paper and this is unnecessary for her target readership. The referencing style should be changed at the next reprinting to a numbered Vancouver style and the author could introduce some informality by using the first and last names of authors in the text.

Who should read this book? All missionaries, all Christians working overseas or making visits as part of their Christian calling, all candidates, all returned, bruised or wounded mission partners, all missionary/Christian aid agency home staff, all those in local churches responsible for overseas personnel, and all church members with an interest in overseas mission. That should include every church member. It should be on every church bookstall, in every missionary training college and given to every candidate and serving mission partner by their agency. It is a superb book that I commend unreservedly.

Michael Jones

Realized Religion Research on the Relationship between Religion and Health



Theodore J Chamberlain & Christopher A Hall
Templeton Foundation Press 2000
US$29.95 Hb 256pp
ISBN 1 890151 45 9
US$15.95 Pb 248pp
ISBN 1 890151 53 X

It has been said that if there is just a five per cent advantage in clinical benefit from a certain treatment, then the advantages and disadvantages of this should be discussed with patients. There is now growing evidence that having a religious faith brings considerable advantages. Have we come to the position when it could be considered negligent not to advise our patients to find a faith that stands to help them?

'Realised Religion' is a scholarly book that comprehensively reviews the large volume of literature on the relationship between faith and well-being, whether it be physical or psychological. The effect of both pro and anti religious biases in the writers of these papers is discussed.

The first chapter on the 'Role of Prayer and Healing' reviews several academic studies. Most found a real advantage in the group prayed for, only a few found no difference.

Articles on 'Faith Healing' are reviewed honestly. Though little evidence is given to suggest patients are being objectively healed of organic pathology today, there is evidence presented that patients can have a feeling of well-being from such experiences. One major study found that the problems helped were usually psychological, physical or religious as opposed to behavioural, social and moral concerns. A major analysis of Catholic Pentecostal healings determined that the healings actually fell well short of 'cures'. However religious faith is correlated with lower blood pressure levels!

The chapter on 'Mental Health' shows clearly that committed, actively religious persons have better overall psychological adjustment, feeling of well-being and high self esteem. They conclude, 'Mental Health workers need to be aware of the positive potential of religious involvement'. Overall 'fully eighty per cent of psychiatric research on religion and health conclude that a faith is advantageous'.

Many studies in 'Life Satisfaction' all show that there is a direct relationship between spiritual commitment and contentment. A number of studies conclude that 'materialistic people generally have been found to be unhappy'. This sense of well-being is accredited to the effect of individual beliefs as well as from active involvement in religious communities and activities.

Further chapters review the evidence on the effect of faith on suicide and alcohol and drug abuse and find clear evidence that faith is advantageous.

The writers conclude, 'The scientific evidence convincingly demonstrates that the natural by-product of religion realised is longer life, less illness, better physical and mental health, more marital stability, less divorce, less suicide and less abuse of alcohol and other substances'.

The final chapter is an investigation of the Bible's teaching and reminds us that the pursuit of religious truth and commitment should not be because of health benefits because then religion has become a means to an end since 'Jesus never promoted or advocated such a reversal'. This book is really

a summary of large numbers of trials and surveys. The evidence is strong that doctors should be helping their patients find a vibrant meaningful faith.

Bernard Palmer is a Consultant General Surgeon in Stevenage

Psychology, Religion and Mental Health

Montagu Barker
Rutherford House 2000
£5 Pb 102pp
ISBN 0 946068 83 6

Is religion good for your health? This is one of the questions Montagu Barker addresses in this book based on his four Templeton lectures. The aim of these lectures is to integrate science with modern issues in medicine, psychiatry and religious experience. Dr Barker states that his 'aim has been to challenge the sceptic to be more reflective in analysing spiritual experience, and to challenge religious enthusiasts to be more rigorous in evaluating their own religious experience'.

In the chapter 'Religious Observance, Health and Safety', Dr. Barker cites modern scientific research to show that regular Judaeo-Christian worshippers live longer because of a reduction in the incidence of heart attacks and strokes. Significant benefit to mental health was found with participation in religious services, social support, prayer and perceived relationship with God. Interestingly, *small* amounts of religion can actually be detrimental to mental health, ie the less active the commitment, the higher the levels of worry, anxiety and guilt!

The chapter entitled 'Religious experiences and psychological explanations' gives a fascinating overview of the way religious experience has been perceived by six members of the psychiatric and scientific professions over two centuries. Dr Barker shows how the anti-religious effect of the nineteenth century materialist psychiatrist Sir Henry Maudsley influenced many British psychiatrists to see any unusual religious experience as madness.

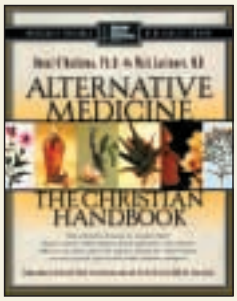
Dr Barker's chapter on 'Conversion, Cults and Brainwashing' gives a robust endorsement of the need for the Christian convert to 'please bring your mind with you'. He contrasts the 'call to examine the life, teaching and credentials of Jesus Christ and to make up one's mind as to the validity of the Christian faith' with those who join certain Christian groups which 'can be just as coercive in their persuasive techniques and as pressured in their expectations of specific experiences as the new religious movements'.

The chapter on 'Spiritual Healing and Alternative Therapies' probably tries to cover too much material to do justice to either the two main themes of the heading or indeed the third theme which he introduces, namely the psychotherapist as healer.

I thoroughly recommend Dr Barker's book, since it provides such an excellent understanding to those who are interested in the relationship between the Christian faith and many important mental health issues.

Dominic Beer is Senior Lecturer, Division of Psychological Medicine (Guy's, King's & St Thomas' Institute of Psychiatry) and Honorary Consultant Psychiatrist in Challenging Behaviour and Intensive Care Psychiatry (Oxleas NHS Trust)

Alternative Medicine The Christian Handbook



Donal O'Mathuna &
Walt Larimore
Zondervan 2001
US$19.99 pb 477pp
ISBN 0 310 23584 7

This impressive book, endorsed by the Christian Medical Association of USA, is an honest attempt to evaluate alternative medicine, bringing together both faith and science. It is packed with valuable information and is particularly useful as a handbook for Christian carers who do not have opportunity to research these areas for themselves.

Although evidence based medicine is widely acclaimed, alternative therapies, so often lacking in firm supportive evidence, are increasingly fashionable and steadily encroaching into conventional medicine. In these days when 'informed choice' is an ethical watchword, this book contains much sorely needed information to help with our decisions.

Using a clear format of four sections, it gives a fascinating overview of the origins and development of both conventional and alternative medicine, the first often deficient in knowledge and the second including therapies based on Eastern religious concepts or pagan rituals and beliefs. It emphasises that many popular alternative therapies, with their ancient origins, are now associated with New Age spirituality and healing techniques.

Included in the second section is a helpful, biblically based and, at times inspirational, discussion concerning the difficult and age-old issues of pain, illness and suffering, followed by some salutary advice on a healthy lifestyle.

Part three examines the principles underlying alternative therapies. These are generally based on the concept of 'universal life force' or energy, eg ch'i (acupuncture), vital energy (homeopathy) , prana (ayurvedic medicine) and the chakras or energy centres of yoga. Christians are clearly warned of the potential dangers of becoming involved in therapies dependent upon a non-Christian belief system.

The fourth and largest section makes an important distinction between alternative therapies which are dealt with somewhat concisely and herbs, vitamins and dietary supplements which are dealt with in more meticulous detail. Although these latter remedies may be 'natural', they are not necessarily safe. They are, however, unlikely to lead to harmful spiritual effects, (except possibly via the therapist!) and some may well prove valuable after further evaluation.

Finally, there is a 'quick reference' table matching common symptoms and illnesses with a wide mixture of possible alternative remedies. This is sometimes at variance with information and advice given in previous chapters. I found it disappointing that this therapeutic table does little to dispel the persistent confusion surrounding some areas of alternative medicine. Despite some inconsistencies, however, this book is a useful resource if viewed as a whole and with discernment!

George Smith is a Dermatologist in Reading

BOOKS

Healing

Frances McNutt
Hodder & Stoughton
2001
£7.99 Pb 333 pp
ISBN 0 340 66140 2

This is the ecumenical version of the seminal work on healing, which in its original form stimulated so many of us in our thinking about the healing ministry.

Paradoxically, it is perhaps a shame to have lost the original foreword, which describes the influences which brought Francis to his conviction that the healing ministry is present reality.

The book has a direct approach. The challenge the Sanhedrin faced in Jesus 20 centuries ago is applied to us. Look at the evidence for his healing ministry: is it true? Should we be doing something about it? The Sanhedrin suppressed it; the common people loved it. 'You have hidden the Kingdom from the wise and learned, and revealed it unto little children.' The first chapter is a powerful, yet gentle, defence of the healing ministry, and challenge to engage, not ignore. McNutt clarifies that the need is not for *either* good social/medical structures and facilities *or* Christ's healing at an individual level: it is *both* these things. He touches on the power of counselling, prayer and medicine being used together, and later develops the theme further.

He then looks at all the common resistances to the healing ministry and shakes each one for truth, concluding that the good news is that God still intervenes in our lives to heal, and that he is not constrained by the lack of extraordinary saints through whom to work. He uses believers. He traces the change in perspective about healing, and concludes that God actually does want us whole.

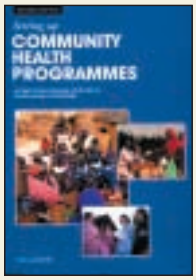
McNutt peppers his book with apt quotations; 'the glory of God is man fully alive', 'even God cannot play on a broken violin', 'every time you meet Jesus in the Gospels, he is either healing someone, or has just come from healing someone, or is on his way to heal someone'. He is unambiguous in his declarations, but not unbalanced. Hence he accepts that death comes to us all and there is a time not to pray for healing. He accepts that there is a truth in the receptiveness of suffering, quoting Paul's affliction with blindness which opened his spiritual eyes, but he clarifies his conviction that this is the exception rather than the rule.

McNutt also covers deliverance and exorcism in a helpful and encouraging way.

It is quite long, and perhaps a little repetitive at times, but always interesting, always informative and well written, and as topical now as it ever has been. It seems to me to be a foundational text. All it needs is chapter summaries to focus the message more effectively… but writing one's own is good discipline!

Michael Harper is the Medical Director of Burrswood Hospital, Kent

Setting up Community Health Programmes A Practical Manual for use in Developing Countries Second Edition



Ted Lankester
Macmillan Education Ltd 2000
£12.50 Pb 333pp
ISBN 0 333 67933 4

Dr Lankester packs this manual for community health workers with practical advice on how to help a community tackle causes of ill health, and treat disease cheaply and effectively using home-grown community health workers.

He starts by explaining the philosophies of Community Based Health Care, and the practicalities of working as partners with the community, and raising awareness about health. Motivation to change comes from understanding the importance of an action, and also from the action becoming 'the fashion'.

In the section of the manual covering management, evaluation and sustainability, his detailed advice is worth heeding. 'Setting up a project is difficult and expensive. It takes many years. It is better not to start at all than to start, then run out of funds and have to stop. The developing world is full of projects that have been abandoned, and people whose hopes have been disappointed.'

If you are thinking of setting up a programme training community health workers or a community health clinic this manual will be a joy to you. The middle section of the book deals with this in detail following the latest WHO guidelines for interventions. Pointers for further reading are helpfully included. There is also a chapter on AIDS by Ian Campbell and Alison Rader of the Salvation Army, which I found interestingly different from the WHO guidelines.

What I looked for and didn't find, was the sections on expanding our health programmes to include agriculture and animal husbandry for better nutrition, land and tree conservation for greater productivity, and improved housing. Dr Lankester tells us that these should be included in our programmes as soon as we are able .

This book is full of easy-to-read headings, catchy ideas in boxes such as 'cured patients make good teachers', and cartoons which speak a thousand words. If you were wondering how your team could afford to attend the next CBHC conference in your area, maybe you could buy them all a copy of this manual instead, and go through it together.

Janet Lefroy is a General Practitioner in Staffordshire

Life is a fatal disease

'Life is a fatal disease' was a phrase frequently used by one of my favourite consultants. He was right. We are born, we die, and in between we experience the perversity of British weather (or the luxury of no such experience if you are an overseas *Triple Helix* reader). Apart from undertakers, mortuary workers and butchers, the medical and nursing professions probably come across death on a daily basis more than any other.

Most people fear death. Woody Allen, comedian extraordinaire, remarked that, 'It's not that I mind dying, I just don't want to be there when it happens'. Some Americans have had their bodies preserved through cryotherapy in the hope that when a cure is found for their cause of death, they can be brought back to life. The fact that some could only afford preserving their heads smacks of sheer absurdity!

If we were to stop and view the mounting death toll in the world today, from the scourge of AIDS, to the revenge killings in Israel and Palestine, and even amongst the patients entrusted into our care, we could be forgiven for feeling overwhelmed. Death demands an explanation as an impostor on the world stage. As Paul acknowledged, 'If only for this life we have hope in Christ, we are to be pitied more than all men' (1 Corinthians 15:19).

When Jesus was faced with Lazarus' death he 'wept' (John 11:35). We see a troubled Jesus, a deeply moved Jesus. To quote John Stott,[1] 'Death was a foreign body. Jesus resisted it; he could not come to terms with it.' Yet out of the whole crowd gathered around the tomb that day, Jesus was the only one who knew what would happen next! 'I am the resurrection and the life. He who believes in me will live, even though he dies, and whoever lives and believes in me will never die', he proclaimed, and then proved it was true by raising Lazarus!

As believers now, we know that Jesus has the power to raise us too. Death is no longer the end of life but a brief interlude on a journey. I could but smile when my seven-year-old friend (with grade 4 neuroblastoma at presentation) said to me, 'It's like calling in at McDonald's when on the motorway'.

Death is inevitable. It's not a failure of modern medicine but a consequence of living in a fallen world. The gift of eternal life is also, alas, optional. I say 'alas' because 'small is the gate and narrow the road that leads to life, and only a few find it' (Matthew 7:13,14). Many are rather on that 'broad road that leads to destruction'. I'm grateful for the person who led me to Christ, for my relationship with Jesus, and the certain hope of eternal life. As a result I can look forward to death, as a checkpoint along the way, with the best still to come. As Christian doctors we are in a privileged position to share the phenomenal truth of Jesus' victory over sin and even death itself with our patients, and their relatives and friends. Can others that we meet today have the opportunity of hearing the same Good News so that they might join us on the journey … and mine's a Big Mac and fries when we get there (and in heaven, calorie free of course!)

Sophie Critchley is a Paediatric SHO in Bradford

1. Stott J. *The Cross of Christ*. Leicester: Inter-Varsity Press. 1987:65

CHRISTIAN MEDICAL FELLOWSHIP

READY FOR SERVICE

- Uniting Christian doctors
- Increasing Christian faith
- Promoting Christian values
- Advancing Christian mission
- Publishing Christian literature
- Supporting Christian students

To find out more...telephone, visit our website or send off the enclosed coupon today

CMF, Partnership House, 157 Waterloo Road, London SE1 8XN
Tel: 020 7928 4694 Fax: 020 7620 2453
Email: info@cmf.org.uk Website: www.cmf.org.uk