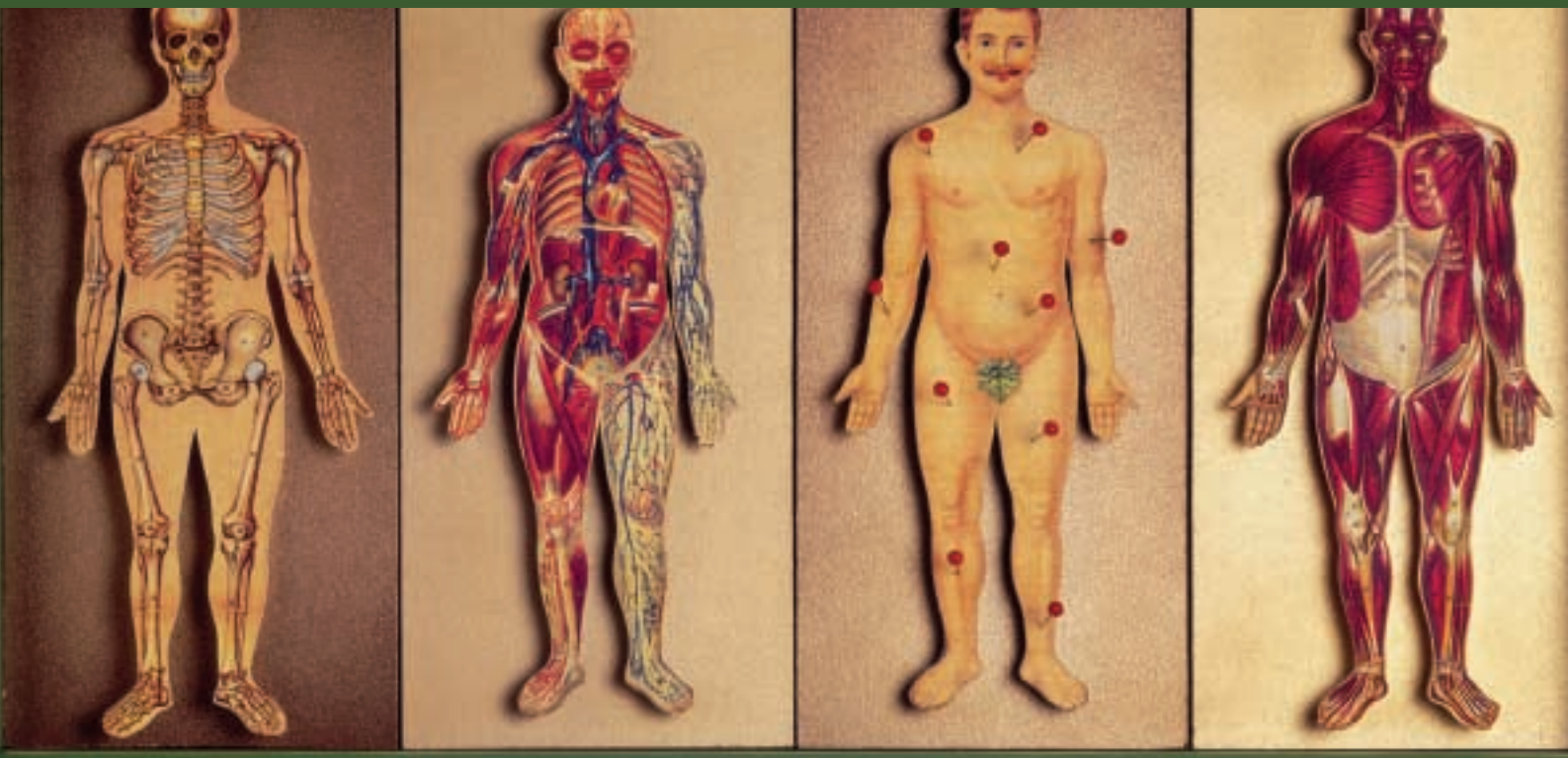
TRIPLE HELIX

Spring 2003

For today's Christian doctor



ALTERNATIVE MEDICINE

ASSISTED SUICIDE

HIGHER EDUCATION

MEDICALISATION

HEALTH AND THE NATION

ABSTINENCE EDUCATION

DRUG ADDICTION

MALAWI

JUNIOR DOCTORS

RETIREMENT OPPORTUNITIES

OVERSEAS OPPORTUNITIES

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NO. 23. SPRING 2003

EDITORIALS

See Zurich and die?

Reality TV crosses new boundaries

Photo: PA

Reginald and Wyn Crew

On 20 January a British man with advanced motor neurone disease ended his life in Switzerland with the help of a group called *Dignitas*. Reginald Crew aged 74, a retired car worker from Liverpool, is thought to be the second such Briton to visit this controversial 'clinic' in Zurich. His £50 fee covered a consultation and a drink lethally laced with barbiturates. An ITV crew from *Tonight with Trevor McDonald* accompanied him and his wife Wyn to film all but his last hour. What are we to make of it all?

Euthanasia is defined as 'the intentional killing by act or omission of a person whose life is felt not to be worth living'. Assisted suicide is euthanasia one step back. Few of us can see any morally significant difference, and although a BMA conference in 2000 was at one stage expected to recommend a change in law, BMA policy remains firmly against it.

Switzerland has allowed assisted suicide since 1918 provided it is motivated by altruistic considerations. The rest of us have rightly asked the question: how could we ever be sure of the motivation when the key witness, the person the police would most like to interview in order to confirm this, is dead? Switzerland ignores this question and interestingly, unlike the Netherlands, Belgium, and Oregon, has not required the involvement of health professionals. Any altruistically motivated person can help kill and the patient does not have to be terminally ill.

This curious state of affairs had passed virtually unnoticed until British lobby groups cynically upped the profile of the euthanasia debate. Fearing adverse publicity about 'suicide tourism' – numbers grew from three in 2000 to 55 in 2002 – the Swiss parliament has introduced a bill to end the tourism aspect but that cannot become law until end-2004. Disability groups in the UK have vehemently condemned the hopelessness conveyed by such TV coverage. Palliation of motor neurone disease is difficult, but we do not need to kill the patient in order to kill the symptoms, and we can bring hope.

Meanwhile Merseyside police are considering prosecution. I would leave Wyn Crew alone. Her distress was obvious: 'It's like taking him out to be shot at dawn'. But the other crew worries me more. Reality TV may rack up ratings but until they show medical killing in abortion, they should not show the prelude to medical killing in such a propaganda piece.

Andrew Fergusson
Former CMF General Secretary and Medical Advisor to CARE

The future of higher education

There is much in the Bible about debt

The Future of Higher Education white paper[1] proposes radical reform of university funding in England and Wales. Up-front tuition fees will be abolished and instead, universities will charge up to £3,000 per year of a course, to be paid after graduation when the student earns over £15,000. Education Secretary Charles Clarke said: 'They [universities] will be given the right to set their own fees and therefore be given a market incentive to provide the best courses for students and the economy'.[2] The government will pay fees up to £1,100 per annum for students whose family income is under £10,000, and reintroduce a grant of less than £1,000 per year for students with a family income under £20,000. Medical students will have access to means-tested non-repayable bursaries in years five and six.[3]

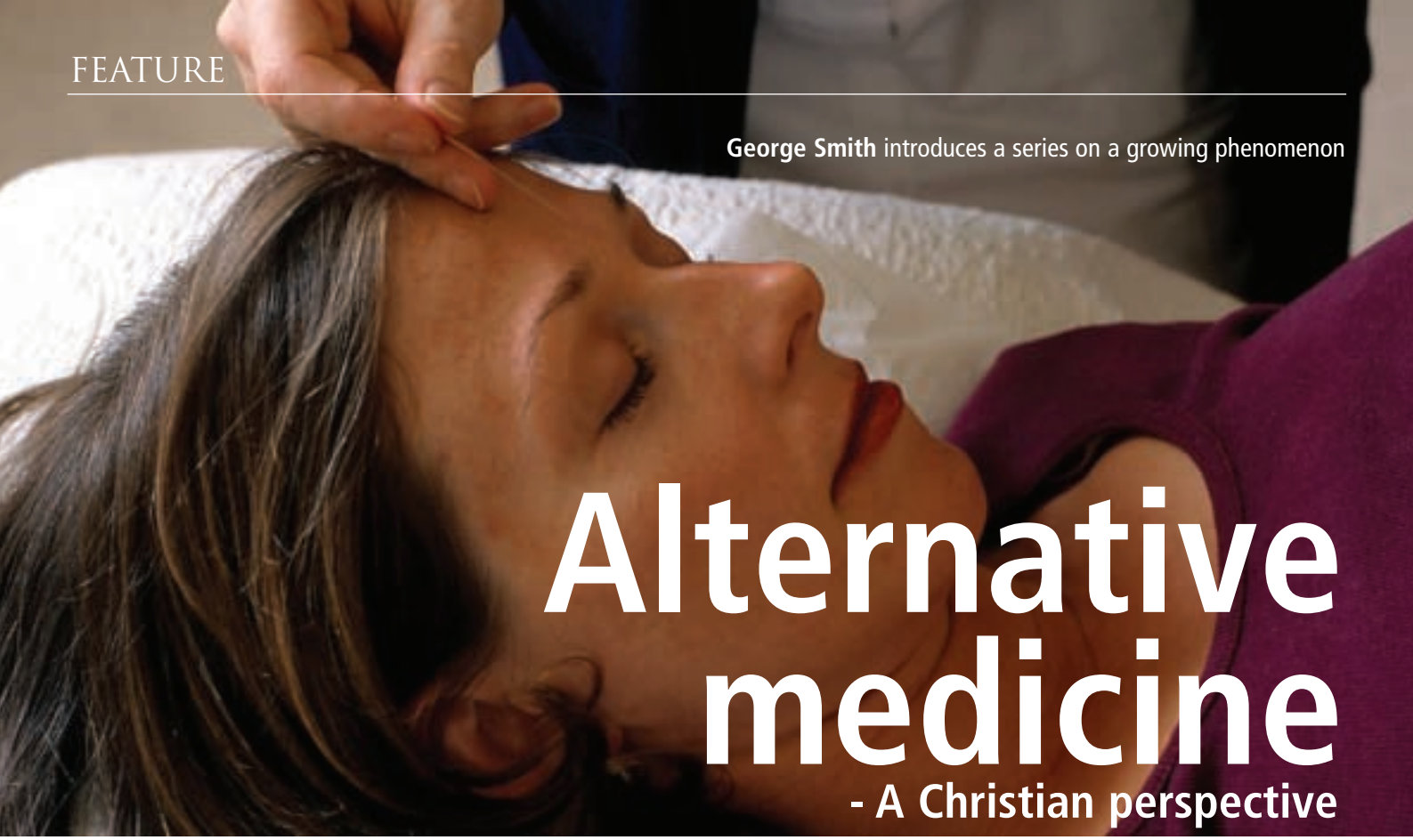
Medical students already leave university with an average debt of £13,000.[4] Under the proposed changes Mr Clarke estimates that the average debt after a three year course could be £21,000. Medical students may therefore emerge with double this burden and this could discourage applications. Dr Colin Smith, Chairman of the BMA's medical academic staff committee said: 'The Government is struggling to recruit the extra doctors to the NHS yet its plans for higher education will penalise a workforce that they desperately need'.[5]

Although there is no biblical mandate for free education, as Christians we should be concerned about any policy which may deter those from low-income families from applying because of cost, keeping medicine as an elitist career. Universities have improved access for such students and it would be unfortunate to see this reversed. Introduction of these new fees could further promote a debt culture among students, and also add to the already great pressures facing junior doctors starting work.

Debt in the Bible is permissible, not ideal. Loans in Israel were charitable and given to help a countryman through a period of poverty.[6] It was not permitted to charge interest,[7] except to a foreigner,[8] and debts had to be cancelled every seven years.[9] Jesus extended this, commanding Christians to lend to their enemies and to those possibly unable to repay them.[10] Should this paper be accepted by parliament, an incentives scheme to encourage universities to raise funds through endowments will be instituted. Perhaps we as salaried doctors should consider relieving the financial burden on our student colleagues by setting up such endowments. The consultation process for this white paper is open until 30 April 2003; please consider raising these concerns with your MP or writing to the consultation unit.[11]

Clare StarkToller
Senior House Officer in Buckinghamshire

1. *www.dfes.gov.uk/highereducation/hestrategy/pdfs/DfES-HigherEducation.pdf*
2. From Charles Clarke's press release on the white paper *www.dfes.gov.uk/pns/DisplayPN.cgi?pn_id=2003_0008*
3. DFES spokeswoman quoted in *BMA News* 8 February 2003
4. Survey of Medical Students' Finances 2001-02 *www.bma.org.uk/ap.nsf/Content/medstudentsfinance02?OpenDocument&Highlight=2,student,finance*
5. BMA press release 22 January 2003 *www.bma.org.uk/ap.nsf/Content/medstudentsfinance02?OpenDocument&Highlight=2,student,finance*
6. Leviticus 25:35
7. Exodus 22:25; Leviticus 25:36, 37
8. Deuteronomy 23:20
9. Leviticus 35:8-55
10. Luke 6:32-36
11. Consultation Unit, Department for Education and Skills, Area 1D, Castle View House, East Lane, Runcorn, Cheshire, WA7 2GJ or e-mail *hestrategy@dfes.gsi.gov.uk*



George Smith introduces a series on a growing phenomenon

Alternative medicine

- A Christian perspective

KEY POINTS

The rise of complementary and alternative medicine (CAM) has been fuelled by disillusionment with orthodox medicine and the attractiveness of New Age spirituality. CAM is frequently rooted in Eastern religion and mysticism and the underlying aim of treatment is often to achieve a balance in the flow of 'vital energy', by various means. Whilst some alternative therapies might justifiably become part of conventional medicine in the future, each individual modality needs to be evaluated both medically and biblically. Does it have a scientific basis? Does it work? Is it safe? What are its religious roots? Are there specific spiritual dangers involved?

Alternative medicine began to flourish at the end of the 1970s. Before then, therapies such as homeopathy, acupuncture, osteopathy and herbal medicine had dedicated adherents but were considered distinctly suspect and unconventional. In 1914 the General Medical Council issued a warning notice to newly qualified doctors, directing that there should be no associating with unqualified persons or collusion with therapists using conventional or alternative therapies without appropriate qualifications and registration with the GMC.[1]

The 1980s saw mushrooming interest in and practice of alternative therapies with medical and nursing journals such as *The Practitioner* and *Nursing Times* devoting increasing space to them. The BMA and House of Lords commissioned various investigations. Although significant evidence for the efficacy and safety of such therapies did not emerge, official attitudes changed surprisingly. In 1991, Stephen Dorrell, Minister of Health, issued GP guidelines for the use of such therapies and relationships with alternative therapists.

Recent surveys suggest that almost half of the population in the UK use alternative therapies and over half of GPs practise or advise such treatments. Interest in alternative medicine has been closely paralleled with an interest in the New Age and Holistic Movement. Alternative medicine has been called its 'medical arm'.

Definition

The terminology has changed significantly over the years. When it was realised that alternative therapies could not replace conventional medicine, particularly in serious disease, 'alternative' gave way to 'complementary'. The term 'holistic' also became fashionable, implying treatment of the whole person (body, mind, emotions and spirit). At present 'Complementary and Alternative Medicine' (CAM) is generally being used but is now being superseded, particularly in the USA, by the term 'Integrative Medicine'.

Precise definition is very difficult. In the UK these therapies are described as 'those which are not widely used by orthodox medical professionals nor widely taught at undergraduate level in medical and paramedical courses'.[2] A similar definition applies in the USA. However, these definitions are becoming blurred as an increasing variety of therapies are now being used in NHS primary care centres, wards and outpatient clinics.

CAM falls broadly into three categories:

1. Therapies such as acupuncture, yoga, reflexology and homeopathy, which have roots in either Eastern religion (Taoism or Hinduism) or in the concept of vital life force or energy. This is the largest group, often having New Age associations and therefore needing careful investigation from a Christian perspective.
2. Medicines based on herbs such as St John's Wort and Ginko Biloba. These do not have spiritual associations in themselves; after proper evaluation, they could become part of conventional pharmacopoeia.
3. Systems of medicine such as naturopathy, ayurvedic medicine and Rudolph Steiner's anthroposophical medicine include perfectly sound advice on diet and lifestyle but are combined with one or more therapies from the first group.

Why is it so popular?

1. **Disillusionment with Orthodox Medicine.** Despite the pursuit of clinical excellence, there are problems in the NHS: inadequate finance and staffing, long waiting lists, postponement of operations and prevalence of resistant bugs (MRSA) in hospitals. Faults in the system contrast with easy access to alternative practitioners who give more time to patients, though at a price! Unfortunately, the personal doctor/patient relationship has become somewhat rushed and remote: reassuring touch has become less frequent than the click of a computer keyboard!
2. **Iatrogenic Illness.** This is understood as illness caused by doctors and their treatments and includes the toxic effect of drugs, allergic reactions, dosage mistakes and addiction to tranquilizers.
3. **Royal Patronage.** The Royal Family's interest in alternative therapies can be traced back to the use of homeopathy by Adelaide, wife of William IV, in the early nineteenth century. Homeopathy appears to have been practised by the Monarch until the present day and Prince Charles has been a strong advocate of this and other alternative therapies, drawing considerable attention to them during his term as President of the BMA. Much media attention has also been focused on other members of the Royal Family as well as prominent figures in public and political life who use such therapies.
4. **Religion and Culture.** As a result of increasing transmigration between East and West, ethnic groups settling in the UK have brought their traditional cultures with them including methods of healing based on their religious beliefs.
5. **Holism.** By definition, holistic medicine includes caring for spiritual ill health. In these days, there is a greater awareness of the supernatural and spiritual, making the concept of 'whole person' medicine attractive. For Christians, this means care under the direction and power of the Holy Spirit. Therefore, we need to beware of any opposing spiritual forces being involved through alternative therapies and therapists.

Comparison of essential principles

Conventional medicine is based on the facts of anatomy, physiology, biochemistry and pharmacology. Diagnosis depends upon symptoms, signs and scientific investigations such as blood tests and X-rays. The aim is to find a specific cause for the disease. Treatment aims to be evidence-based with a scientific evaluation of efficacy, dose and toxicity. Valid clinical trials are very important and law strictly regulates it. It is essentially non-spiritual.

Alternative medicine is based on healing systems or concepts, folklore and 'individual revelations'. It is frequently rooted in Eastern religion, mysticism or vital force/energy. The diagnosis is essentially non-scientific (except when the practitioner is medically qualified) and may involve divination, the occult, astrology, dowsing or pendulum swinging. Treatment aims to be holistic, and the 'healing power' often relates to energies within oneself. Essentially, it involves a spiritual dimension but the concept of 'God' is of a cosmic force rather than a personal Father God. It is largely not regulated by law.

The underlying aim of treatment is to achieve a balance in the flow of energy: different cultures and therapies give these different names. The ch'i of acupuncture with its two components (yin and yang, representing negative and positive energy) is the most widely known.

In assessing individual therapies, there are some suspicious phrases: life force, cosmic/vital energy, flow of energy, blocked channels, lines of force, meridians, chakras, potentisation and natural magnetism. No valid scientific evidence has been presented for the existence of meridians, energy centres or chakras.

Practical assessment of alternative therapies needs to be considered from both medical and Christian perspectives, applying checklists to each therapy.

Medical Checklist

1. Does it have a rational, scientific basis? Do the claims fit the facts?
2. Does it work? Is there consistent, reliable evidence?
3. Is it safe? Are there significant side effects?

Christian Checklist

1. Taking into consideration the lack of scientific evidence available, can it be recommended with integrity?
2. What are its roots? Is there an eastern religious basis (Taoism or Hinduism)? Is it based on life force or vitalism?
3. Are there any specific spiritual dangers involved? Does its method of diagnosis or practice include occult practices, all forms of which are strictly forbidden in Scripture. [3]

Photo: Anthea Sieveking/Wellcome Photo Library

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TABLE 1

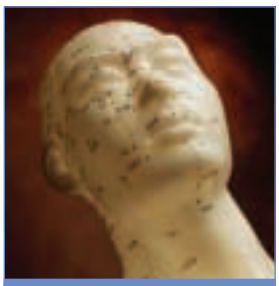
Universal cosmic energy

Name	Origin
Ch'i	Chinese Taoism
Ki	Japanese Shintoism
Prana	Hinduism
Mana	Maori
Orende	North American Indian
Ojas	Ayurvedic medicine
Lung-gom	Tibetan Buddhism
Vital Energy	Homeopathy
Etheric Body	Anthroposophical medicine (Steiner)
The Innate Intelligence	Chiropractic (DD Palmer)
Universal Cosmic Energy	New Age

TABLE 2

How energy flow is balanced

Method	Therapy
Needles	Acupuncture, Auricular Therapy
Massage/Pressure	Reflexology, Acupressure, Shiatsu, Zone Therapy, Cranial Osteopathy
Manipulation	Chiropractic, Osteopathy
Hands	Therapeutic Touch, Psychic Healing, Reiki
Dilute, Potentised Medicine	Homeopathy
Plant Essences	Aromatherapy, Bach Flower Remedies, Chinese Herbal Medicine
Food/Diet	Macrobiotics
Exercise, Movement, Posture	Yoga, T'ai Ch'i Alexander Technique
Meditation and Mantras	Transcendental Meditation
Postures, Breathing and Shouting	Martial Arts
Multiple Techniques	Naturopathy, Anthroposophical medicine, Ayurvedic medicine



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2. BMA Board of Science and Education Working Party. *Complementary Medicine, New Approaches to Good Practice*. London: BMA, 1993
3. Deuteronomy 18:10-12; Ezekiel 13:20; Hosea 4:12; Galatians 5:20
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5. Garrow, J. Healthwatch poses questions on complementary medicine to BMA. *Healthwatch Newsletter* 1997; 25:1
6. Rowlands B. *Which? Guide to Complementary Medicine*. London: Which? Ltd, 1987:10
7. Ibid:39
8. Matthew 7:18
9. Angell, M et al. Alternative Medicine – The Risks of Untested and Unregulated Remedies. *NEJM* 1998; 339(12):841

Does it work?

Due to the admixture of techniques, rituals, medicines and belief systems involved in various therapies, it has been argued that standard forms of investigation and clinical trials (such as randomised controlled trials) cannot be applied to CAM. But what is the alternative?

In the first British University Department of CAM at Exeter, Professor Edzard Ernst and his colleagues evaluate clinical trials and correlate information by meta-analysis with meticulous care producing *FACT*, a quarterly journal, as well as holding a yearly international conference. Whilst investigations show varying degrees of promise, there is little conclusive evidence. When alternative therapies appear to work, this may be due to inaccurate diagnosis, natural remission, concurrent use of conventional treatments or to the placebo effect, when the patient may feel better without significant improvement in the pathological process. Professor Ernst believes that there is 'an astonishing and embarrassing lack of knowledge and information' on the subject of CAM, even that relating to the most fundamental question: 'Does CAM work and is it safe?'[4]

A 1986 BMA investigation into CAM concluded that the evidence for efficacy was scanty.[5] This view was reiterated in 1997 when *Health Watch* interviewed Professor J Howell, chairman of the BMA's Board of Science and Education. The careful review in *Which? Guide to Complementary Therapy* is prefaced by the warning, 'Many complementary practitioners are well aware that they still have to prove to the world that their therapies work'.[6]

Investigation of individual therapies produces little convincing evidence for their effectiveness. There are a few apparent exceptions such as acupuncture for dental pain, nausea and vomiting as well as chiropractic and manipulative treatment for back pain. St John's Wort seems helpful for depression and Saw Palmetto may improve prostate enlargement but unwelcome side effects have been observed.

Is it safe?

The popular view of CAM is that its therapies are advertised as being natural, safe, free from side effects and perhaps 'God given'. Complete safety is by no means assured. Some medicines (such as some Chinese herbal preparations and aromatic oils) have been demonstrated as having toxic properties, particularly on the liver. Physical complications such as pneumothorax may arise from acupuncture. Cerebrovascular accidents and neurological damage have been recorded following chiropractic and other manipulative therapies. Whilst these complications may be uncommon, a particularly worrying aspect is possible delay or incorrect diagnosis, especially if serious organic disease is missed and conventional treatment delayed. Tragedies do occur as a result. The 1997 *Which? Guide* states, 'Complementary medicine can be extremely harmful if used as a substitute for proper diagnosis and treatment'.[7]

PRACTICAL ASSESSMENT OF ALTERNATIVE THERAPIES NEEDS TO BE CONSIDERED FROM BOTH MEDICAL AND CHRISTIAN PERSPECTIVES, APPLYING CHECKLISTS TO EACH THERAPY

From a Christian perspective, there are other important considerations. Some therapies have roots that clearly arise from Eastern religious beliefs: for example, the acupuncture of Taoism and the yoga of Hinduism. Whether these roots are accepted as important is controversial but the Bible clearly teaches that roots are important: 'A good tree cannot bear bad fruit, and a bad tree cannot bear good fruit'.[8] Some Christian pastors and counsellors have observed 'spiritual ill health' (manifested as anxiety, depression, fear, lack of Christian assurance and interference with prayer life and Bible reading) in those who become involved with these therapies or therapists. There may also be evidence of demonic oppression.

Conclusion

A salutary note was sounded in the *New England Journal of Medicine*: 'It is time for the scientific community to stop giving alternative medicine a free ride. There cannot be two kinds of medicine - conventional and alternative. There is only medicine that has been adequately tested and medicine that has not, medicine that works and medicine that may or may not work. But assertions, speculation and testimonials do not substitute for evidence'.[9]

Alternative medicine is a challenge to Christian doctors and other care providers. Rather than being prejudiced, we need to be informed about therapies that are so popular and about which we are often asked. We need to respond with truth, integrity and biblically based attitudes. Many of our patients are clutching at straws and we should be sensitive to this. Fundamentally, we need to ask whether there is a vacuum in our own practice of whole person care, a void that is being filled by alternative therapists and New Age practitioners. We are called to heal the sick and to preach the gospel: surely this is biblical holistic medicine!

'Finally brethren, whatsoever things are true, whatsoever things are honest, whatsoever things are just, whatsoever things are pure, whatsoever things are lovely, whatsoever things are of good report; if there be any virtue, and if there be any praise, think on these things…and the God of peace shall be with you.' (Philippians 4:8,9 KJV)

George Smith is a retired Dermatologist in Berkshire

Is medicine interfering too much with life? **Sarah Ross** reviews the arguments

Beyond reasonable boundaries

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The *British Medical Journal* recently devoted an entire issue to the subject of 'Too much medicine?' The term 'medicalisation' was much in evidence, having been appropriated for any situation where medicine has expanded outside its reasonable boundaries; where medicine does more harm than good or interferes too much with life. The *BMJ* issue, for example, contained articles on sexuality, pregnancy, old age, palliative care and disease-mongering. The concept of medicalisation is attributed to Ivan Illich, who first wrote on the subject in 1976. He proposed that modern medicine had become detrimental to society, by amongst other things, 'launching ... an inhuman attempt to defeat death, pain and sickness'. By doing so, he argued, medicine had deprived individuals and societies of their ability to cope with sickness and death. Although Illich's remarks are over 25 years old, they ring true in our society. There is an inability to deal with illness and death.

Similarly, we no longer want to deal with certain social problems as morally based. Alcoholism, for example, has previously been thought of as a moral problem, but if described as a medical issue gains much more sympathy. The pursuit of a genetic basis for homosexuality seeks to turn another moral issue into a medical one.

Illich also described 'clinical iatrogenesis', the harm done to patients by medical treatments, and 'social iatrogenesis', the effect of making medical 'non-diseases'. The later describes the attempt to make medical something that is not, or 'disease-mongering' as it has become known. Most often this is in order to make money (in the case of drug companies) or to provide legitimacy (in the case of patients or pressure groups).

Issues in patient care

Medicalisation is a difficult issue when talking about patients. The gain in financial, psychological and practical terms of having a recognised illness can be large. Problems such as chronic fatigue syndrome, attention deficit disorder and many others have been suggested as non-diseases. Some of these are more problematic than others. In some instances there is a good argument to be made for the possible harm caused by treating something that may not be an illness. For example, the medical treatment of attention deficit disorder could be sceptically described as 'mass drugging of children.... a displacement strategy for the difficult task of improving family and school life'. Conversely, it is important that patients know that they are being taken seriously and the suggestion that a problem like chronic fatigue syndrome has psychological origins may not be accepted.

The pharmaceutical industry

In the case of pharmaceutical companies the problem is less personal. Targeted 'education' of doctors to increase the exposure of a disease, with the intention of increasing drug prescribing, may well lead to over-treatment with harmful medication as in the case of 'lotronex' for irritable bowel syndrome (after being marketed in this manner, the drug was withdrawn due to serious adverse effects).

Another example of profit-driven medicalisation is viagra. An increase in society's emphasis on sex has increased expectations, and changed what people think is normal in terms of sexual behaviour. Viagra has cashed in on this. The medical treatment of a condition has in part to do with whether there is an available treatment and how serious the problem is. Pharmaceutical companies are producing treatments and then creating or exaggerating conditions to sell them (for example female sexual dysfunction).

Our society cannot accept that bad things happen ... we must have an explanation

Effects on the profession

Another issue in the medicalisation of conditions, is its effect on the profession. In the *BMJ* there was a weariness amongst doctors, a frustration with a medical service which is asked to shoulder so many of society's problems. The burden on the medical profession from society's inability to deal with fundamental issues of life and death is heavy. The overlap of social problems with medicine asks many of us to work outside our sphere of knowledge and training, or in areas which are less amenable to treatment.

Solutions?

Jesus had no difficulties with going outside any one particular aspect of his work and addressed the whole person; if that meant providing practical items (such as food), emotional support, physical healing, spiritual rebuke or social debate, he did so. When Jesus healed the paralysed man in Luke chapter 5, he did not deal immediately with the man's physical need, but tended first to the pressing problem of his spiritual need for forgiveness. In the same chapter, when healing a leper, Jesus took time to ensure the man would be rehabilitated into society by instructing him to take the appropriate steps to be declared clean.

Although we might want to delineate the boundaries between medical, social and other problems, patients do not often do this. I think that we are obliged to assist as far as we can, whilst perhaps referring to more suitable services. Perhaps we should take this as an opportunity to show the love of Christ and his truly holistic care. Where colleagues may lack the internal resources, we have an endless wellspring of life from God.

In the larger arena, we as the church must provide an alternative answers to life's questions. The Christian Medical Fellowship should continue to be a voice in the medical establishment. In particular we should be prepared to challenge pharmaceutical companies, the media and other groups who wish to use medicine to their own ends. Jesus had no qualms about holding society and its various elements to account and Christian doctors must do the same.

Sarah Ross is a Clinical Research Fellow in Aberdeen

The NHS is failing for socioreligious reasons, argues Nick Spencer

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Health and the nation

Biblical anthropology recognises human beings as autonomous and therefore heavily responsible for their own health

Nigel Lawson once described the NHS as the closest thing the English have to a religion. This may be somewhat rhetorical but it is still rooted in reality. Health has been the top spending priority in the British public mind for every single one of the last twenty years. The National Health Service (NHS) employs nearly one in 30 of the working population. 95% of families have contact with their general practitioner in any given two-year period. The NHS is always considered the most important issue facing the nation, except when war or recession loom.

Yet this national icon appears to be in rather poor condition. Beset by medical scandals and funding crises, the NHS is more of a national soap opera than the crowning glory of the welfare state. The reasons for its ill health extend a long way beyond government healthcare policies to incorporate our changing attitudes to health and humanity and in particular the social and cultural climate in which the West finds itself at the dawn of the third millennium.

Health and humanity

The 20th century was the age of medical triumph in the West. British life expectancy rose from 47 to 77 years and infant mortality fell from 14% to 0.5%. History's great killers were conquered and millions were provided with inoculations, regular medical check-ups and accurate dietary advice.

Yet medicine became a victim of its own success. As acute infectious diseases were defeated, 'lifestyle conditions' such as lung cancer or coronary heart disease took their place. This change in demand was accompanied by medicine's ever-growing capability and resulted in something of an ideological crisis in the medical world. With its historic remit largely satisfied, what was Western medicine's future role? How far should medics be responsible for preventing 'lifestyle disorders'? Indeed, where was the dividing line between a medical disorder and sense of personal disaffection?

The medicalisation of life effected by this growing competence and changing need has inevitably increased the pressure on Western health services. In the 20th century, medical enterprise combined with popular reductionist notions to result in patients seeing medics as dealing in happiness rather than health. Increasingly, people think of 'my problems' as 'my body's problems', or 'my mind's problems'. 'I' and 'my responsibility' are removed one step away and it has become much more reasonable to expect someone else to fix my problems. As Christian media personality Malcolm Muggeridge wryly observed, our song today is 'I will lift up mine eyes unto the pills'.

The nation

The social and cultural conditions in which Western health services operate have also transformed. Over the next two decades, Western nations will experience unprecedented demographic rebalancing as the elderly rise to outnumber the young. This creates a double bind for the NHS: rising demand coupled with a falling number of people to pay for it.

Secondly, our ingrained consumerist culture influences healthcare provision. Health may have very little in common with high street goods but the consumer's worldview is pervasive, promising personal fulfilment by means of financial exchange.

As patients become customers and choice becomes a birthright, the NHS is under increasing pressure to deliver to the standard demanded by the marketplace. Failure to do so has resulted in the rapid growth of legal claims, an immensely costly trend in terms of money and morale.

A third important factor is that current British society has a very different attitude to trust and authority than it did in 1948 when the NHS was founded. Authority is automatically questioned and scepticism is the accepted norm. Operational transparency is a necessity: anything that goes on behind closed doors is automatically suspect. Medics are no longer the authoritative and trustworthy figures they once were. Whilst this may not sound too acute a problem, philosopher Onora O'Neill pointed out that no society or organisation can operate effectively without trust.[1] In an institution that employs 1.5 million people and treats ten times that many every year, an atmosphere of mistrust can have seriously detrimental effects.

Finally, there is the effect of liberal humanism whose most successful myth claims that we will only make the most of this life once we have recognised that there is no other chance. Evolving against the background of 19th century Christianity (with its afterlife being the reward that sanctioned poverty in this world), the idea sounded admirable. Liberated from the bribe of eternal bliss, mankind was free to build his heaven on earth. 150 years later, utopianism has gone sour but its personal implications remain strong. With the loss of any widely accepted concept of resurrection, afterlife or eternity, Western man has developed a perfectly reasonable idolatry of health, not to mention beauty and appearance. We naturally think that if the here and now is all I'll ever have, I need to make absolutely certain that it will be perfect!' Failure will not be tolerated. Believing that we have no other life ensures that we demand the most from this one. And this means demanding the most from those who are in a position to optimise our health and happiness.

A biblical response

The idea of turning to the Bible to aid our thinking on healthcare may seem strange at first. Biblical teaching knows nothing of biomedicine and has no concept of an institutionalised healthcare service. What possible link is there? One answer to this can be seen in the structure of Roy Porter's magisterial history of medicine, *The Greatest Benefit to Mankind: A Medical History of Humanity*.[2] Loosely speaking, this has two plots that intertwine with one another in alternate chapters. The first is the story of medical discovery: anatomy and bacteriology, William Harvey and Louis Pasteur. The second is the tale of how such discoveries were used in society: the story of hospitals, slum clearances and vaccination programmes, Florence Nightingale and Aneurin Bevan. In the popular imagination, it is the former that saves lives. However, in the words of Ian McColl, former Professor of Surgery at Guy's Hospital, 'It often comes as a surprise [to learn] that the health of a nation is more dependent on public health and social issues that the clinical activities of doctors'. It is precisely this important social application of biomedicine that biblical teaching can help with.

The biblical concept of shalom must provide the starting point of any analysis. Shalom incorporates physical, mental, emotional and spiritual health, and when used of a community, it means societal and relational wholeness. It stands opposed to both reductionist concepts of health and humanity and to mystical dualist ideas in which the human essence or soul is considered separate from the body, as in Greek thinking two millennia ago. Biblical health is incarnate but more than simply meat.

The biblical model of covenant can be used as an antidote to modern consumerism. Models of covenant vary considerably according to situation and participants but the commonplace emphasis on mutual loyalty, obligation, trust and responsibility are instructive. Not only should 'consumers' not expect the same relationship with hospitals as with High Street retailers but they also need to recognise their own responsibilities.

The fundamental biblical principle that human beings have an intrinsic worth which is not contingent on their physical strength or economic viability will be of vital importance given the prospective demographic shifts in the West. In an organisation that is driven by economic considerations, it is all too easy for the 'uneconomical' elderly to be seen as 'bed blockers' who are a 'burden' and 'drain resources'. This problem is increasingly pressing, given the breakdown of families and community networks. The repeated biblical injunctions to honour the elderly and care for those who fall outside natural support networks need to be heeded.[3]

Biblical teaching provides other pointers. Radical other-person-centredness calls us to 'carry each other's burdens'.[4] Biblical anthropology recognises human beings as autonomous and therefore heavily responsible for their own health. The holistic nature of shalom recognises that emotional and spiritual health can profoundly affect physical health (and vice versa). None of these offers a panacea for the problems facing Western health services but they should guide and inform our thinking on this most iconic and 'religious' of topics.

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Nick Spencer's booklet 'Health and the Nation: A Biblical Perspective on Health and Healthcare in Britain today' is available free from The Jubilee Centre. To request a copy please e-mail jubilee.centre@clara.net or tel 01223 566319.

KEY POINTS

The failings of the NHS owe more to changes in the social, cultural and religious climate than to government policy or the clinical activities of doctors. The NHS is being swamped by a changing demographic balance, increasing consumerist expectations, loss of trust in authority figures and the rise of liberal humanism with its promise of 'utopia in this world'. A biblical response recognises that health is rooted as much in societal and relational wholeness as in good healthcare provision. A healthy nation results when individuals and communities take responsibility for their own health and for the care of those who fall outside natural support networks.

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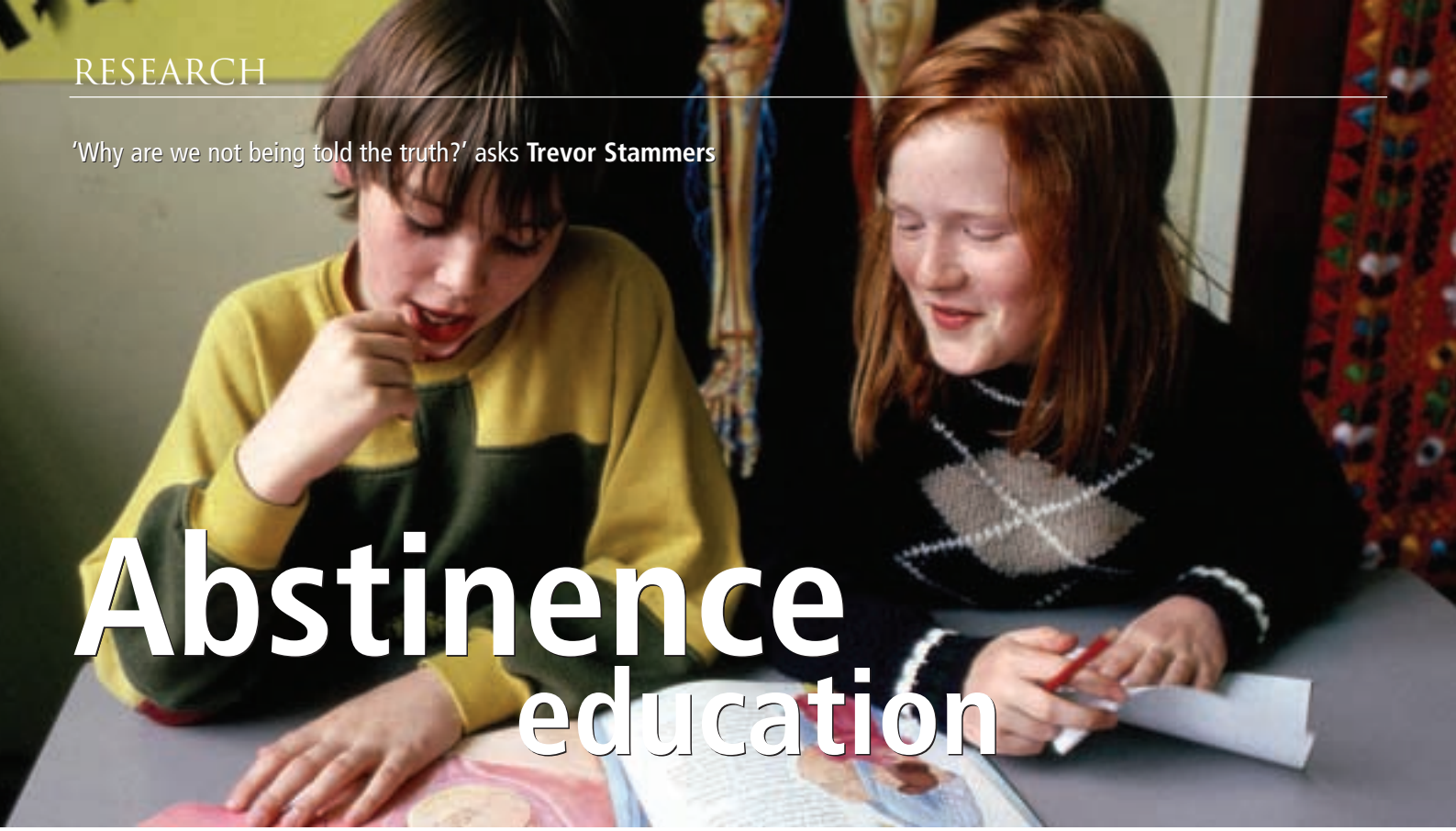

'Why are we not being told the truth?' asks **Trevor Stammers**

Abstinence education

KEY POINTS

The Chief Medical Officer's claim, that there is no evidence sexual abstinence programmes work, is simply untrue. The best data for their effectiveness come from the USA, where abstinence education has been well funded and rigorously evaluated, and Uganda where sexual abstinence is a major factor in plummeting HIV rates. However it is very difficult to get this message across in our hedonistic and post-modern culture where sex education is more ideology-driven than evidence-based. The difficulties have been accentuated by the church's general approach to sexuality which emphasises control rather than celebration and saying 'no' to sex rather than saying 'yes' to God's pattern for it.

If a lie is repeated loudly enough and often enough, it is not surprising that many people who ought to know better will believe it. I was surprised though, that the Chief Medical Officer did not check the evidence base for his recent claim in an Update sent to all GPs: 'Evidence does not exist to suggest that abstinence approaches are effective'.[1] This is simply untrue. The Department of Health may be unaware of the evidence or perhaps reluctant to engage in debate about it. Still, the evidence does exist and its strength is growing year on year.

The largest amount of data comes from the USA, where abstinence education has been both well-funded and certainly as rigorously evaluated as any safer-sex programs. In 1998, a randomised controlled trial compared both abstinence and 'safer-sex' interventions (including, even in the latter group, the information that abstinence was the 'best choice') with a control group (who received neither intervention).[2] At three month follow–up, subjects in the group receiving the abstinence intervention were significantly less likely to report sexual intercourse compared with the control group. This effect was not sustained at six months, but even a three-month delay in initiating intercourse is a worthwhile outcome in the high-risk group of mainly low-income, urban African-Americans studied.

A comprehensive and balanced review, 'Teen pregnancy: do *any* programs work?' (my emphasis), reviewed eleven primary pregnancy-prevention programs and showed published evidence of effectiveness as far back as 1987.[3] At least four of these are abstinence-focused approaches.[4,5,6,7,8,9] In the community-based abstinence programme there was a significant drop in the pregnancy rate during the full implementation period of the program.[10] Even some of the more contraceptive-focused programs include a strong abstinence message.[11]

Another community–based program to help adolescents avoid health risk behaviours was presented to children up to the age of eleven in Seattle.[12] At nine year follow-up when they reached the age of 21, participants in the programme were less likely to have started having sex by age 21, were significantly older at first sexual experience, had fewer sexual partners, were less likely to have become pregnant and were more likely to have used a condom at first intercourse. The striking features of this program are that it had no specific sex education component at all, though good decision-making (including abstinence) in many fields was encouraged more generally. The effects of this programme lasted for many years after completion.

The authors of a comprehensive database analysis concluded that making a virginity pledge (one of the aims of some USA abstinence programs) delayed the onset of sexual intercourse by up to three years. Even though this strong effect was conditioned by both age and social context, it still constitutes powerful evidence for some elements of abstinence education.[13,14]

Another recent paper describes the highly significant effect of an abstinence program in Monroe County, New York.[15] By the third year after implementation of the program, the percentage of students reporting intercourse by the age of 15 had fallen from 47% to 32%. The slope of the regression line for the fall in pregnancy rates of 15-17 yrs olds in Monroe County was two to three times that for surrounding areas of New York that did not run the program.

The wealth of data from the USA is given added weight by results just emerging from abstinence

education projects in Uganda.[16,17] ABC programs (Abstain, Be faithful or wear a Condom – very much in order of emphasis) are the norm in Uganda, following the strong leadership of President Museveni and his wife. HIV rates are plummeting in Uganda and sexual abstinence is a major factor. In one district between 1994 and 2001, the percentage of 13-16 year olds who had sex fell from over 60% to 5% for boys and from 25% to 3% for girls.[18] At the UN child summit last year, First Lady Museveni was quite blunt: 'The young person who is trained to be disciplined will, in the final analysis survive better than the one who has been instructed to wear a piece of rubber and continue with business as usual'.[19] The CMO and indeed the Government's current Sexual Health Inquiry would do well to act on her comments, rather than making indefensible statements opposing abstinence education.

This is even more important at a time when the effectiveness of condom and contraception promotion alone is being increasingly questioned and the myth of Holland's teenage sexual utopia is gradually being exposed.[20,21,22,23] Often there is a way, like condom promotion, that superficially looks right but it ends in death.[24] Far from being unrealistic, abstinence is the only pathway for teenagers to find sexual heath and fulfilment in later life, whether in subsequent marriage, temporary singleness or in lifelong celibacy.

However, it is extremely difficult to get this message across in our hedonistic, post-modern culture. For many people, the only ethical question to be asked about sex is 'Is it consensual?'. If the answer is 'Yes', then anything goes. The task is not made any easier by two frequent imbalances in the church's general approach to sexuality.

Firstly, we have given the impression that sex is a detrimental legacy of the Fall, rather than an integral component of Creation.[25,26] In emphasising control, we have forgotten celebration. Yet many teenagers, as well as older Christians, can and do celebrate their sexuality in celibacy. *Newsweek* recently ran several major articles on abstinence in the USA. The comments of young people interviewed were typified by one who said, 'It's a pretty special thing…Abstinence has to do with "Hey, are you going to respect this person?"'[27]

Secondly, we have failed to set a positive agenda by proudly proclaiming the positive dynamic of scriptural teaching on sex. This has meant Christian pronouncements about sex have largely been negative responses to specific issues such as abortion or homosexuality. For example, we have emphasised I Corinthians 7 rather than The Song of Songs. In promoting sexual chastity, we need to remember that it is not so much saying 'No' to sex but saying 'Yes' to sexuality expressed as God intended for our good.

Trevor Stammers is a London-based GP tutor who writes and broadcasts on issues of family and sexuality

Photo: Anthea Sieveking/Wellcome Photo Library

The monstrosity of sexual intercourse outside marriage is that those who indulge in it are trying to isolate one kind of union (the sexual) from all the other kinds of union which were intended to go along with it and make up the total union. The Christian attitude does not mean that there is anything wrong about sexual pleasure, any more than about the pleasure of eating. It means that you must not isolate that pleasure and try to get it by itself, any more than you ought to try to get the pleasures of taste without swallowing and digesting, by chewing things and spitting them out again.
CS Lewis, Mere Christianity

Photo: Anthea Sieveking/Wellcome Photo Library

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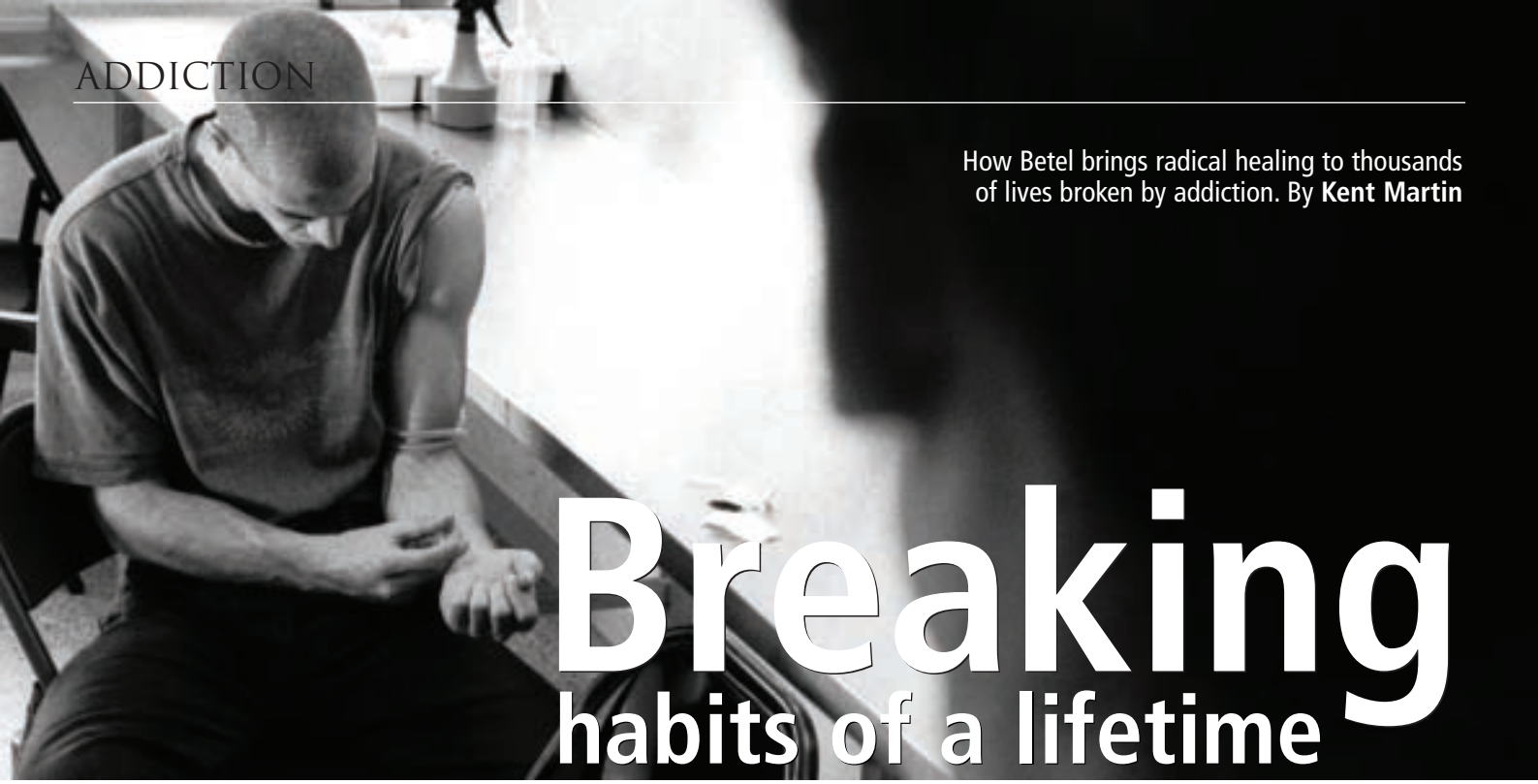

How Betel brings radical healing to thousands of lives broken by addiction. By **Kent Martin**

Breaking habits of a lifetime

On a typical day nearly 100 Betel residences in 11 countries host 1,200 recovering men and women

Imagine Paul arriving on your doorstep. After thirteen years injecting heroin, ten of those doubling up on methadone, he's been living in squats, prison or on the streets. Now he says he wants to change his life. At age 35, he's beginning a little late, according to his methadone-prescribing GP in Stoke-on-Trent. He told Paul that he'd never known anyone to come off hard drugs, not after ten years anyway. Studies showed that no one breaks the habit after that long.

That day in the surgery Paul not only accepted those fatalistic medical facts. He believed them and gradually the wish to die became his only hope. 'I'd never known anyone else to get off heroin or methadone – while alive,' Paul reflected later. He can name 29 dead mates to prove it.

Paul arrived on the doorstep of Betel of Britain in June 2001. Of the 1,550 men and women who have entered our doors free of charge since 1996 – like Paul – one-third have abused hard drugs or alcohol for more than ten years. 80% of the men and 62% percent of the women are ex-offenders. Today Paul beams when I remind him that it's been 18 months since he last touched heroin, methadone or any other mood-altering drug. He's 'clean', healthy, running a Betel business, and mentoring twelve recovering addicts as leader of a Betel residence.

As a hardcore addict Paul thought he had tried everything to change – cold-turkeying in prison, alternative drug therapies, professional counselling, lofexidine detoxes. Betel, however, was his first encounter with simple, radical Christian faith and the challenge of an abstinent lifestyle.

Betel (Spanish for Bethel) began in 1985 as a spontaneous street outreach to the large number of homeless and substance abusers living in northeast Madrid. When a young WEC International missionary dared to welcome one withdrawing addict into his flat, dozens of his junkie friends were soon begging to join them. Since then Betel has taken in nearly 60,000 recovering addicts free of charge in provinces across Spain and a total of 50 cities in Portugal, Italy, France, Germany, England, USA, Mexico, Russia, India and Greece.

Remarkably, in 45 of those 50 cities, Betel centres are run by men and women who themselves once entered from the streets seeking freedom from substance abuse. On a typical day nearly 100 Betel residences in eleven countries host 1,200 recovering men and women.

Betel of Britain

Betel launched in the UK in January 1996 following visits to Spain by several British rehabilitation specialists and church leaders. They invited Betel's directors to try establishing a successful alternative to conventional, government-funded rehab by adapting our income-generating model to the UK.

Seven and a half years later the charity runs nine houses: in Birmingham, Derby and Nottingham, offering 140 beds for men and women. The UK headquarters, located on a five-acre Bournville Village Trust property near Birmingham hosts 44 men.

Last year, 69% of the charity's income was generated via seven charity furniture shops, three gardening teams, a painting and decorating crew, two furniture restoration workshops, and a women's re-upholstery team. Senior Betel residents run all these business ventures. Remaining income is from housing benefit (18%) and donations (13%). A new programme to be launched this year will enable men and women to earn national vocational qualifications as they work, increasing their employability upon leaving Betel.

One of the benefits of generating most of our own income is that residents can stay beyond six or twelve months, the usual restraint on government funding. It means that people are freer to advance at their own pace. Those who feel the need to stay longer can. Another benefit is that people wishing to enter Betel don't have to wait three to six months to access Social Services funding. Betel can often accept people the

Photo: PA

day they call but normally it's possible within seven days, depending on available bed space.

Turning chaotic addicts into people like Paul who's become a responsible businessman running a painting and decorating team, doesn't come without a price tag. Radical problems require radical solutions. Men sometimes return from court hearings to report that judges, well acquainted with their criminal record, prefer to send them this time to Betel because the rules look stricter – and infinitely more purposeful – than what awaits them again in prison.

Upon entering Betel men and women must sign off primary or 'cashable' state benefits, which they readily admit serve little more than to help fuel the addiction treadmill. Drugs, alcohol and tobacco are off limits. Right from the start the goal is to break every chemical link in the chain to addictive behaviours.

As for withdrawal syndrome, most entrants don't manage to complete a medical detox before they arrive, which can take months to schedule. They undergo cold turkey. Unlike any previous cold turkey they've experienced, peers – people who've been through it – surround them in Betel. This helps strengthen their will for as many sleepless days and nights as necessary.

Many do leave in the face of this rigorous induction. No addiction is easily broken. But many return. In 2002, of the 409 men and women who entered our residences, 94 of them (or 23%) returned at least once. 'Easy entrance, easy exit' is our motto.

What of those who make it through six months, a year or more? Visitors often ask what motivates these hurting people to stay on, let alone work for the first time in years. Most are signed off the dole for the first time in adulthood.

The Earl of Shaftsbury wrote of the Salvation Army's early impact on a generation of East London alcoholics: 'The working classes will never be reached but by an agency provided from among themselves.' The reasons that helped quench the insatiable urge for alcohol and rebuild lives in the late 1800s are the same simple, if intangible, ones that motivate abstinence in the Betel men and women of today.

I've asked and listened to reasons for twelve years. They are not clinical, medical or professional. They cannot be crunched into statistics. In contrast to the cold isolation of prostituting themselves or thieving for drugs, wearied by guilt, bitterness and rejection, most say they stay in Betel simply because they feel loved. The obvious change in other tattooed recovering addicts around them inspires courage.

They stay, too, because of a deep gratitude and newly found purpose in their relationship with God. With passing time what keeps them persevering is the satisfaction of ownership – the role they play in building Betel. They're proud to feel part of something that is impacting society's most perplexing problem – the destructive power of which they know first hand – but which the government's deepest pockets and sharpest thinkers are still unable to solve.

A new database is helping us research the impact we've made since opening in 1996. In our first six

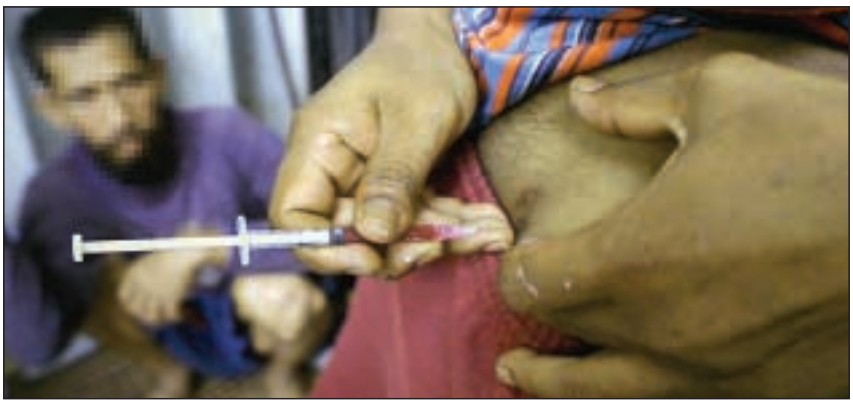

Photo: PA

years we hosted 1,072 first-time entrants free of charge. (Another 278 returned more than once.) More than 70 percent of first-time entrants arrived homeless (defined as either sleeping rough or declaring no fixed abode). Some 481 or 45% made it through the first two weeks of detoxification and stayed beyond 15 days up to six months. And of the 481, 31% or 150 men and women stayed completely drug free for more than six months.

In 2002 it cost us £180 per week to host each resident – half what another centre I know charges the Social Services. Our businesses generated £120 of that – or two-thirds per person. So only £60 per week came from external sources.

As the nation's drugs problem continues to grow, Betel is committed to breaking into the middle ground between hostel dwelling and rehabilitation, city by city. We plan to rescue those on the slippery slope of homelessness and addiction who want to rebuild their lives in a 'clean' living environment but who can't get into overburdened, under funded rehabs.

Betel is a safe, structured environment to make a fresh start in life but no one would call it 'clinical'. Residents often compare it to extended family, a family that many never had. Our local GP sees residents almost daily in his surgery; in seven years the local police have never had to respond to a single incident. In short, it's where broken men and women can gradually rebuild trust, faith and self-dignity with life's two building blocks that elude them most: meaningful relationships and meaningful work.

Paul and his three-man painting and decorating team get paid tomorrow. They are on schedule to earn £6,000 this month. His customers are awestruck by his story. He had lost hope of being anything but an opiate-addict for life, always taking from others. Now he thanks God to be giving something back, paying his own way to recovery.

In contrast to the cold isolation of prostituting themselves or thieving for drugs, wearied by guilt, bitterness and rejection, most say they stay in Betel simply because they feel loved

Kent Martin is Director of Betel UK

To refer people to Betel, receive free videos and literature (including leaflets for use in doctors surgeries), or find out about visitors days, write, ring or e-mail

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Peter Hill tells how a GP's dream led to a remarkable partnership

A tale of Two Sams

It seemed ambitious, but they sensed God could use them to bless war torn Sri Lanka and also Southern India

Six years ago Sam Mutheveloe, a GP in Milton Keynes, invited Sam Thevabalasingham to come to the UK to recuperate after a further outbreak of violence in Colombo. It seemed ambitious, but they sensed God could use them to bless war torn Sri Lanka and also Southern India. They prayed and discussed and soon Homsa (Hope Outreach Ministries of South Asia) came into being.

Then in 1999, a UK fact-finding group toured Sri Lanka to look at Homsa projects. Sam Thevabalasingham wanted to provide some medical help for the desperately poor local population. So he arranged for two doctors on the trip, together with a local colleague and his team, to do a one-day clinic. Starting at 9am and finishing at 10.30pm, 350 patients were seen. There was certainly a need. Since then three expeditions have taken place.

Key principles

The clinics have developed a number of principles. They aim to work in a way that reflects Jesus who came as a servant, healed and preached. At our first site, local pastors assist with the running of the clinic and minister to some patients by counsel and prayer. Through their involvement, a number of people have become Christians and one new congregation has been established.

A further principle is partnership. The aim is always to compliment, not supplement. We only go where invited, work within existing structures and respond to the lead of locals. Another aspect is education. At the hill country site we teach and provide equipment for the local practitioners who are only trained to the level of medical assistants. The clinics play their part in reconciliation being completely open to all sides of this fractured community. Finally, we believe continuity is crucial. It is planned to do a trip on an annual basis and train up locals to maintain care in between.

At present there are two bases. The first is the site of the rural pastors' training college in the hill country, caring for the desperately poor tea plantation community. The second is in the war-affected eastern area close to Batticaloa. This base is a Christian orphanage and church complex. The children are lovely chattering companions and the clinics are conducted under palm trees and within earshot of the welcoming Indian Ocean.

The medical clinics have developed a pattern. All patients are registered, weighed and have their blood pressure taken. Proper registration enables us to collect some statistics and undertake limited audit. Some see a nurse who does basic laboratory tests, asthma reversibility tests, inhaler teaching (asthma is a very severe problem) takes ECGs and does dressings. We usually operate with between four and six doctors and non-Sri Lankans need a translator. Twice in the past, we have gone with a dental team.

Moments to savour

It was a special joy to see Mr S, a 28-year-old, on his return to the clinic. He originally came with severe shortness of breath and unable to do a full a day's work. He had severe untreated asthma that was managed effectively with the inhaled capsules that we brought and are not normally used locally. Through the clinic he came into contact with one of our rural pastors and was deeply and dramatically changed following the screening of the Jesus Film.

Eight months on, he is able to do a full day's job, given up his dependence on beetle chewing, cigarettes and alcohol and has stopped his wife battering behaviour. The neighbours in the village were surprised at the change in his life, and wanted the same for themselves. Through his witness there is now a thriving home church of 60 persons formerly from the Hindu faith. He was physically, economically, domestically – and more importantly – spiritually restored to wholeness.

The future

God gave a dream to an NHS GP and his pastor friend. The dream is coming true. God-willing we would be pleased to enlist anyone who can spare either ten days or three weeks to join us on subsequent visits.

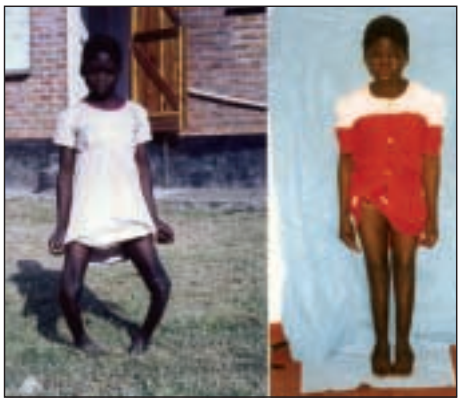
Peter Hill is a General Practitioner in Birmingham

Chris Lavy reports on a new Christian orthopaedic hospital in Malawi

PLUGGING A HUGE GAP

Malawi is a small, landlocked and very poor country in central Africa. It has been in the world news a lot recently. There has been a severe famine, but it has enormous needs in many other areas. It is estimated that there are 50,000 people who need elective orthopaedic surgery. It has a road accident rate that is ten times that of the UK. It has a chronic shortage of doctors. In 1998 there was only one orthopaedic surgeon in Malawi. Now there are four, which is a great increase, but it is still only one per three million. For the same population of twelve million, UK for example would have about 300 orthopaedic surgeons.

The BCTI Orthopaedic Hospital in Blantyre



Young girl with bow legs due to Blounts disease, before and after surgery

Something new

A new hospital has just been opened in Blantyre, the second city, which houses the ten year-old Malawi College of Medicine. The hospital was financed by a generous grant from the Beit Trust in UK and is run by CURE International, a Christian medical charity. It is called the Beit Trust CURE International Orthopaedic Hospital (thankfully this mouthful has already been shortened to 'BTCI'). It has 75 beds and two operating theatres. It takes both adults and children but concentrates on elective reconstructive surgery in children, as this is such a needy group. Poor children are treated at no charge but there is a small eight-roomed private wing giving treatment to richer patients to help cover costs. The medical director is Mr Jim Harrison FRCS(Orth), a CMF member from Newcastle, and the project director is Mr Arthur Aseka, an experienced hospital manager from Kenya. Both Arthur and Jim have come to Malawi specifically to run the hospital, bringing with them their wives Edna and Gail and a total of five children between them. They have been joined by Richard Brueton, an orthopaedic surgeon from St Thomas' and Guy's in London, and his wife Valerie.

The caseload for the hospital is varied, but the common diagnoses include club feet, angular deformities such as bow legs and knock knees, malunited and ununited fractures, osteomyelitis, septic arthritis and TB of the spine. A leg lengthening/bone transport service will be set up and arthroscopy, hip and knee replacement will be available.

Widespread Links

We do not want the hospital to be an isolated institution. We will be doing our best to link with, support, and encourage other healthcare and training institutions. The hospital has joined with the College of Medicine in the training of undergraduates and will form the cornerstone of a new postgraduate orthopaedic training scheme that is about to start. There is a library and research room set up by a generous grant from the Wishbone Trust UK and the orthopaedic department of Carlisle hospital. The hospital has two full time surgeons who both spend a day each week at the local government hospital in order to cement good relationships with the Ministry of Health and to help with the trauma load that fills the government hospital's orthopaedic beds.

Linkages outside Malawi will also be encouraged. Elective medical students and orthopaedic specialist registrars will be able to spend time seeing cases they rarely find in UK, learning a new health culture, and learning that there are many countries of the world where health services have to run on 1% of the NHS's resources.

Training Programmes

In addition to the undergraduate and postgraduate surgical training mentioned, the hospital will be the base for a training programme for orthopaedic clinical officers (OCOs). This is a group of paramedical clinicians that are unique to Malawi and have developed because of a longstanding lack of doctors in the country. They are trained in basic conservative fracture and injury management but have essential operative skills for emergency techniques. These include debriding open fractures and draining septic joints. Some 14 OCOs are trained each year and they are the backbone of the country's orthopaedic service. Most of them work in isolated district hospitals where there is only one doctor, who is often away. Surgeons from the new hospital will make regular visits to districts to support and encourage OCOs, to help them with their own cases and to see any referrals to the new hospital for more complex surgery.

Spiritual Ministry

BTCI hospital will strive to be an efficient and well-run hospital with as high clinical standards as possible. It will also be distinctively Christian in that the message of God's love will be at the very heart of the hospital. Each day will start with prayers. A hospital chaplaincy team is available to talk to any patient or guardian who wants to know more about the good news of Jesus Christ and his offer of new life. They will do this with great courtesy and respect in a multi-faith country with increasing Muslim influence.

Chris Lavy works in Malawi for CBM International. He is honorary professor of orthopaedic surgery at the University of Malawi, and chairman of the board of the BTCI hospital. His wife Vicky, a GP by training, is currently setting up a palliative care service for children, and is chairman of the Malawi CMF.

Olive Frost reflects on a change in career direction

The author (front left) with doctors and students in Central Asia

Out of the RECYCLE BIN

I would urge many doctors at the end of their professional lives to consider using their skills and sharing their faith in other environments

In June 1999 it seemed right to resign from a consultant post in the NHS and move into what might be compared to a recycling bin. At the time I felt I would like to be somewhere in the 'less developed world'. I thought I would like to be teaching women's health, with opportunities that involved more than dealing with physical needs and teaching. I wanted a change from my over-busy clinical load. So was such a position available and if so where?

One day I was turning these questions over in my mind when these words, 'You have wandered long enough in these hills, go north' became very meaningful. If I'd been in my home in North Wales I might have wondered whether I should go to Scotland or the North of England. But I was in Mazar in northern Afghanistan. From there Central Asia is rather directly north. So much of the time since has been spent there, teaching women's health and trying to encourage existing local believers in the health field and hoping for an increase in their numbers.

This area is part of the so-called 10/40 window. This is a term coined by global mission strategists to designate a huge region of the world (between the 10th and 40th parallels) where the gospel has least penetrated. There are many windows of opportunity within these windows at present. But although these opportunities abound now, we don't know for how long. So the more people who climb through them while they are open, the better.

The people of Central Asia are very hospitable and friendly. As anywhere else they have a mixture of beliefs. Many are nominal Muslims but are affected by the atheistic teaching of the last decades. Now that there is more freedom there is an understandable desire to return to roots that are mostly Islamic. But there is also a vacuum to be filled especially in the spiritual sense. With this has come an openness to hear, digest and accept good news. There is a great interest in Western medical information and practice as the medical system there is mostly based on Russian methods and teaching.

God speaks in ways unfamiliar to us Westerners and we need to discern his voice and leading. Recently I was asked to take a Russian Bible to a person living in a rural town. She had dreamt that someone would give her a book with the good news about Jesus. One of her tenants soon gave her a book but it was in Kyrgyz, while she was more at home in Russian. Hence the request to me which was rewarded with a lovely Kyrgyz meal and the news a month later that she had become a believer. She happened to be a midwife.

Leading a basic beliefs course through translation is one of my most memorable experiences. 'If this man died, was buried and got up again and has no known grave he must be alive now!' 'How good that perestroika occurred – we can now sit here learning from the Bible.' One nurse in the group came because her husband over ten days had stopped smoking, drinking and beating her. Why? Six days later she was a believer, too.

On speaking at a meeting on termination of pregnancy, I was brought flowers and three doctors befriended me. One said she had believed two years previously and she would like to meet with other health field believers for fellowship. Another said 'I read my Holy Book, but don't really know God – when did this happen to you?'

These are common experiences and many believe. But of course there are problems, too. There are many parents and traditionalists who do not want their children to be different and give them a hard time. Some politicians wish to change laws to restrict the present freedom and to make it more difficult for groups to be registered and function as they would wish.

For me this experience is a wonderful entry to what could be described as the autumn of my life – the colours are startling and changing and one wants to achieve as much as possible before winter comes. Life is not always easy and much patience is needed, for example in dealing with different ways and time frames for obtaining visas and to face fatty foods from day to day.

TCA no longer means 'To come again' but 'Third culture adult' – someone who is more at home in the presence of 'passing peoples' than a more stable population – something of course which has its own problems. But the rewards outnumber the problems and I would urge many doctors at the end of their professional lives to consider using their skills and sharing their faith in other environments.

Olive Frost, formerly a consultant at the Women's Hospital in Liverpool, is now based mainly in Central Asia. She specialises in Obstetrics, Gynaecology and Public Health.

Oluwarantimi Atijosan talks about a new initiative

Open House
Junior Doctor Style

Most house officers are shocked and ill-prepared when faced with all the responsibilities and lifestyle changes that go along with house jobs. Tiredness, cynicism and materialism soon begin to overshadow the enthusiasm felt on graduation day. Even in these shorter New Deal days, a junior's life can be at odds with maintaining an individual (and corporate) relationship with God.

This realisation led to the idea of an Open House. In Summer 2000 a group of Birmingham juniors saw a need for 'an informal venue where medics could meet together and share in the struggle to walk close with the Lord during the early years of clinical life'.[1] Like all the best ideas, it was simple. Open Houses meet regularly in a home (hence the name) and provide a forum where people can drop in and get to know one another. Juniors can talk about their concerns and struggles and encourage one another to face them as opportunities to witness for God and experience a deeper relationship with him.

Birmingham's Open House takes the format of regular meeting at one particular venue: they start at eight o'clock with snacks and follow on with a discussion and then 20 minutes of prayer. Afterward, there is some time for eating and fellowship.

Since then, various junior doctors' groups have sprung up all over the country, each one taking on a different form in order to serve the needs of its area. For example, having seen many friends struggle through their house jobs, one Liverpool-based medical couple began hosting monthly meetings. Their aim in meeting together is based on Scripture: 'And let us consider how we may spur one another on towards love and good deeds. Let us not give up meeting together as some are in the habit of doing, but let us encourage on another - and all the more as we see the Day approaching'.[2]

Leicester's Open House started from a *Saline Solution* course in 2000 and so the group is called Saline Solution. This Open House continues to meet at least once a month and aims to support fellow Christian juniors through fellowship, prayer and discussion. They plan to run *Saline Solution* courses in the future as they give good grounds for discussion and encouragement.

Interface began in the heart of one London A&E doctor who found herself working alongside a surprising number of Christians. This Open House is spluttering along, seeking ways to meet the particular needs of London juniors. Its main difficulty is finding a central London home to use as a regular venue.

The Dundee group started because an Aberdeen doctor had previously experienced Christian support and fellowship in another city and wanted this to continue in his new location. Monthly meetings at different people's houses provide venues for fellowship and prayer. They too have problems, sharing the common problem of difficulty in keeping-up with which juniors are coming into their area.

Having given a sample of some of the groups meeting around the UK, I hope to inspire you to go and seek out your local group. Each one has individual strengths and weaknesses, quirks and challenges; still, they all seek to provide 'a forum for Christian junior doctors to meet to have fellowship and to challenge one another so that we not only survive but we face up to and enjoy the opportunity of being the best for God'.[3]

If you're a student or junior doctor then these are great places to be encouraged, to have fellowship, to develop friendships and deepen your relationship with God. If you already have enough encouragement, fellowship, friendship, then you could go and share this with others. Open House teams always welcome people who are willing to come and help out.

Even if your hair were somewhat greyer than the average junior doctor's, we would still love you to come along. These groups provide an established means for fostering fellowship between juniors and seniors at local levels. Open House groups always welcome more help: as a speaker, mentor (someone who is slightly further along the proverbial path), prayer-partner or even financier!

If there isn't already an Open House in your area, why not consider starting one yourself? To help you on your way, the Birmingham Group have written a starter pack (now being used internationally) that is available from CMF central office.[4]

However this article touches you, I hope you will be encouraged to know of this ministry as it seeks to further strengthen, encourage and enable junior doctors to grow and deepen their relationships with God.

Oluwarantimi Atijosan is a general surgical SHO in London

For more information please contact your Junior Doctor Representative on the back of CMF News or contact me at CMFInterface@hotmail.com.

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2. Hebrews 10:24-25
3. Atijosan O, Beckles V. *Interface Leaflet*. London: CMF, 2000
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EUTYCHUS

Patient-Assisted Dying Bill

A new bill aiming at the legalisation of euthanasia had its first reading in the House of Lords on 20 February. It is due to be debated in May 2003.

Designer Baby Decision

Triple Helix readers may have missed the fact that just before Christmas *Comment on Reproductive Ethics* (CORE) won a High Court judicial review against the Human Fertilisation and Embryology Authority (HFEA), by successfully contesting the right of the HFEA to permit pre-implantation genetic diagnosis for the creation of human embryos as specific tissue matches for sick siblings. CORE had argued that the HFEA was overstepping its remit and taking decisions that were Parliament's alone. The prestigious Science and Technology Committee had already criticised the HFEA on this very issue of tissue-typing in its 2002 report on Developments in Human Genetics and Embryology: 'Parliament does not need protecting and democracy is not served by unelected quangos taking decisions on behalf of Parliament'. (*Evening Standard* 2002; 20 December:5)

30th anniversary of Roe vs Wade

Over 40 million abortions have been performed in the US since the Supreme Court's historic Roe vs Wade ruling of 22 January 1973 authorised the legal killing of unborn children nationwide. Former abortionist Bernard Nathanson, in his 'Confession of an ex-abortionist' in which he admitted to being personally responsible for 75,000 abortions, described the tactics he (and others) used to change the law as a founding director of NARAL (National Abortion Rights Action League): 'We persuaded the media that the cause of permissive abortion was a liberal enlightened sophisticated one. Knowing that if a true poll were taken we would be defeated, we simply fabricated the results of fictional polls. We announced to the media that we had taken polls and that 60% of Americans were in favour of permissive abortion laws. This is the tactic of the self-fulfilling lie. Few people care to be in the minority. The number of women dying from illegal abortions was around 200-250 annually. The figure we constantly fed to the media was 10,000. These false figures took root in he consciousness of Americans.' 1.3 million American women still have abortions every year and despite recent gains the Pro-Life movement's goal of overturning Roe vs Wade has remained elusive.

Demographic shifts

Britain's high abortion rate (almost 6 million since 1968) and falling birth rate will mean that over 65s will outnumber under 16s for the first time by 2014. The findings are reported in the social trends survey published by the Office for National Statistics (ONS) for England and Wales. Penny Babb, one of the authors of the report, said: 'We are in the midst of one of the most striking demographic shifts for generations as the ageing population has become a reality'. (*Daily Mail* 2003; 30 January) The former President of the European Bank for Reconstruction and Development, Jacques Attali, has stated in an essay in *L'Avenir de la vie*: 'As soon as he goes beyond 60-65 years of age man lives beyond his capacity to produce, and he costs society a lot of money...euthanasia will be one of the essential instruments of our future societies.'

Unsupervised sex

Most teenage sex takes place at home, and a significant number of 'encounters' happen before 6pm according to a survey reported in *Pediatrics*. The association between lack of supervision and risky sexual behaviour was borne out by the observation that boys who were unsupervised for more than five hours per week were twice as likely to have gonorrhoea or chlamydial infections.

(*www.pediatrics.org/cgi/content/full/110/6/e66*)

Spirituality and clinical care

Spiritual values and skills are increasingly recognised as necessary aspects of clinical care according to a leading article in the *British Medical Journal*. Larry Culliford, Consultant Psychiatrist in Brighton, reviewed the literature and cited a signal publication by Koenig et al, covering 1200 studies and 400 reviews. The article also quotes a World Health Organisation report which asserts that 'Patients and Physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process', and concludes that 'spirituality and clinical care belong together' and that 'the time is ripening for doctors to recall, reinterpret, and reclaim our profession's sacred dimension'.

(*British Medical Journal* 2002; 325:1434-1435, 21 December)

Oregon apologises

Oregon's governor, John Kitzhaber, has officially apologised to thousands of state residents who were sterilised under a eugenics bill which was passed in 1913 and stood until 1983. A total of 2,648 people who were mentally ill, had epilepsy, were criminals or were homosexuals were sterilised by castration, tubal ligation, hysterectomy or vasectomy. Oregon was only one of 33 US States to enact eugenics laws between 1900 and 1925.

(*British Medical Journal* 2002; 325:1380, 14 December)

Discrimination against Muslims

An article in *The Times* has reported that British medical schools have started to restrict the number of Muslim students because they refuse to learn about abortion. The proportion of medical students from ethnic minorities in Britain has risen from 10% to 33% over the last 20 years, and the Council of Heads of Medical Schools has expressed concern that tutors are now unable to teach the full syllabus on account of the refusal of Muslim students to participate in certain courses that run counter to their faith. Many Muslims (and Christians) still seek to abide by the principles of the *Hippocratic Oath* and *Declaration of Geneva* (1948) which forbid abortion and it appears that this may work against them in 'enlightened' 21st century Britain.

(*The Times* 2003; 17 February:4)

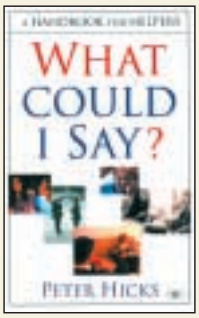
Dolly dead!

Dolly, the first cloned mammal, has been put down after developing a lung infection at the Roslin Institute in Scotland. At the time of *Triple Helix* going to press it remained unclear as to whether her early death was linked to flaws in the cloning process. Meanwhile the claim of members of the Raelian cult, to have successfully cloned a human born over the Christmas period, remains unsubstantiated.

(*Observer* 2003; 16 February)

BOOKS

What Could I Say?



Peter Hicks
IVP 2000
Price £9.99 Pb 305 pp
ISBN 085115381

Peter Hicks has set out to produce a handbook for the Christian lay counsellor or 'listening friend'. The result is admirable and would prove a valued resource for any caring Christian organisation or home. The first section is a short description of some of the major principles of Christian counseling. These are outlined in brief, easily read subsections such as, 'I sat where they sat', 'Make it easy to be honest', 'Don't judge'. Acceptance, listening, openness, empathy, care, confidentiality and thoughtfulness are all emphasised and combined with Christian spirituality.

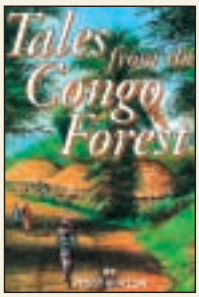
The much longer second section addresses 71 life events and issues. Some, such as pornography, occupy only two pages, while others, such as marriage and bereavement are discussed more extensively on six or seven pages. Subjects addressed include singleness, single parents, sexual issues, divorce and parenting, as well as those less commonly considered such as change, disability and step families. Also selected are common medical problems such as depression, addiction, substance abuse, Alzheimer's disease, miscarriage and abortion.

There is no pretence to deal with anything in depth. Each section has a helpful but brief overview that is usually followed by a subsection on offering practical help, and another entitled 'What could I say?' A number of Bible references are given, relevant to each particular section. Many sections are concluded with a carefully selected list of useful books or Christian resources, as well as national secular and Christian agencies relevant to the problem.

The author does not attempt to solve the many ethical issues, but is to be commended on his encouragement to assume a distinctly Christian approach. If you are looking for radical or alternative insights, this is not the book for you. Rather, it is 'a safe pair of hands' for the lay Christian who wants to help. It would not be out of place on the bookshelf of a caring professional.

David Child is a General Practitioner in Birmingham

Tales from the Congo Forest



Peggy Burton
King's Highway Books
2002
£ 6.99 Pb 163pp
ISBN 0 9541015 2 9

At a recent whole day meeting on 'Surgery in the Tropics' at the Royal College of Surgeons in London, several speakers regretted that little had changed in tropical Africa. Indeed, thirty years after some had spent time working there, conditions appear to have regressed economically and medically. This collection of stories by Peggy Burton, a nurse who worked with her doctor-husband in the Belgian Congo fifty years ago, remains a useful and challenging source of information about conditions likely to be met there.

How does one manage to make diagnoses and treat desperately ill patients when there is no X-ray machine, pathology laboratory or blood bank? Has any reader had to stuff a burst tyre with grass in order to get home? Without proper tools, how do you deal with an impossibly large tree trunk lying across the road? This book is a valuable source of lateral thinking and improvisation. Over and over again, Peggy and her husband James Burton describe how God answered their prayers in difficult medical and life situations.

Fascinating chapter headings such as 'A Weighty Problem and a Goat', 'River Boat Riots' and, 'Pythons and People Power', provide an insight into the culture and lifestyle of the village dwelling Congolese. The chapters are short and the whole volume is light reading, although there is a heavy ending. The Burtons returned home for health reasons shortly before the ghastly events of the Simba rebellion following the granting of independence from Belgium in 1960. Many of their missionary and African Christian friends were appallingly treated at this time and several lost their lives.

This book is a companion to their autobiography 'Born to Serve', which also tells how God used these seeming disasters in their lives to prepare them for other fields of service. It is a challenge to any young Christian of an adventurous character and would make an excellent Christmas or birthday gift.

Arthur Wyatt was formerly a Consultant Surgeon in Greenwich and latterly has made many short-term overseas working visits

The Saline Solution

Sharing Christ in a Busy Practice – Small Group Video Curriculum
Christian Medical & Dental Society, P O Box 7500, Bristol, TN 37621-7500 USA
A Paul Tournier Institute Video Release 1999.
$99.95

Christian doctors often face a challenge and dilemma. We know that we have been called by God to be witnesses to Jesus. We work with patients who often have anxieties and spiritual needs as well as physical illness. We would like to address these needs but feel uncertain about what to do. Is it ethical to talk to vulnerable patients about faith? Are we only in medicine for the patient's medical care or has God given us other responsibilities?

The Saline Solution is a practical training programme that addresses these questions and enables doctors to become witnesses to Jesus in the workplace. The course promises that doctors will learn to discuss spiritual matters with their patients in a way that is comfortable for both parties. The course teaches how to take a spiritual history, how to write a 'spiritual prescription' and how to develop a 'spiritual-consult network'.

The Saline Solution was devised by Walter Larimore and William Peel for the Christian Medical and Dental Society in the USA. The course material consists of a written Participant's Guide together with videotaped presentations. The programme is divided into ten sessions that can be followed as a weekend retreat or as ten separate meetings. Each session contains video segments, a case study, group discussion and prayer time. It is envisaged that this material could be covered

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in about 90 minutes. The most effective way to use the course is to participate in a group with other learners.

The Participant's Guide is an impressive publication. As well as steering people effectively through the course, it is packed with well researched essays on such issues as 'The Faith Factor in Health - what does the research show?' The ethics of evangelism in the doctor-patient relationship is tackled thoughtfully. Practical skills are taught in a way that is easy to retain, for example, the questions involved in taking a spiritual history are encapsulated in the mnemonic SPIRIT.

The videotaped material is produced professionally. There are presentations from the course authors and testimonies from participants on the course. Professional actors are used to portray doctors in different settings, highlighting issues for discussion and consideration by the course participants.

Overall, this is an excellent course that should really help Christian doctors to integrate their faith with their medical work. The only drawback is that the material is written and presented in the context of American culture. This means that some of the written material is less relevant to British medicine, for example one session is devoted to 'office environment', which might be difficult to change into an NHS hospital outpatient clinic. Sometimes the style of the videos is reminiscent of American news programmes, which British participants might find less accessible. I would certainly commend the course, but feel in time that we need an Anglicised version.

Chris Summerton is a Consultant Gastroenterologist in Manchester

David Livingstone: The Man behind the Legend

Rob Mackenzie
Christian Focus Publications 2000
£11.99 Hb 389pp
ISBN 1 85792 6153

This book is the third biography of David Livingstone to appear in the last few years. It avoids the modern tendency to historal revisionism so common in many biographies today and provides a clear, honest and straightforward account of the life and work of Livingstone as a pioneer Christian missionary in Africa. The author has lived long in Africa and has read widely in the primary and secondary sources of his material.

He describes the three themes that dominated Livingstone's life as those of 'evangelism, exploration and emancipation'. To these we must add his robust Christian faith and unwavering sense of vocation which inspired all his activities. The author gives graphic accounts of the incidents of Livingstone's life, many of which have formed part of the 'legend', but which nevertheless were actual and historical.

There are numerous references of medical interest in the book. Livingstone prescribed his own pills, 'the Zambezi rousers', for treatment of fever and although they contained only three grains of quinine, they were even said to be successful in treating malaria. Attacked by a lion in 1884, he sustained a compound fracture of his left humerus from which a false joint eventually resulted. This false joint was one of the features by which his body was identified when it was received in London in 1874. An appendix to the book reproduces the report of the post-mortem examination of Livingstone's body after it had been brought to London 'by faithful hands over land and sea'.

There are many references too to Livingstone's work as an evangelist, mostly quoted from his diaries and letters. He spoke to individuals in personal evangelism and to groups in informal services. However, Livingstone soon learned that the task of pioneer missionaries like himself was to be sowers of the seed, not reapers of the harvest. That was left to others who came after him.

This book contains much more than can be indicated in a brief review, but it can be confidently recommended as a handy, readable and well-informed factual account of the life and work of one who was a faithful servant of God and of the people of Africa in his generation.

John Wilkinson is a retired Consultant in Public Health and a former medical missionary

Rebuilding the Matrix – Science and Faith in the 21st Century

Denis Alexander
Lion 2001
£12.99 Pb pp510
ISBN 0 7459 5116 3

This book on the interface of science and faith is a real work of scholarship that should be in the library of all serious readers. It is written by Denis Alexander, a Fellow of St Edmund's College, Cambridge and current Chairman of the Molecular Immunology Programme at the Babraham Institute. The early chapters show how easily false paradigms with no foundation of truth can be insidiously assimilated into our worldview. Scientific discoveries have by no means 'disproved' the existence of God but are continually used by secularists to promote their view that this is so. The following chapters trace the development of scientific enterprise from its medieval roots to today's post modernism.

A central chapter, 'Reweaving the Rainbow' makes a powerful case for Christian theism. The later chapters cover three aspects of evolutionary theory, firstly showing that it is by no means incompatible with belief in a creator God. Then follows an excellent critique of the claims of those who see evolution superseding belief in God as either creator-sustainer of the universe or the source of moral behaviour. The author thirdly suggests that care for our neighbour depends on our often-unacknowledged belief that he or she is made in God's image.

There are descriptions of a huge number

of historical figures (the index of names occupies seven pages) who demonstrate the consistency of the link between the study of natural science and the Christian faith. We see the origins of conflict 150 years ago when 'scientists' were first so labeled and had to fight to wrest their terrain from the powerbrokers who were often clerics. The battle was more one of professional rivalry than God versus Science. The penultimate chapter focuses the miracles and resurrection of Jesus. The length of the book is daunting but the chapters are complete in themselves and the author has a light, sometimes humorous touch, making it easy to read. It is thoroughly recommended.

Caroline Berry is a retired Clinical Geneticist and Secretary of Christians in Science

Jesus, MD

David Stevens with Gregg Lewis
Zondervan Publishing House 2001
$16.99 Hb 224pp
ISBN 0 31023 433 6

David Stevens starts from the premise that very few people these days have contact with shepherds, princes or kings, but to describe Jesus in terms of the Great Physician will strike a chord as everyone has had contact with a doctor. Stevens is currently the Chief Executive Officer of our sister organisation in the United States but writes from his life experience as a doctor in the USA and as a medical missionary in Kenya. He is a great storyteller.

In his introduction he asks what sort of doctor Jesus would have been, and which speciality would have claimed him as its own. He made the lame walk, the blind see, the deaf hear, cured infectious diseases, heart failure, palsy, menorrhagia and had much contact with children and the mentally ill. More importantly, he suggests, 'by looking at both the practice and the person of Jesus I have begun to see not only the kind of doctor but the kind of person I want to be'.

Using the template of a doctor's working life, Stevens develops his theme using intriguing chapter headings, each starting, 'The Great Physician…', and ending, 'regularly spent time with his chief', or, 'established his own residency programme', or, 'knew the power of touch'. Stevens goes on to say that people didn't require an appointment to see Jesus, interruptions were taken as opportunities and that Jesus knew what it was like to be 'on call'. Jesus practised excellence with compassion, knew how to 'properly scrub', 'advocated a unique saving plan' and 'specialised in impossible cases'.

This is a scripturally based book but the Americanisms are a bit off-putting and it took me a while to work out what some of them meant. The book is lavishly illustrated with stories from Stevens' own experience and having been a missionary doctor himself he can't help but identify Jesus as the missionary medic *par excellence*.

He hopes that the book's usefulness will extend beyond the medical fraternity. I doubt this, but it will certainly open the eyes of doctors to the excitement and challenge of missionary medicine and I would love to see it put in the hands of all students setting off for an elective overseas. It shows us all the way that Jesus approached people and how we should practise medicine if we want to follow in his footsteps and walk in his ways.

Peter Armon is CMF Overseas Support Secretary and formerly a Consultant in Obstetrics and Gynaecology

Hand to Hand – a Marine's Journey from Combat to Healing

Nigel Mumford
Hodder & Stoughton 2002
£5.99 160 p pb
ISBN 0 340 78714 7

Written by Marine Commando Nigel Mumford following the reported miraculous healing of his sister, this book covers the story of his journey through which he overcame disorders such as post-traumatic stress syndrome to become a minister of healing. As the reviewer, I have two relatives with chronic, incurable diseases - an infant with Cystic Fibrosis and a young mother with progressive Multiple Sclerosis. I write this with them in mind.

The biblical basis for the author's ministry is typical of the genre: 'We are commanded to preach the kingdom and heal the sick' (p64). There is no reference to the next phrase, 'raise the dead', or to the command not to take the Gospel to the Gentiles (Matthew 10:5-10). The Great Commission of Matthew 28 gives a very different mandate. Mumford quotes 1 Corinthians 12:4-12, writing, 'I believe that we are all, without exception, given gifts of healing' (p124). This is the exact opposite of the central point that the apostle Paul is making in this passage; different gifts are given to different Christians for the common good. The author then goes on to say, '[James 5:14-16] offers, in my opinion, the biblical root of the healing ministry…these words need to be read and re-read to know this is where the journey of healing begins. It incorporates the laying on of hands…' (p120). This passage, however, does not mention the laying on of hands but rather anointing with oil and praying by the elders.

Even in his treatment of the Gospel, Mumford appears to be muddled: 'God sees us as perfect creatures', (p40) but he then says, 'The past is gone. We may still have our guilt but with God's help we can let go of the pain' (p112). He has little to say about the Cross or forgiveness of our sins, even in his prayers. He does not distinguish Christ's miracles from ours, and asks how we can carry out the healing ministry of Jesus (p123).

There is no medical documentation on the medical cases. A kidney stone passes naturally, avoiding an operation. A clinical diagnosis is not confirmed by investigations. His 'best case' is an infant with bowel obstruction due to a (umbilical?) hernia. It resolved spontaneously (p105). While he claims the benefit of prayer can never be scientifically proven (p46), I would suggest that these are everyday medical events.

In a section strangely entitled, 'Why are some healed and others cured?', he focuses on a five-month-old baby with Cystic Fibrosis. As he prayed, the sun came out and shone on the child. 'It was to me as if God was sending us a message of hope'. It is not clear what he means by this and he appears to have no understanding of incurable diseases. I think this book is naïve, deeply subjective and seriously unhelpful.

Peter May is a General Practitioner in Southampton

OPPORTUNITIES ABROAD

Specific Vacancies by Continent and Country

Posts mainly 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: *MMA HealthServe* at Barker House, First Floor, 106-110 Watney Street, London, E1 2QE. Tel: 020 7790 1336
Email: info@healthserve.org
Website: www.healthserve.org

China

JHF Medical Services are recruiting helath professionals for two programmes.

1. A three month programme in Qinghai Province in NW China teaching local doctors basic medical sciences. This is currently running and continues until April
2. A two week spot programme in Eastern China to a rural area near Beijing. It runs from 31 May to 5 June. It will also involve teaching local doctors.

Contact: Dr Douglas Noble.
Email: Douglas.noble@doctors.org.uk

India

CMC Ludhiana is planning to start a Rapid Response Unit along the lines of paramedic teams in the UK. They are looking for a doctor with skills in A&E to train the team. Their original trainer has had to drop out. Ideally they would prefer to run a six month course but someone able to run an intensive 3-4 week course would be acceptable. Board & accommodation provided but otherwise self-funding required.
Contact: foluk@charis.co.uk

Nigeria

Teleserve is looking for Orthopaedic and Plastic Surgeons for Short term trips to a crisis situation in Nigeria, to carry out reconstructive surgery and provide training for local surgeons. Teleserve provide Telemedical support to 'volunteer workers' in remote parts of world. Currently four GPs act as gatekeepers for emails from individual workers or expatriate doctors. There are opportunities for both GPs and specialists. Further details are at www.teleserve.org

For further details of either project **contact:** Tim Lyttle. Email: tim@lyttle.org or Tel: 01691 655795.

Russia

PRIME needs tutors for Samara Russia, one week early summer (July). A teaching course on Communication and Ethics has been requested in Samara with an estimated group of 50-60 doctors. If you are interested, please **contact:** John Geater on 01424 424955 or Email j.geater@which.net

Uganda

Medical Superintendent needed for **Kiwoko Hospital** in Luwero, Uganda. Ideally to be in place by April 2003. Needs to be a doctor with at least five years experience. Involves supervision of all the hospital activities including community care (CBHC), junior doctors, a nurses training school and chairing the management team. The hospital comes under the Church of Uganda and while the candidate would not need to be an Anglican.

Contact: Nick Wooding, Kiwoko Hospital, PO Box 149, Luwero, Uganda.
Tel: 00 256 77 588606
Fax: 00 256 41 610132

Zimbabwe

Bonda Hospital is still looking for a third doctor to work in this rural Anglican mission hospital in the picturesque Eastern Highlands of Zimbabwe. It has 150 beds, 50 nurses and two doctors. The ideal candidate would have at least four years experience including medicine, surgery, obstetrics and paediatrics. The job offers a demanding but rewarding experience as part of a small team responsible for all aspects of health care in the hospital and surrounding district. For more information please **contact** the Medical Superintendent, Bonda Hospital,
Box 3896 Bonda, Zimbabwe.
Email: mmcnally@healthnet.zw

Prison Fellowship International

PFI is looking for doctors to serve for one to two weeks in some of the world's poorest and darkest places and prisons. Since 1995 the Global Assistance Programme (GAP) has mobilised some 500 medical professionals and support volunteers to bring relief and hope to more than 55,000 individuals in prison and prison communities around the world. GAP runs ten projects a year and is always looking for people to serve. If you would like further information and or a 2003 project schedule contact us or visit www.pfi.org and look under programmes and services. Salary: raise your own.

Contact: gap@pfi.org

EVENTS

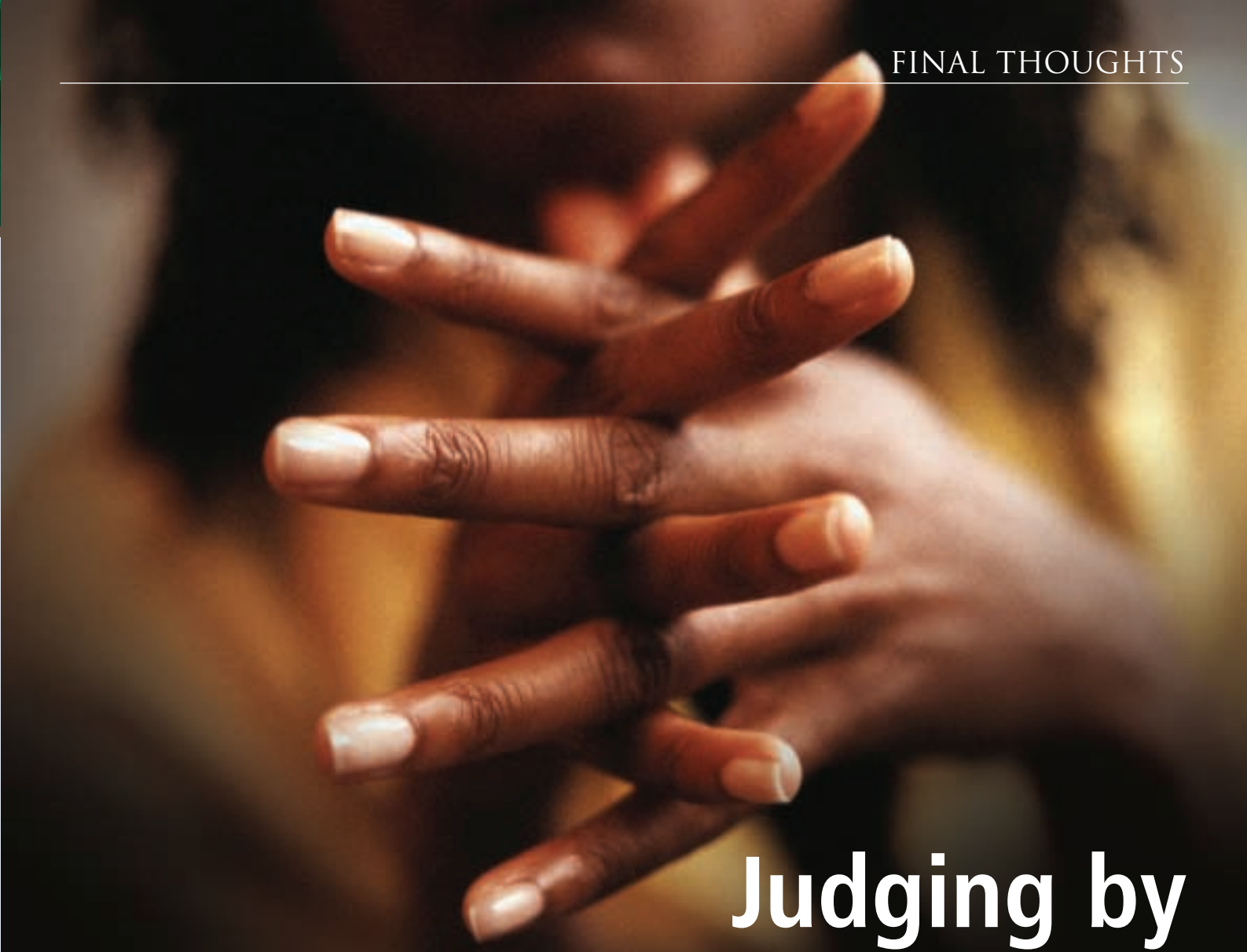
The Residential Refresher Course 7-18 July 2003 at Oak Hill College in North London. The programme is now virtually complete and will soon be posted on the website: www.cmf.org.uk This year's course will include some interactive workshops on AIDS, paediatric, surgical and obstetric emergencies as well as the usual wide ranging coverage of medical issues. **If you or anyone you know is contemplating working overseas or you have mission partners home on leave, this is a 'not to be missed' opportunity to enhance your knowledge and skills. (Recognised by RCP for CME)**

MMA HealthServe Day celebrating 125 years of their existence will be held on 12 July 2003 in the midst of the Refresher Course and at Oak Hill College. Aimed at informing healthcare workers of the needs and opportunities overseas, there will be seminars and keynote speakers with a thanksgiving service to wind up the day. **Contact** Steve@healthserve.org for details

Medical Missions Day Conference – 28 June 2003 organized by CMF and held at Partnership House, London. Open to medical students and graduate members. The day is aimed at medics at all stages of their training and careers. David Carling and Ted Lankester will be giving key note addresses on '***A Scriptural framework for medical mission***' and '***Changing concepts in medical mission***' respectively. There will be a wide choice of seminars looking at opportunities to get involved and related issues.

ITEMS NEEDED

Sonicaid(s) urgently needed for Bonda Hospital in Zimbabwe. Please **contact** Sharon Kane. Email kane@telco.co.zw



Judging by appearances

She was only 15 years old. Both she and her parents were in tears when they came to my clinic in Tanzania. The story came tumbling out between her sobs. She had just been expelled from school. They said she was pregnant. She vehemently denied it saying that she didn't even have a boyfriend. In a country where secondary schooling was at a premium and places for girls like gold dust, it was totally unacceptable for her to be pregnant and expect to stay on at school. She knew that.

Once everyone had calmed down a bit I took a careful history and examined her. She certainly looked as though she might be pregnant. Her abdomen was enlarged to the size of a term pregnancy and a pregnancy test was positive. However, I couldn't feel any fetal parts or pick up the fetal heart with a Sonicaid. We didn't have access to ultrasound and had minimal laboratory facilities. I was able to get an x-ray to look for bony parts and this proved negative.

The girl was relieved to be believed. We agreed to an exploratory laparotomy. She proved to have a very large ovarian cyst and my suspicions were confirmed that this was a malignant teratoma (later shown to have elements of choriocarcinoma within it). There was secondary spread to other organs and it was impossible to remove it all. We had very limited supplies of chemotherapeutic agents but she was given what little we had over the course of the next few weeks. The cancer proved unresponsive and spread rapidly. She died within a few months.

Things aren't always what they seem to be. How often, however, do we jump to conclusions and rashly judge people by outward appearances? First impressions can be misleading. Reputations can so easily be irreparably tarnished and – as in this case – gross insult and humiliation added to injury by a hasty judgement.

In the Old Testament the prophet Samuel almost makes the same mistake. He was looking for a king for Israel. Several of Jesse's sons pass before him. He is ready to anoint any one of the first three, thinking 'surely the Lord's anointed stands here before the Lord?'. God had to speak firmly and clearly to him. No, this was not the one. God reminded him, 'The Lord does not look at the things man looks at. Man looks at outward appearances, God looks at the heart.' (1 Samuel 16: 6-12)

We need to make sure we are in possession of all the facts before we act. We need to be sure we see things from God's perspective and have 'the mind of Christ' before we speak out.

Peter Armon is CMF Overseas Support Secretary

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