TRIPLE HELIX

Spring 2004

For today's Christian doctor

ACUPUNCTURE

KOREAN CLONES

JOFFE BILL

CHOOSING HEALTH?

IMITATING CHRIST

MMR AND AUTISM

CHILD PROTECTION

GENDER IDENTITY

METHADONE

OVERSEAS OPPORTUNITIES

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EDITORIALS

Korean clones

Unsafe, unnecessary and unethical

The February announcement[1] that South Korean Scientists had cloned 30 human embryos generated the media frenzy and overhyped predictions we have come to expect in this area of research. But the true facts were less impressive.

The team at Seoul National University used 242 eggs from 16 women donors; from which they derived 30 blastocysts. They ended up with just one line of stem cells, derived from a blastocyst made from an enucleated egg and transplanted nuclear material *from the same woman*.[2] The theoretical possibility of producing stem cells for therapeutic purposes from cloned embryos has thus moved one step closer but many practical difficulties remain.

First, the low efficiency of mammalian cloning (only 0-5% become viable offspring)[3] highlights the high frequency of genetic abnormalities resulting from the technology. It is not yet known whether similar abnormalities would occur in stem cells derived from cloned embryos, but it stands to reason that they would. Second, some of the diseases given as candidates for cell therapy are autoimmune conditions like type I diabetes; suggesting that cloned stem cells derived from the patient would induce the same rejection when transplanted and thus be ineffective. Third there remain concerns, based on the difficulty of controlling the growth of transplanted fetal cells, about embryonic stem cells functioning abnormally after transfer.

These concerns about the likely effectiveness and safety of therapeutic cloning have not been truthfully conveyed to a public fed on 20 second soundbites which fail to do justice to the scientific facts or complex ethical issues involved.

Even if the practical difficulties are overcome, the key ethical objection remains. The end of saving life cannot ever justify the means of creating and cannibalising human embryos, cloned or otherwise. Furthermore, allowing such research at all will lead inevitably to attempts to produce reproductive clones, as long as rogue scientists exist. And meanwhile, huge advances in the ethical alternative of adult stem cell technology continue to make embryo cloning rapidly redundant.

It is very sad that the British media and public have been consistently misled into seeing cloned embryos as a panacea for treating diseases like Parkinson's and Alzheimer's, through the Government's failure to highlight the dangers and to rectify misconceptions about the properties of adult stem cells propagated in the now seriously dated 2000 Donaldson report *Stem Cell Research*.

Selective interpretation and presentation of scientific data is both irresponsible and dangerous because it falsely raises the hopes of vulnerable people. Honest and balanced reporting of the facts should always take precedence over the prestige and profit motives of the British government and biotech industry.

Cloning and cannibalising embryos for stem cells in the way that the Korean scientists have is unsafe, unnecessary and unethical. A gullible and ill-informed public needs to be better informed of the dangers and made more aware of safer ethical alternatives for developing treatments for people with degenerative diseases.

1. *www.sciencemag.org/cgi/content/abstract/1094515*
2. Radford T. Korean Scientists clone 30 embryos. *BMJ* 2004; 328:421 (21 February)
3. Wilmut I. Are there any normal cloned mammals? *Nature Med* 2002; 8:215-6

The Joffe Bill returns

Still a Trojan horse for euthanasia

Lord Joffe's *Patient (Assisted Dying) Bill*,[1] which seeks to legalise Dutch-style euthanasia in the UK, has returned, after running out of time last parliamentary session. Skilfully reworked and renamed the *Assisted Dying for the Terminally Ill Bill*,[2] it passed its second reading in the House of Lords on 10 March and now goes to a Lords' Select Committee for detailed scrutiny. The last such Select committee in 1994 firmly opposed any change in the law to allow euthanasia but the debate has since moved on with high profile cases of motor neurone disease adversely influencing public and medical opinion.

The revised Bill seeks to legalise euthanasia for 'terminally ill' patients for whom palliative care cannot ease suffering, but the definitions of 'terminal illness' and 'unbearable suffering' remain loosely, ambiguously and relativistically defined.

It remains a dangerous document that Christian doctors should oppose. Christian doctors should make every effort to ensure that the committee hear again the many good arguments against legalising euthanasia, along with specific critiques of the Bill's revised wording.

1. Saunders P. Patient (Assisted Dying) Bill. *Triple Helix* 2003; Summer:3
2. *www.publications.parliament.uk/pa/ld200304/ldbills/017/2004017.htm*

Choosing health?

Christian doctors need to respond

The government has launched a new consultation on 'action to improve patients' health', which will feed into the production of a new White Paper this summer. *Choosing health?*[1] builds on government advisor Derek Wanless' new report *Securing Good Health for the Whole Population*[2] and seeks feedback from groups and individuals on ten key public health areas: accidents, alcohol misuse, diet, drugs, exercise, inequalities, mental health, obesity, sexual health and smoking.

Health Secretary John Reid claims that a healthier population could save £30bn a year in NHS spending and says the government needs to 'help people to make healthy choices by providing information, encouragement and support, and by working with the right partners at the right levels'. He wants to 'find the right balance, rejecting the nanny state, and the Pontius Pilate state, which washes its hands of its citizens' health'.[3]

Much of the consultation document is good common sense with the expected exception of condoms being advocated as the key solution to unplanned pregnancy and sexually transmitted disease.

This is a great opportunity for Christian doctors to get involved in an important public debate, and to advocate biblical and evidence-based solutions, rather than leaving a secular humanist agenda to impose itself by default. If merely a handful of Christian doctors submitted a few well worked paragraphs to answer questions in just one of the ten areas of concern it could make a huge difference.

Submissions close on 28 May and the consultation documents can be viewed and downloaded at *www.dh.gov.uk/consultations/live_consultation*.

1. Available free on request from Department of Health Publications, PO Box 777, London SE1 6XH. Tel: 08701 555455. Fax: 01623 724524. Email: *dh@prolog.uk.com*
2. Derek Wanless, February 2004
3. *Doctor* 2004; 12 February:10

Peter Saunders is CMF General Secretary

Dave Short on following Jesus in the workplace

IMITATING CHRIST IN HEALTHCARE

Instructions are useful, but examples are more effective. Today's healthcare workers very much need good role models. Oh, for another Florence Nightingale, a Thomas Barnardo or a Mother Teresa. Well, where did their inspiration come from? None other than Jesus Christ. I suggest there can be no greater role model for us today.

Jesus is a uniquely appropriate model for healthcare workers because his ministry brought him into contact with a wide spectrum of needy and diseased people. Jesus also had a teaching and training ministry. He had students and we can learn important lessons from how he taught them. Moreover, Jesus is totally original. The Gospels give us a glimpse into his private life. So we can see what made him tick and what kept him going.

Considering Jesus lived 2000 years ago, on the face of it a lot of people might struggle to discern any relevance to current problems in the NHS. But although enormous changes have taken place in the practice of medicine over the centuries, and particularly in the last decades, none of these has displaced the centrality of the medical consultation as a one to one relationship between a person in need and someone with power to help.

Of course healthcare workers do not have the exact same calling as Jesus, the Saviour and Redeemer. Even so, we are part of a team that is in the business of making people whole and this inevitably involves the spiritual dimension. Rightly understood, our healthcare duties can be regarded as a vocation to heal.

Nor do we have the same nature as Jesus. He was divine, and had an insight and authority and power to which we cannot aspire. But even if we view him merely in human terms we would see in him the very best to which we can aspire.

Jesus was uniquely gifted. He was never at a loss for the appropriate word or illustration. Nevertheless, as a man, he was severely and repeatedly tempted to take easy alternatives to his Father's will. We see that in Jesus' relationship with the religious elite of his day. He could be uncomfortable, challenging the established consensus and the accepted ways of doing things. At times he would have been a challenging colleague. But he never fell. Although we are all too fallible, we have Jesus' promise of his Spirit if we ask for this gift.[1] So I believe Jesus is a role model for everyone, whatever his or her calling, a role model who the apostles Peter and Paul exhort Christians to emulate.[2,3]

I suggest, however, that Jesus is especially relevant to healthcare workers, even though it is important to recognise that it is not possible to follow Jesus effectively without first submitting to his authority. He must first be our Saviour and Master before he can be our pattern. Then, when we do follow him, it is not a matter of slavish obedience to a set of rules or an attempt to earn merit, but the impulse of love.

'I have come down from heaven not to do my will but to do the will of him who sent me.'[4] Everyone's life is dominated, consciously or unconsciously, by some supreme desire, which determines all his or her actions. For a healthcare worker, it may be promotion or respect or reward: good pay without too much hard work or the satisfaction of a job well done. Jesus' supreme desire was to please his Father.[5,6,7] Nothing deflected him from this course. So the night before his crucifixion, Jesus' prayer to his Father, in agony of spirit, was 'My Father, if it is possible may this cup be taken from me. Yet not as I will but as you will.'[8]

This supreme aim determined all Jesus' attitudes and actions. It was because he wanted to do his Father's will that he waited behind in the temple, at the age of twelve, to hear what the rabbis were teaching, while his parents set off for home. When they finally found him, he answered their reproach with, 'Didn't you know I had to be in my Father's house?'[9] It was because he wanted to do his Father's will that he waited to the age of 30 to start his public work; allowing only three years for a ministry that was to change the world. It was because of his determination to do his Father's will that he never married, in spite of the fact that he regarded marriage as the norm and lived in a society that shared this outlook. He chose, instead, to surround himself with a community that had close, affectionate - yet chaste - relationships with men, women and children.

It was for the same reason that he spent hours in prayer and meditation on God's Word. He made a habit of attending the synagogue services. It was in obedience to his Father's will that he was judicious in his use of time and didn't do everything he might have done. He made the training of his twelve select disciples his priority.

It was to fulfil his Father's will that he followed the Old Testament moral law and legal requirements, such as commanding patients cured of leprosy to report to the priest for confirmation. And yet the uncomfortable Jesus had a strong sense of which laws were central and which were merely human traditions. His willingness to heal on the Sabbath is a powerful example.

So, then, what is our overall aim? As followers of Jesus, can we justify all our actions on the basis of our supreme allegiance to him. For Jesus, obedience to his Father's will involved sacrifice - the supreme sacrifice. And he made it clear that each of his followers, likewise, must be prepared to 'take up his cross'.[10]

David Short is Emeritus Professor of Medicine in Aberdeen

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1. Luke 11:13
2. 1 Peter 2:21-23
3. Philippians 2:5-8
4. John 6:38
5. John 4:34
6. John 5:30
7. John 6:38
8. Matthew 26:39
9. Luke 2:49
10. Matthew 16:24

CMF salutes two stalwarts

Serving the master

John Alford


John Alford

John joined the staff of CMF as Office Manager in 1990 at the time of the liberation of Eastern Europe and the break up of the Soviet Union. Throughout the 1990's, the growth of Christian medical groups worldwide was phenomenal, as doctors and medical students came to faith in countries previously closed to the gospel. One of the most pressing needs was for good Christian medical literature.

John was not a writer, or an editor, but he made the writings of Christian doctors accessible at a time when needs were immense, doors of opportunity were wide open, and the internet and the associated spread of the English language were making the world a global village. He made an enormous contribution in helping CMF embrace and make the best use of new systems and technology and managed the production and distribution of journals and newsletters, booklets and books, brochures and CDs, tapes and webpages.

I expect that John will get quite a pleasant surprise when the Lord shows him the fruit of his labour: reaching literally thousands of Christian doctors and medical students, not just in the UK but in over 50 countries around the world, secondary school students in 3,000 British schools, and over a million visitors to the CMF website. People whom he never met, and who probably had never heard his name, but who have benefited from what he did.

Rather like Jeremiah's scribe Baruch, John didn't seek great things for himself, but sought rather to make others great. Not least among these were members of CMF's student journal committee. Many remember his patience, practical help and attention to detail when often hard pressed by his own deadlines and his generosity in helping some of them to become the great Christian medical writers of the future.

All of us in the office have special memories. For me what will live is seeing him just a week before he died when he popped in just to be sure that everything was OK. He was pale and short of breath and obviously unwell, and yet cheerful and enthusiastic. What I will treasure most is the way he spoke about his children Matthew, Beki and Peter of whom he was so immensely proud.

One of John's last projects was a book on Christian healing. For reasons that will probably remain a mystery to us, God chose not to heal John in this life. But now John is in the presence of the risen Lord and Saviour he loved and sought to serve and his healing is complete. It's perhaps a poignant reminder that Jesus did not come ultimately to empty the hospitals but to empty the graveyards.

Peter Saunders is General Secretary of Christian Medical Fellowship

John Reader


John Reader

An American friend was walking up the gravel drive of John and Thea's home when he noticed a blade of grass poking through, and teasingly remarked, 'however did you allow that to grow in the wrong place?' No- one who has seen John's immaculate gardens, his highly organised garage or him working on the house in his spick and span boiler suit could have the slightest doubt that any practice or organisation would be run with the utmost efficiency and care.

Unlike so many people, John combined attention to detail with a broad vision and international perspective. He never failed to see the wood for the trees. He combined high personal standards with sympathetic partnership and teamwork, efficiency with compassion and an infectious sense of humour.

John qualified from Liverpool University Medical School in 1957 and was among the last but one group to be called up for national service. Returning to civilian life he worked in general medicine and clinical pathology but realised that he wanted to look after the whole patient rather than become highly specialised. So he entered general practice. John started in a two-person partnership in Marple in 1965 and stayed there for 29 years. The practice grew from two to five partners. He knew and was loved by the whole community and one of his former patients remarked 'I always had the utmost respect for Dr Reader' and that could be echoed a thousand times.

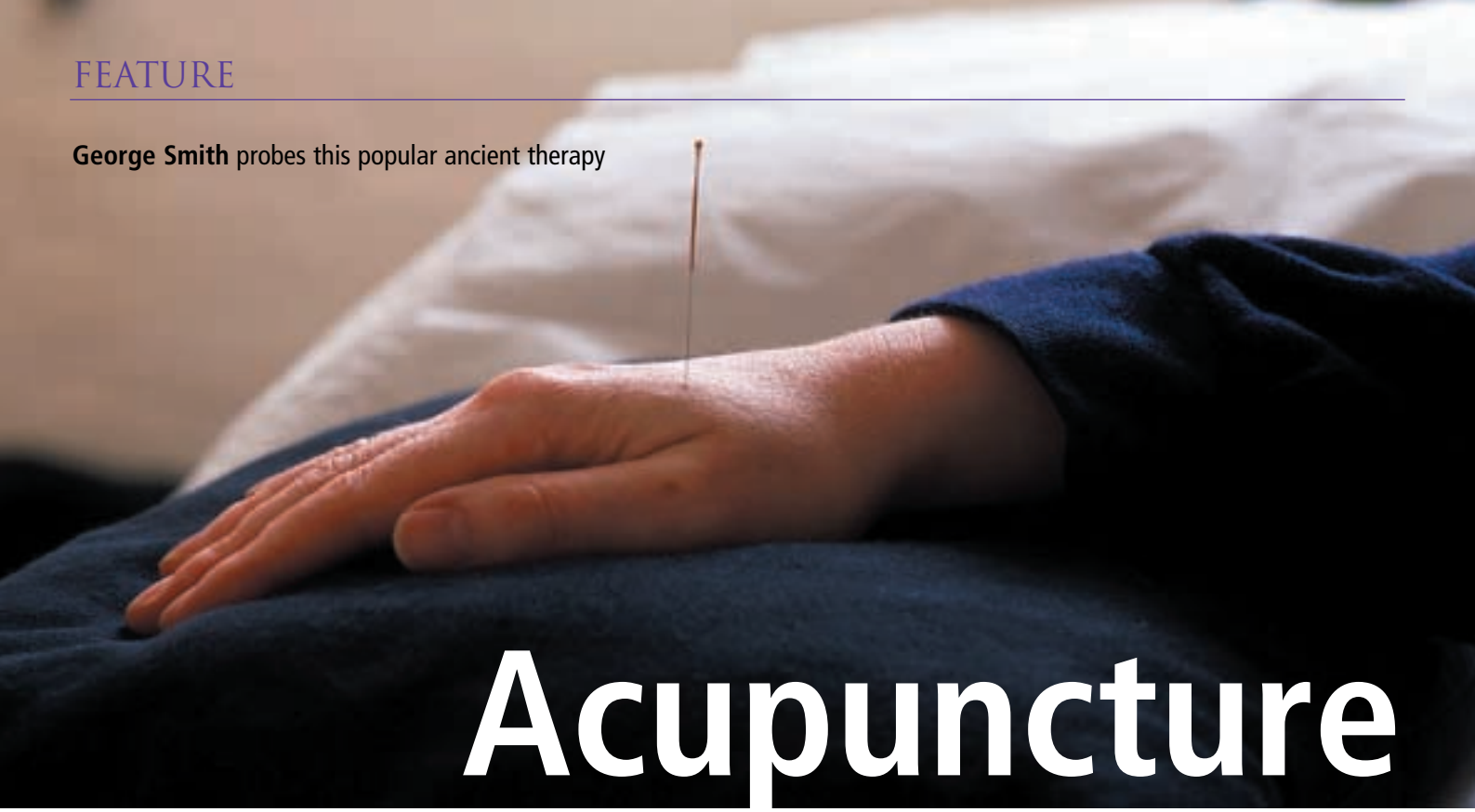
He joined CMF as a second-year student and was on the executive committee as a junior doctor. Later he became chairman. He showed his organisational skills early on, starting conferences in northwest England and later national conferences. He was already exploring wider horizons as the International Christian Medical and Dental Association (ICMDA) was developing.

In 1992, two years before he retired from practice, John and Thea became joint general secretaries of ICMDA. The work grew. The bedroom in their Cambridge home was soon too small, so an office was found. When they took over there were 26 member countries and contacts in eight others. Eight years later there were 44 and links with 36 more. John visited 23 different countries, many of them with Thea.

The last World Conference John and Thea attended was in Durban, South Africa. There were 800 delegates from 57 countries. It was a moving experience to hear singing to African rhythms in a packed conference hall. John was already looking forward to a far bigger international conference, with 'a great multitude that no one can count', not 57 nationalities but people 'from every tribe, people and language', singing before Christ's throne.

Alan Johnson is Emeritus Professor of Surgery in Sheffield and CMF President Elect

George Smith probes this popular ancient therapy



Acupuncture

KEY POINTS

Acupuncture is an ancient Chinese therapy with philosophy and principles based in Taoism. Its traditional exponents believe that needling the skin helps to restore the flow through the body of life energy or ch'i that gets disrupted in disease states. Western doctors who use acupuncture attribute its success to counter irritation, endogenous opiate release or relief of myofascial trigger points. But although it has been extensively investigated, evidence for its specific efficacy is limited and safety concerns cannot be ignored. Christian doctors should be suspicious of its non-Christian roots and rigorously objective about the evidence-base claimed by western advocates.

Acupuncture is one of the most popular alternative therapies. It can be described most simply as the insertion of needles into the skin at specific points in order to treat disease or promote good health.

Used in many NHS practices, particularly pain clinics, acupuncture is acquiring increasing respectability. A UK regulatory body is being considered. The British Acupuncture Council (BAcC) exists for the non-medically qualified and the British Medical Acupuncture Society (BMAS) for doctors.[1] Training courses vary from a few weekends up to two years. Chinese training lasts six to ten years.

Related techniques include acupressure, auricular acupuncture, electroacupuncture, reflexology and shiatzu.

Origins

Archaeological evidence suggests that acupuncture was practised in the Stone and Bronze Ages. Used in China for over 3,500 years, the first textbook was the *Yellow Emperor's Classic of Internal Medicine* (Huang Di Nei Jing Su Wen) around 500 BC, followed by *The Classic of Acupuncture* (259 AD).[2]

Persisting as part of traditional Chinese medicine for centuries, it was challenged by western medicine during the early twentieth century but reaffirmed by the communists in the 1950's. It was introduced into Europe in 1683 by Willen Ten Rhijne, a Dutch physician.[3] It was first mentioned in the *Lancet* in 1823 as a treatment for rheumatism.[4] It has been at the forefront of the recent surge of interest in CAM (Complementary and Alternative Medicine).

Principles and practice

The philosophy and principles of Chinese acupuncture are based on Taoism, incorporating its concept of life force or ch'i (qi) that pervades all things, animates all life and flows freely through the body in normal health. It has two components, yin (negative force) and yang (positive force). The ch'i circulates around the whole body but particularly through twelve main channels, termed meridians.

When ch'i is in balance, the body is healthy; if it is blocked or out of balance, ill health results. Needling specific points connecting to meridians restores energy balance. Around 365 regular points are described.

Intervention is usually by dry-needling the skin with solid needles (0.12 – 0.3 mm gauge) to depths of one to two millimetres (shallow needling) or five to 60 millimetres (deep needling). The needles may be manipulated and then withdrawn or left in situ for 30 minutes or more, sometimes accompanied by electrical stimulation or moxibustion, the burning of powdered mugwort plant around the needles. Presently, self-acupuncture is uncommon. Herbal remedies may also be advised. As foods are believed to be yin or yang in effect, dietary advice may be given.

In auricular acupuncture, specific points relating to the whole body are said to be represented on the ear but these cannot relate to the normal meridian positions.

Diagnosis in traditional Chinese acupuncture assesses the state of ch'i in the body and specific organs. This involves detailed inspection of the tongue and pulse, identifying up to 28 qualities (such as 'empty' and 'floating') in six pulses in each wrist.[5]

Medical checklist

Does it have a rational scientific basis?

There is no supporting scientific evidence for the existence of ch'i, life force or meridians.[6] They cannot be identified with anatomical, nervous or

vascular channels. Attempts to localise acupuncture points by histological examination have failed and electro-physical investigations have been inconclusive.

Western medical acupuncture

Attempting to distance itself from Taoist roots, a western version has evolved based on three theories:

1. **The gate control of pain theory** suggests that insertion of needles can modify the sensation of pain by closing a 'pain gate' in the nervous system.[7] This stops pain sensations passing up the nervous system whilst the 'gate is closed' in response to the needling. This is traditional counter-irritation, as when using kaolin poultices.

2. **The opioids theory** suggests that endogenous analgesics (such as endorphins) are responsible for acupuncture's efficacy.[8]

3. **Myofascial trigger points**. It was believed that these were points of fibrositis or other painful soft tissue or rheumatic conditions. However, their existence and significance is in doubt. Their possible correlation with acupuncture points is being researched but no definite evidence has emerged.[9]

Whilst there may be scientific validity in these theories, much more research is needed. Significant evidence would emphasise the gap between the rituals of traditional Chinese acupuncture and western therapy.

Does it work?

Acupuncture is probably the most researched of all alternative therapies. It is therefore surprising that there is little convincing evidence for its efficacy. Acupuncture research is complex, particularly regarding the provision of a credible placebo in randomised controlled trials. 'Sham acupuncture' employs a Steitberger needle or Park Sham Device: the point is withdrawn into a hollow needle without skin puncturing.[10]

An in-depth investigation indicated possible benefit in dental pain, low back pain, nausea and vomiting but there was inconclusive or completely negative evidence in a wide range of other conditions reviewed.[11,12] These findings were confirmed by a ten-year assessment of systematic reviews, meta-analyses and random controlled trials in the Department of CAM at Exeter University. 'Close to 100% of pain sufferers benefited from "sham acupuncture".'[13] Rather than showing specific efficacy for real acupuncture, many of the results indicated that both real and sham acupunctures were good placebos. '…minimal acupuncture is easily incorporated into primary care consultations but there is no convincing evidence for its effectiveness'.[14]

Is it safe?

It is a popular myth that acupuncture is safe. At least 50 fatalities have been recorded from lung, cardiac and nervous complications.[15]

Acupuncture hazards

- Incorrect or delayed diagnosis
- Local reactions: pain, bruising, infection, and haematoma
- Moxibustion burns
- Trauma: pneumothorax, cardiac tamponade, spinal cord and peripheral nerve damage
- Retained needles
- Systemic illness: hepatitis, endocarditis, septicaemia, osteomyelitis, auricular perichondritis and HIV
- Fainting and post treatment drowsiness

The incidence of adverse effects is around one in 10,000-100,000. A Norwegian survey reported that 30% of acupuncturists and 12% of doctors noted adverse effects.[16] A recent paper reported five adverse reactions including a fatal case of pneumothorax and cardiac tamponade.[17]

Christian checklist

There is no real dispute that traditional Chinese acupuncture is rooted firmly in the Taoist religion with its concepts of ch'i, yin yang and Universal Life Force. Tao means 'The Way'. The Yellow Emperor explains: 'Yin Yang is the way (Tao) of heaven and earth, the principle of everything, the parents of all changes, the origin of life and death, the palace of god. Healing of diseases requires the seeking of the origin…'[18]

This is quite foreign to biblical Christian teaching and faith in a personal sovereign Creator God and heavenly Father.

Western acupuncture seeks to distance itself from these beliefs and engage with the scientific. Despite the sincerity of those who attempt this, I believe the gap is too wide and leads to confusion and compromise.

Conclusion

Despite considerable research, no compelling evidence has been established for acupuncture's effectiveness and safety concerns cannot be ignored. The Christian carer's attitude to acupuncture must reflect integrity, respect truth and reject life and faith principles based on a non-Christian belief system. Consequentially, this precludes the use of traditional Chinese acupuncture and careful biblical discernment is required when considering the use of western acupuncture.

Prove all things; hold fast that which is good. Abstain from all appearance of evil.
(1 Thessalonians 5:21-22 KJV)

Jesus said, 'I am the way, the truth and the life'.
(John 14:6 KJV)

George Smith is a Dermatologist and former GP in Berkshire

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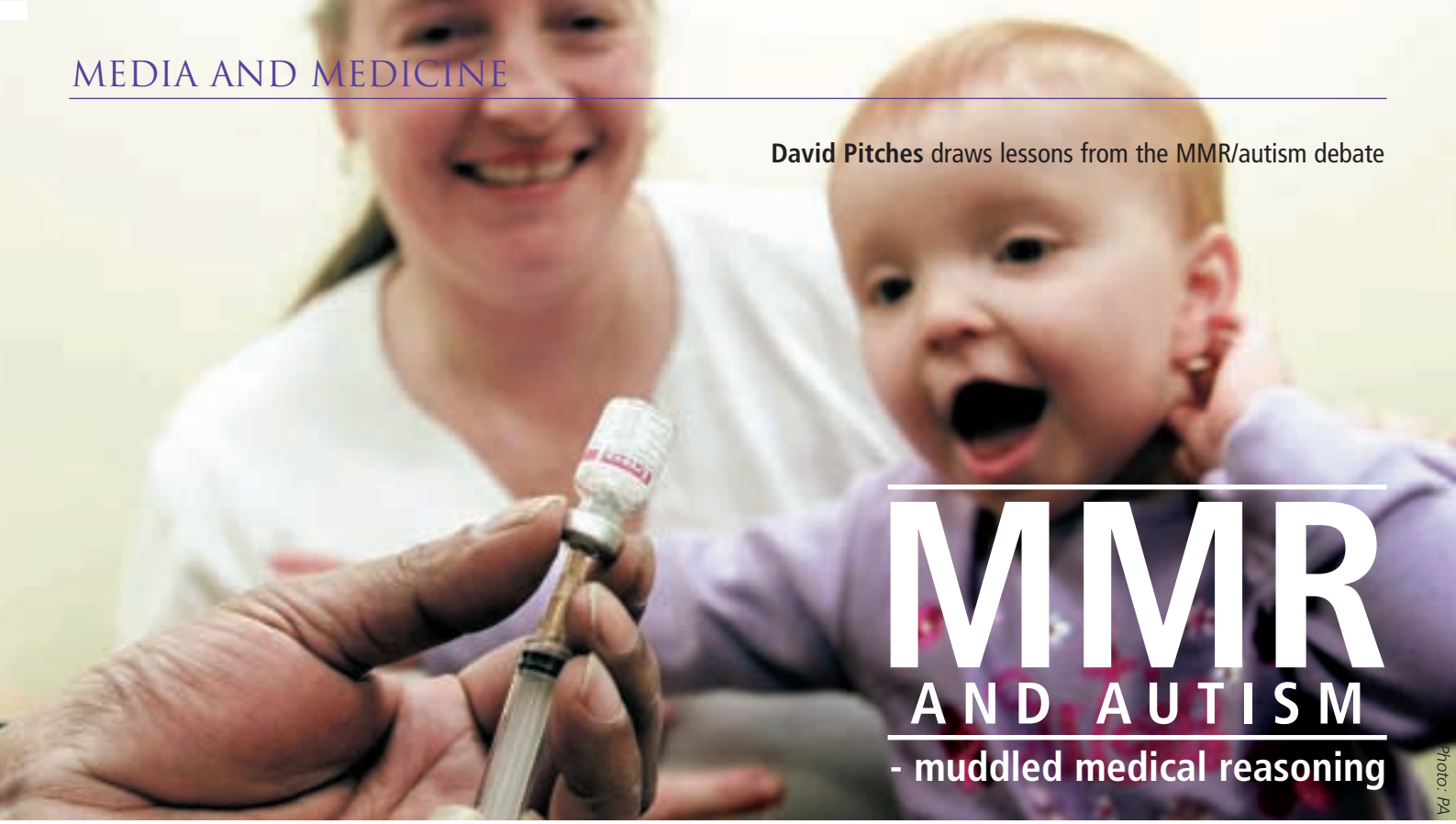
David Pitches draws lessons from the MMR/autism debate



MMR AND AUTISM
- muddled medical reasoning

Photo: PA

KEY POINTS

Recent systematic reviews have failed to confirm the link between the MMR vaccine and autism claimed in Andrew Wakefield's original research. But despite a retraction of his paper by the Lancet, and the exposure of possible vested financial interests, many people remain unconvinced that the vaccine is safe and vaccination rates remain dangerously low. The case raises serious issues about how scientific information should be handled by government, the courts and the media. Christian doctors should also take to heart lessons about responsible research and reporting, being honest about conflicts of interest and working hard to win the trust of our patients.

It is more than six years since the *Lancet* published Dr Wakefield's paper describing a new syndrome of bowel disease and autism in MMR (measles-mumps-rubella) vaccinated children.[1] Almost none of the subsequent research has found any evidence to support this causal link. Yet the controversy rages on. Rather than living with the theoretical risk of autism, many parents are facing the known risks of measles, mumps and rubella, or are paying for multiple, single immunisations.

At times the Government's continuing reassurance has strengthened its opponents' armoury.[2] After all, Dr Wakefield is a dedicated doctor (though neither a paediatrician nor epidemiologist), a father himself, whose painstaking work suggested the unthinkable: that a routine vaccine might be partly responsible for the surge in autism diagnoses over the past two decades. When he refused to end his research, his consultant position at a London teaching hospital became untenable. Eventually, with his supporters claiming persecution in Britain, he moved his research to the United States.

Some argue that general practitioners advocating MMR are not objective as the uptake proportions affect their practice incomes. Yet doctors who have seized the opportunity to set up single vaccine clinics have hardly brought honour to themselves but have cashed in on the fears of the lay public.

Systematic reviews

Meanwhile the evidence against a link between MMR and autism continues to grow. Recent systematic reviews of over 20 previous studies have failed to find any evidence of a link. This presents a dilemma for the media, which tends to present both sides of an argument, even when one side is a minority, maverick viewpoint.[3] Imbibing the media's reports, a confused public now feel that evidence in favour of a link between MMR and autism is finely balanced. Yet the idea behind systematic reviews is familiar to us all. Before buying a new car, many of us read every car magazine we can get hold of. If most reporters give it a glowing report, we ignore the one who gave it the thumbs down and follow majority opinion. So why do we act so differently over the immunisation of our children?

Immunisation levels

Year	Percentage of MMR vaccinated two year olds in England[14,15]
1995-1996	92
2001-2002	84
2002-2003	82
July-September 2003	79.8

An immunisation rate of 95% is needed to confer herd immunity. In 2000, a Dublin measles outbreak of 355 cases resulted in three deaths. The MMR uptake rate in the affected area was only 70%.[16] Experts predict similar outbreaks here.[17] South East London had the lowest uptake in 2002-2003: only 66% of two year olds were immunised. The risks for measles encephalitis and death are around one in 1,000.[18]

Legal action

Recently, the Legal Services Commission withdrew support for a class action involving the families of over 1,000 autistic children who sought compensation from MMR's manufacturers. £15 million of legal aid – £15,000 per child – had already been spent unsuccessfully attempting to

What happened when?

1988	MMR vaccination of children under two is introduced in UK.
1998	The *Lancet* publishes Dr Andrew Wakefield's study. [19]
2000-2002	Dr Wakefield's group describes a new variant of autism associated with inflammatory bowel disease and the presence of measles virus in the gut. [20,21] Other investigations do not support this. [22] Evidence suggests that the increasing prevalence of autism is linked with broader diagnostic criteria and greater awareness. [23,24,25]
2003	Epidemiological reviews fail to identify a causal link between MMR and autism. [26,27,28,29]
2004	*The Sunday Times* highlights a conflict of interest in Dr Wakefield's work. [30] A paper demonstrates no relation between autism and MMR, even in children with developmental regression or plateau, the subgroup covered by Dr Wakefield's 1998 study. [31]

Photo: PA

demonstrate a link between MMR and autism. This compares starkly with £3.5 million committed by the Government in 2002 to the Medical Research Council's autism research programme. In pursuit of compensation, a number of these autistic children underwent colonoscopy and lumbar puncture. As no British hospital would perform them, seven children were flown to the United States for these tests. The results were unvalidated and uninterpretable. [4]

Conflict of interest

Recently it emerged that some of the children in Dr Wakefield's study had been referred and funded through legal aid, despite no acknowledgement of this in his 1998 paper. Subsequently, Dr Richard Horton, editor of the *Lancet*, announced he would not have published the paper if he had known of this conflict of interest. [5] Since then, ten of Dr Wakefield's co-authors have issued a joint public statement, retracting the interpretation placed upon their findings. [6]

Disturbing questions

This debacle raises many disturbing questions about the nature of scientific research and the conveyance of its findings. It highlights the importance of high research standards. It was entirely reasonable to raise concerns about MMR's safety if research suggested harmful effects. However, prior discussion with other experts would have ensured that appropriate methodologies were followed. Editors of prestigious medical journals carry much responsibility. Had the original paper been published in an obscure paediatrics journal, subsequent medical history might have been entirely different. Vaccine opponents often take the line we should avoid MMR until scientists can prove beyond doubt that it does not, under any circumstances, cause autism. Yet science cannot prove a negative.

Are courts ever an appropriate place to prove or disprove medical beliefs? Indeed, had the MMR case proceeded to court, it would have made a disturbing precedent for future groups seeking legal aid to fund research for speculative claims. Is funding from any other source less controversial? After all, MMR's manufacturers and the Government sponsored Medical Research Council funded several of the studies that failed to find a link between autism and MMR. Opponents of the vaccine criticised these studies for potential conflict of interest whilst failing to admit their own. In the present climate, could any study be funded and conducted without attracting criticism from the 'other side'?

Learning points

What can Christians learn from this unhappy saga? Firstly, we should not be afraid to pursue research but must do so in a responsible manner. We must recognise the limits of our abilities and not be afraid to seek advice from others. [7] Secondly, we should be aware of any conflict of interest, particularly financial. [8] Thirdly, we must elicit the trust of our patients and the wider public. Patients who supported Dr Wakefield commented that they trusted his team because they were really listened to. [9] Sadly, previous doctors had failed to inspire such confidence! Finally, it brings us back to the profound question that Pontius Pilate asked Jesus. What is truth? [10] Is it a commodity that can be bought with enough research resources or eloquent legal arguments? How do we convey truth when we believe we have it?

Christianity is an evidence-based faith. Events narrated in the Bible were diligently recorded to preserve what eyewitnesses saw as the truth. [11] Yet knowing the truth is not sufficient preparation for sharing it. Experts who are called upon to defend MMR's safety believe passionately in it. Yet, simply 'knowing the truth of MMR' and conveying this to the media has not been enough to persuade the public. Rather than merely confronting patients with hard medical facts, it is important to listen to their fears, build up trust and lead by example. 'Yes, I thought about it too but chose to protect my children with MMR.' Similarly, whilst we can be confident about the truth of the Bible, simply passing on these truths to sceptics is akin to tossing pearls before swine. [12] We should always be prepared to give an answer to those who ask us but in gentleness and with respect. [13]

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Clare Cooper reports on welcome legislation to stop a barbaric practice

Photo: PA

Female genital mutilation

A young woman in her late twenties presented at Kapsowar Hospital, Kenya with a vesico-vaginal fistula. For four years she had been a social outcast, rejected by her husband and village because of the 'shame' of her condition. Further enquiry uncovered a history of female genital mutilation in childhood which caused vaginal stenosis. She had subsequently married and become pregnant but during the second stage of labour progress was arrested and the baby died in the birth canal. The infant had to be removed surgically and the young woman was left with a fistula which leaked urine continuously. The subsequent repair of the fistula changed this woman's life and enabled her to make a new start (picture left).

The *Female Genital Mutilation Act 2003*, which took effect at the beginning of this year in England and Wales, makes it illegal to take girls abroad for female genital mutilation (FGM). It also increases the maximum penalty for committing or aiding the offence to 14 years in prison.

FGM includes various procedures in which the healthy female genitalia are removed or mutilated causing serious complications. The 1985 *Prohibition of Female Circumcision Act* made the practice illegal in the UK but left many girls at risk of being taken overseas for the ritual – whether as a young baby or at any time up until marriage.

FGM is practised in 28 African countries, parts of South East Asia and the Middle East. In the UK, communities originating from such countries (mainly Eritrea, Ethiopia, Somalia and Yemen) may continue the practice.[1] About 7,000 girls under the age of 17 are thought to be at risk in the UK, and at least 74,000 women have been subjected to the procedure.[2] Worldwide between 100 and 140 million females are thought to have been affected.

FGM is regarded as a traditional cultural practice by those who support it, seen by some as a cleansing process, protecting virginity and family honour. It is not, as sometimes stated, a religious requirement. It is sometimes intended to provide more sexual pleasure for the husband and increased fertility. Women may support it as an aspect of their community identity.

The view from the West is of an abusive event, commonly excising all or part of the clitoris and/or labia, and sometimes stitching together the labia majora. (In some communities the latter may be reversed after the marriage ceremony and it may be redone after childbirth). Pain, haemorrhage, infection and sometimes death may result in the short term. In future years problems of menstruation, urinary and pelvic infections, psychological symptoms, sexual difficulties, infertility and difficult childbirth may ensue. The risk of dying in childbirth is doubled, the risk of stillbirth is increased three or four times.[3]

Clearly FGM is no 'female equivalent' of male circumcision. It has no foundation in religious writings or as a covenant sign. It is more a sign of male domination over a woman's life.

In the book of Genesis, God creates Eve from Adam's side, to be at his side and to be united with him throughout life.[4] However, as a consequence of the Fall husbands began to rule over their wives and the complementary relationship that God originally intended for marriage was lost.[5] The new covenant that Jesus gave to the world brings a new freedom for all who believe in him.[6] There is no place in God's kingdom for abuse and oppression, nor for the idea, bound up with FGM, that sexual pleasure is only for men. *Song of Songs* reminds us that both the lover and the beloved take pleasure in physical love. The Song says of the beloved that her own body is hers to give.[7] Therefore no one has the right to abuse it.

Paul reminds husbands to 'love their wives as their own bodies'. He goes on, 'He who loves his wife loves himself. After all, no one ever hated his own body, but he feeds and cares for it'.[8] Such care is grossly distorted when FGM is perpetuated by adults who have failed to see the harm it does and who have promoted it within the family they love.

Attitudes are changing thanks to education about the consequences of FGM. Several African countries have banned the practice and others are pursuing educational programmes. In the UK, girls aged seven to nine are most likely to be mutilated and doctors should be vigilant. Insensitive handling of child protection procedures may result in the child being taken abroad. The new legislation makes this less likely and is to be welcomed but there is no room for complacency. There is a need for continuing education of healthcare professionals and involved communities, both in terms of discontinuation of the practice and giving help to those already mutilated.

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Peter Sidebotham offers biblical guidance on a complex issue

Child protection

In the field of child protection, the pendulum of public, and perhaps more importantly, media opinion seems to be swaying uncontrollably, and consequently quite dangerously, at the moment. A year ago, Lord Laming published his inquiry into the death of Victoria Climbie.[1] Lord Laming highlighted the seriousness of the extreme end of child abuse and emphasised that child abuse should be treated with the same rigour as any other potentially life-threatening disease. Professionals were blamed for not listening to the child, for missing signs of abuse and for poor communication. Perhaps above all, many professionals at all levels were blamed for not accepting responsibility for their role in the child protection process.

Now, less than a year later, we have seen prominent paediatricians brought before the GMC because of concerns about their actions in diagnosing child abuse, the overturning of three cases where mothers were convicted of having murdered their babies, and a review of a huge number of cases, both criminal and civil, where expert evidence has influenced the legal process in suspected child abuse.[2,3,4] So what are we to make of these swings in opinion? What are the likely impacts on children, families and professionals? And can we find ways of working that avoid some of the difficulties that have been highlighted?

Professionals working in the child protection field have always been vulnerable and open to criticism. That has been seen before in situations such as the Cleveland Inquiry, and in the numerous public inquiries into the deaths of children from abuse. My perception is that this vulnerability is, at least amongst paediatricians, but probably also on a much wider basis, even more marked now than ever before. There is a general perception that 'you are damned if you do and damned if you don't'. One direct consequence of this is that we are already seeing reluctance amongst many professionals to get involved in this area.[5] The potential knock on effect of this is that with fewer professionals entering the field, or being prepared to take on child protection work as part of their remit, child abuse could be missed, or inadequately assessed, and children could be put at greater risk. There is also a specific issue in relation to expert evidence. Few of these cases are clear-cut, and there is always the need for professional opinions, based on the best available evidence. Where that evidence is limited, as it too often is in this field, the courts will necessarily have to rely on conjecture and individual expert opinions. Again, fewer professionals are now prepared to stick their necks out and offer their opinions for fear of being pilloried one way or another. Again the consequences are likely to be detrimental to children, with more prolonged or inconclusive legal proceedings.

The problem here seems to lie more with the systems we have for dealing with these complex cases than with the individuals who are currently being blamed. That, I believe gives hope for significant change. A lot is happening in the wake of Lord Laming's inquiry and the publication of the green paper *Every Child Matters*[6] and the recent *Children Bill*,[7] with improved systems for multi-agency working, information sharing, training and audit. But there is still a lot to be done, both in national debates and policy, and in local implementation. As Christians we need to be engaged at all levels, influencing debates and developments.

For those of us who are working with children and families, I believe the biblical advice in Micah 6:8 provides perhaps the best principles for our personal and professional approach to the field. Micah suggests that the Lord requires three things of us:

To act justly. We must work for justice, seeking to promote the truth, and to speak out on behalf of the vulnerable. Primarily we need to keep the welfare of children paramount, even more so for those who are particularly vulnerable: the disabled, those from ethnic minorities, asylum seekers, those living in poverty. But we also need to remember that many parents too are vulnerable. We need to seek integrity in our legal systems and in the procedures we use to protect and safeguard children. If a parent is wrongly convicted of murdering their child, that is one of the gravest miscarriages of justice that can occur and a double tragedy for the family concerned. However, if a child dies because of professional or societal failures to protect that child, that is even more of a tragedy. To minimise the risks of either tragedy occurring, we need a clear framework and approaches that recognise the paramount importance of the welfare of the child, whilst also recognising the needs of families. There is a need for a wider debate on whether criminal conviction is necessarily the best response to suspected infanticide[8,9]

To love mercy. Compassion needs to be the bedrock of all our work: compassion for children, for families and even for abusing parents. They too may be victims.[10] It is not always easy to balance justice and compassion, but I believe it can be done. When confronted with inadequate or harmful parenting, we should not be afraid to remove children if that will be in their best interests, but perhaps we should more often be asking 'what is needed to enable these parents to look after this child?' rather than 'can these parents look after this child?'

To walk humbly with our God. Our personal and professional lives need to be marked by humility and righteousness. We all make mistakes and need to be prepared to admit it. We need to recognise our limitations, but within that to do our best to act with integrity. Above all, we mustn't be afraid to engage in these difficult areas, trusting in a God who walks with us as encourager, friend and guide.

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Peter Comont finds advice for doctors from The Teacher of Ecclesiastes[1]

Living with spiritual tiredness

KEY POINTS

Spiritual tiredness results from trying to find satisfaction in things that do not ultimately satisfy; like alcohol, sex, retail therapy or even medicine itself. All such idolatry leads eventually to cynicism, despair and a weariness of the spirit. The writer of Ecclesiastes had learnt from bitter experience about the deficiencies of such a misguided lifestyle, but despite being realistic about the chaos of everyday existence, found hope in taking an eternal perspective. We need to cultivate 'the marks of faith' – being generous to others despite the pressures we feel ourselves, and being bold in what we undertake for God, not wasting our opportunities as though following Christ made no difference.

Most health professionals know all about tiredness. Long hours and the demands of the job leave all of us exhausted. Here I want to address the issue of spiritual tiredness. Spiritual tiredness is a form of exhaustion in our soul, in our innermost being. Spiritual tiredness is not helped by working long hours but its source is not the long hours. Spiritual tiredness comes when we give up believing that Christ was speaking the truth when he said, 'What good will it be for a man if he gains the whole world, yet forfeits his soul?'[2]

It's my observation that in medicine it is particularly difficult to avoid this form of tiredness. Part of the reason is due to the place that medicine has in our national psyche. As Britain has become more and more post-Christian, people naturally tend to cast around for a new source of hope. One of the resources that people often look to is the doctor. The hope for a medical cure in many people's minds is the nearest they get to salvation. Hospitals become temples and doctors the priests of this new religion. In his book *How to be Good*, Nick Hornby portrays a GP called Katie Carr who has been caught up in this idolatry of medicine. She believes her mere status as a doctor makes her good. 'Listen.' She says,

'I'm not a bad person. I'm a doctor. One of the reasons I wanted to become a doctor was that I thought it would be a good - as in Good, rather than exciting or well paid or glamorous - thing to do. I liked how it sounded. "I want to be a doctor." "I'm training to be a doctor." "I'm a GP in a small North London practice." I thought it made me seem just right, professional, kind of brainy, not too flashy, respectable, mature, caring…anyway. I'm a good person, a doctor.'

It's easy to fall in love with the status that we automatically acquire in the medical profession - to be intoxicated with the idea that the skills that we have are the answer to people's problems, because people treat us in that way every day of our lives. But there is a cynicism that follows hard on the heels of such idolatry.

When we place an unreasonable expectation on anything we are never far from experiencing crushing disappointment and cynicism. In his book *The End of Christendom*, Malcolm Muggeridge described this as engaging in 'idiot hopes and idiot despair':

'On the one hand' [he said] 'some new policy or discovery is confidently expected to put everything to rights: a new fuel, a new drug… world government. On the other some new disaster is confidently expected to prove our undoing. Capitalism will break down. Fuel will run out. Plutonium will lay us low. Atomic waste will kill us off.....'

This wild fluctuation is exactly what we see in the book of Ecclesiastes, a meditation on life, as the author puts it 'under the sun'. That is life without

God – or at least life without God as an active loving dynamic agent in our world.

In the first couple of chapters the author, who calls himself 'The Teacher', recalls that he actively explored potential sources of satisfaction 'under the sun'. He indulged in laughter, alcohol, sex, retail therapy – it didn't satisfy. So he pursued wisdom but that actually only helped him see the futility of life more acutely. Like the man who said to Dr Johnson:

'You are a philosopher Dr Johnson. I have tried too in my time to be a philosopher, but I don't know how, cheerfulness is always breaking in.'

Most especially he realised that death strikes a fatal blow to all our idolatrous hopes. We know in medicine that is shoved under our noses. Every person's medical history is terminated by what the American's sometimes rather coyly call 'a negative patient outcome' – death. Living in that world; a world where everyone is only looking at life 'under the sun', draws us inexorably towards cynicism and a profound weariness of the spirit. Then as Ecclesiastes unfolds, however, it starts to become clear that The Teacher cannot sustain his radical scepticism. Faith cannot help breaking through.

The Teacher's faith

For me that is epitomised in Ecclesiastes 11:1. Here The Teacher still affirms that the world is a chaotic confusing place. Trying to do anything of value in the real world is like scattering breadcrumbs in a river. You just set them loose and off they float we know not where. Was it worth showing real love to that patient who simply took the prescription and was gone? Would it have been less costly if we had just been distantly professional? Have I ever seen fruit from praying for my patients? Or is it all chaff in the wind?

True. It is chaff in the wind, bread on the water – all floating away we know not where. But there are results. We just need a longer perspective. The Teacher says we will see fruits 'after many days'. We may even have the privilege of seeing results in our lifetime, but there is no guarantee. Jesus was absolutely clear that the main reward is on judgment day:

'Come, you who are blessed by my Father; take your inheritance, the kingdom prepared for you since the creation of the world. For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in.'[3]

Just occasionally we get encouragements to help us keep going. I know a couple who worked in the 1970s in a hospital in a Muslim country. Recently the wife by accident met a young man who had recently become a Christian. He told her that he had been seriously ill as a baby and his mother had taken him to the very hospital where that couple had been working. Always afterwards this boy's mother had taught him to respect Christians because she said 'it was Christians who saved your life'.

As a young adult he began to search spiritually and eventually was converted. 'Cast your bread upon the waters for after many days you will find it again.'[4]

Cultivating marks of faith

We need to cultivate the marks of faith mentioned in verses 2-6. The first is generosity or liberality. Knowing that life is unpredictable shouldn't paralyse us. None of us know which of our patients will respond to our Christian love and concern, or which prayers God will answer with a yes. So we need to be confident to give and let God sort out what he will do with the gift.

This is one reason why I'm not a great fan of a totally focused life. It's common for Christian doctors to feel that the medical profession is so demanding with so many opportunities that their whole ministry must be focused on that world. It seems to me that an undue focus on one area of ministry can in fact lead to a thoughtlessness and even heartlessness about other areas of opportunity.

The Teacher says you don't know what ministry will bear fruit so spread it around. It may be teaching Sunday school which is the real centrepiece of your crown, or involvement in that small group Bible study, or your befriending of that marginalised person. Jesus got the balance right. He had focus, 'set his face towards Jerusalem' and yet on the way he would turn aside to help people, sometimes to the complete exasperation of his more calculating disciples.

Give portions to seven yes to eight[5]

The second characteristic of Ecclesiastes-like faith is boldness. The Teacher is telling us here that once things have happened they have happened. You see a rain cloud which is ready to shed its load – it will rain. You see a tree fall in a certain direction that is where it will lie. Life doesn't offer reruns.

It may be that you know that there are aspects of your life which require attention. Perhaps it is church involvement, a call to a different ministry, to get your prayer life in order, or to be more public about your faith at work.

You have found Christ – don't waste your life as if it made no difference. A few years ago Os Guinness wrote a book which I would thoroughly recommend. It is entitled *The Call*. The subtitle sums up Christ's call on our lives:

Everything we are.
Everything we have.
Everything we do.

Don't grow weary. Don't grow cynical. Follow Christ – it is worth it.

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SPIRITUAL TIREDNESS... EXHAUSTION IN OUR SOUL, IN OUR INNERMOST BEING.

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2. Matthew 16:26; see also Mark 8:28 and Luke 9:25
3. See Matthew 25:31-40
4. Ecclesiastes 11:1
5. Ecclesiastes 11:2-6

Janet Goodall finds that even mini-disasters can have a purpose

Photo: Wellcome Photo Library

Relax in-to disaster

…and see what God will do

Recently I undertook a round trip of several hundred miles to renew various neglected but inspiring friendships. I found a friend's motto 'relax in-to disaster' an enormous source of illumination as I travelled and talked.

My friend had had to give up nursing after an adverse reaction to a yellow fever vaccination. The discovery of chronic autoimmune disease prevented her intended departure for missionary service. Recently she had developed breast cancer with back pain suggestive of secondaries, but her GP had never before encountered relieved laughter when scans revealed 'only' a slipped disc. Despite all these and other worries, she still undertakes short-term missions and, nearer home, is a cheerful encourager of other cancer sufferers.

My first stopover on the trip coincided with a home Bible study group where I sat beside a young woman whose apparently healthy and beloved stepson had died suddenly during a sports activity. Her husband and their other son were grieving in ways that unintentionally excluded her, but her own trust in God was being greatly strengthened by the sensitivity and prayerful fellowship of that group.

Next came an old friend from university days. Widowed early in life she successfully raised two lovely Christian daughters alongside doing a demanding professional job. Now impaired in health she lives in an apparent backwater to be nearer her grandchildren. Some would find such a changed lifestyle frustrating but she exerts a quiet and consistent Christian influence on two young lives (and several older ones.) In contrast, in the nearby city, I had lunch with a clergy wife whose husband had publicly but controversially backed the authority of the Bible. Now at the eye of the ensuing storm he is being painfully abused, even by fellow Christians.

Travelling on, I stayed with two Christians, converted late in life and now eager to use their lovely home as a base for sharing the Good News with friends and neighbours. A couple of years ago the husband developed a malignant melanoma. It is already pronounced spreading and incurable, but their faith remains unshaken. I was quietly assured, 'We are in the Lord's hands.'

From that home I moved on to a middle-aged paraplegic friend, born with such severe spina bifida that she has been told (in public debate...) that she should not have been allowed to survive at birth. Although now in constant pain, she has helped to establish and maintain a Christian foundation for disabled children in India, making regular visits to see them. They cluster round her wheelchair and movingly call her Mother.

The next call was on a family whose doctor father had given up a job that he found too demanding and too far away to allow adequate time for his children. Intermittent locums now allow family ties to grow stronger whilst he also has more time to wait on the Lord, trusting him to clarify the next step. His serenity was striking.

> GOD CAN TURN SOMETHING THAT LOOKS BAD INTO SOMETHING GOOD

A farmhouse weekend followed, with ample nourishment for body and soul to share with three generations of other good friends, gathered together for a holiday with Grandpa. Over decades he had watched his much loved wife dying of Alzheimer's disease whilst he conscientiously met the taxing demands of church oversight. On retirement he moved to an inherited property, remote from his previous supporters, then became suddenly and dangerously ill. Unexpected but timely visitors were probably instrumental in saving his life. Although still recovering he lives alone in the new home, but keeps a positive outlook, grateful for the attentive love of his family and for the faithful provision of his God.

These encounters were reflected on and jotted down during a long delay whilst a mechanic dealt with a puncture found during the journey. I had met others on my travels but these particular stories showed me the good that was emerging during or after hard times. My friends had variously experienced sudden calamity, bereavement (including retirement), personal hostility, serious illness, chronic disability, unemployment, loneliness and, in some cases, blow after blow. Yet they had each found that their loving Lord was holding them, so often with prayerful support from other believers.

It is naturally hard for us to feel very relaxed when troubles come, but experience of the Lord's ways gently teaches us to respond positively rather than to react negatively; to trust when we cannot see. After all, the crucifixion of our Lord Jesus looked to many like an unmitigated disaster yet, in God's time and through his Spirit, resurrection followed, with the promise of new life and strength to all believers.

God remains able to turn something that looks bad into something good, which glorifies him as we entrust it to his unfailing love. Not only are my friends finding this for themselves but their stories offer a telling witness and encouragement for others -and to think that without the frustration of my punctured tyre I might never have found time to take it all in. Even mini-disasters can have purpose.

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how i'd handle it!

James Tomlinson and **Kevin Vaughan** explain how they would tackle this complex situation

Mistaken gender identity

'I want a sex change.' John, a homosexual man in his forties, feels bad about himself. You have been treating his depression for nine months with antidepressants. Today he is armed with documentation outlining your primary care trust's sex change policy. This involves initial counselling, then referral to a specialist psychiatrist; subsequently, if appropriate, he may be referred for medical and surgical sex change treatment.

I'm surprised that the PCT has a sex change policy! I'd have a silent prayer, then ask some open-ended questions. 'OK, tell me more about why you think you need a sex change?' 'What do you expect from a "sex change"?' 'How do you see yourself: a man attracted to men or a woman in a man's body?' Finally, 'What are you hoping I could do for you today?' This would establish his agenda.

As a Christian doctor, this consultation would raise several issues. Is John's depression being effectively managed? What is the relationship between his depression and self esteem, his sexual orientation and identity? Are there sexual health matters that need addressing such as STI screening? How do I balance supporting John in his struggles and promoting his health whilst not facilitating his sin? My security and identity are rooted in my relationship with God (1 John 3:1). How do I sensitively communicate this?

Before attending surgery, John concluded that he needed a sex change. I would affirm his decision to see me and suggest that we address these issues at further consultations. I would suggest that many other people struggle with their identity and sexuality; sex change treatment may not help him. I would also explain that we have physical, social, psychological and spiritual aspects. Wholeness lies in addressing each of these.

I would defer referring John for counselling until I had considered my PCT's policy further. In any referral, I would mention that, on conscientious grounds, I could not assist him having a sex change. John's genetic status, primary and secondary sexual characteristics make his sex male. Gender is the social characteristics associated with one's biological sex. For John to be considered transsexual, his gender must more closely match that of a female. Sex change treatment would rid John of his sexual characteristics and help him live as a woman. Whilst appreciating his struggles, to participate in sex change treatment would be deceit. God created each of us in his image, male and female, and he doesn't make mistakes (Genesis 1:27).

James Tomlinson completed the VTS in 2004 and is a GP in West Bromwich

As I have been treating John's depression for some time, I would express my concern that he is uncomfortable with his sexuality. I would hope to explore his thinking over the past few months, his motivation for this request and his expectation of what treatment might involve. I would also consider his lifestyle and what he expects afterwards. I would ask how he views his body and what he wants to look like. It would be important to review his depression diagnosis and treatment effectiveness. Recognising that this is a very sensitive subject, I would be willing to refer him for specialist counselling.

However, at some point, I would have to explain my position to him. If the outcome of his counselling were a recommendation for sex change, I could not take responsibility for this myself. It would be against my conscience.

I believe God created us male and female and that no individual (even with the support of a 'specialist' panel) can choose later in life to change the God-given gender into which (s)he was born (Genesis 1:27). This issue has tremendous implications for society at large and the institution of marriage in particular. I would try to explain to John that I believe in a Creator. My understanding of the doctor's duty in treating his/her patients is to restore people to what God originally intended. In my view, giving sex change treatment goes beyond this remit.

Much would depend on how the conversation went. I would express my willingness to see John again about this and to continue his depression treatment. If, after counselling, John was still so uncomfortable with his identity and gender that he was determined to pursue treatment for sex change, I would clarify my legal position with the General Medical Council and my PCT. Then, if required, I would refer him on to another GP for his treatment. This would be a moment to reiterate my concern for John's welfare and to clarify my willingness to see him again for any other condition.

Kevin Vaughan has just left General Practice in Birmingham to take up the post of CMF Associate General Secretary

Photo: Catherine Riley / Wellcome Photo Library

Gender Recognition Bill

Transsexuals' identity documents (such as a passport) may be changed; their birth certificates, however, determine sex by chromosomal, gonadal and genital congruity and so cannot be altered.

But the Gender Recognition Bill proposes a Gender Recognition Panel to issue new birth certificates. Prerequisites will include a gender dysphoria diagnosis, two years of living as the acquired sex, the intention of continuing as such until death but not gender reassignment surgery.

Inevitably, marriage will have to be redefined and many other complex issues raised. This bill legalises institutionalised lying and punishes those who speak the truth.

The latest *CMF File*, Gender Identity Disorder, gives more information on this complex issue.

Do you agree or disagree? Do you have a scenario to discuss? Would you like to join our panel of GP contributors? Email rachael.pickering@cmf.org.uk

HEAD T

John Latham and **Robin Fisher** explain their contrasting positions

Should we prescribe metha

'Yes!' **John Latham** is a GP trainer in inner-city Dublin

Heroin addiction is a chronic disease with associated morbidity and mortality as well as forensic, public health and social consequences. Methadone has been increasingly used since Dole and Nyswander's original trial in 1965.[1] Its half-life is far longer than that of heroin, being 24 and two hours respectively. It can be taken orally rather than smoked or injected like heroin. The fact that methadone itself is addictive is certainly a negative side effect but I believe that this factor is far outweighed by the positive therapeutic effects seen every day in our patients.

Evidence based therapeutics

Methadone is a rigorously well-tested medication that is safe and efficacious for the treatment of opioid withdrawal and dependence… Heroin releases an excess of dopamine in the body and causes users to need an opiate continuously occupying the opioid receptors in the brain. Methadone occupies these receptors and is the stabilizing factor which permits heroin addicts on methadone to change their behaviour and cease heroin use.[2]

Used carefully for maintenance or detoxification, methadone satisfies all the criteria for a good and evidence-based therapeutic intervention. The literature is vast but I recommend Ward et al's book on the subject.[3]

Cessation of heroin use. All other positive effects flow from ending reliance on a street drug that must be administered every few hours and requires total life concentration on obtaining the next fix.

Crime reduction. Several randomised controlled trials (RCTs) support the view that methadone maintenance treatment reduces heroin use and crime.[4] This is very evident amongst my inner-city Dublin patients. The danger of street sale of prescribed methadone can be minimised by careful protocols and dispensing systems such as supervised ingestion.

HIV reduction. Reviews are consistently concluding that methadone maintenance treatment effectively reduces HIV spread and injection-related behaviours known to transmit it.[5] I watched many young patients develop HIV and die in the 1980's and early 90's; now, I feel strongly about the need for interventions to prevent this dreadful infection.

Holistic health improvement. This is very evident in patients treated with methadone in properly run GP led treatment programmes. All other health uptakes are improved: women's health; diagnosis and treatment of hepatitis C and HIV and vaccination for hepatitis B; diagnosis and treatment of mental health problems such as depression as well as improved child health and primary infant immunisation uptake. These are all spin-offs of primary care methadone treatment. Although it is difficult to quantify in the literature, I can report from my own practice that routine and opportunistic health care is almost non-existent in the drug injecting population but very much improved for those who visit my surgery 52 times a year for our methadone programme.

Spiritual benefits. These are readily apparent in many patients on methadone treatment. Those injecting or smoking heroin are rarely in a position to contemplate anything but their immediate physical craving. They cannot easily identify the spiritual void in their lives. There is a deep spiritual dimension to every case of addictive behaviour. In my role as a director of Teen Challenge Ireland, I am aware that some addicts can become drug free without medication by the Holy Spirit's power as they repent and believe in Jesus.[6]

> METHADONE ITSELF IS ADDICTIVE BUT THIS IS FAR OUTWEIGHED BY THE POSITIVE THERAPEUTIC EFFECTS SEEN EVERY DAY IN OUR PATIENTS

Conclusion

I feel duty bound to offer a scientifically proven and ethically approved intervention for a chronic, potentially fatal illness that is very prevalent in the community for which I work. In my opinion, I would have been guilty of medical negligence if I had not gained training in methadone treatment and offered it to appropriate patients.

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6 *www.teenchallenge.com*

O HEAD

done for drug addicts?

'No!' **Robin Fisher** is a prison doctor in Derbyshire

Like teenage sex and smoking, drug addiction is not a medical condition, though its effects too often are. It belongs in a grey underworld of degradation and corruption, not masquerading in the surgery as a disease. Addiction is just one of the areas invaded by the medical model, which is all too eagerly accepted by addicts themselves. 'I will be forced to take drugs if you don't give me methadone.' In other words, 'I am the victim of a disease for which you have the cure and you are responsible.' If we treat addiction as a disease then we turn a moral problem into an illness and transform addicts into victims, barely responsible for their own lives.

As an inner-city GP, I prescribed methadone for four years. In my experience, it almost invariably fails to do anything for drug users. Addicts use it to buffer their habits, cutting down on heroin costs. Morphine substitutes do not really help addicts control their habit and do not break the ingrained behavioural pattern of escaping to drugs in times of stress and crisis.

Morphine substitutes are used because coming off drugs, the 'detox', is seen as a horrific experience that we cannot expect addicts to endure. Yet, coming off drugs is not the real issue, nor is it half the horror that it is imagined to be. Many long-term addicts have 'turkeyed' on a number of occasions. Staying drug free is the problem. How often have we seen addicts come off drugs and then fall back again?

The cardinal aim of rehabilitation for substance users must surely be a substance free life. I firmly believe that we cannot fight substances with other substances. In the prison where I work, the detox regime is a complex protocol involving four different drugs that are issued daily. One of these, buprenorphine, has a high street value and is escaping onto the prison drug market. The same drug is getting into the prison from the surrounding area as the local GPs are prescribing it. At the clinic where these substances are doled out, it is only too obvious that becoming drug free is the last thing on the recipients' minds as they argue aggressively and noisily about the dose regime that they agreed to only a day previously. Some try every way of avoiding swallowing the drugs so that they can go on to sell them. I am so grateful that I am not involved in this professionally disreputable fiasco.

The use of opiate substitutes may also disguise the poverty of rehabilitation programmes where

> THE AIM OF REHABILITATION FOR SUBSTANCE USERS MUST SURELY BE A SUBSTANCE FREE LIFE

the workers have little to offer in the shape of transformed and attractive lifestyles. It replaces what should be of the utmost importance in drug rehabilitation: the devoted care of people committed to rehabilitating drug users, themselves genuinely committed - with all the likely ups and downs - to becoming drug free. The reputed horrors of 'rattling' become very manageable or disappear altogether when highly committed people give withdrawing addicts a constant ministry of prayer and care. This needs to be within the context of an ongoing programme of support as they attempt very difficult personal changes. It is here that Christians have so much to offer as we have the Gospel!

Harm reduction programmes are prevalent throughout medicine. In the context of drug addiction, harm reduction is based on the addict's choice to remain an addict and we are colluding with him or her if we are drawn into it.

Walk the extra mile

Prescribing methadone by itself is a fairly meaningless exercise. It may well play a part in a whole person approach but the most important thing to give each patient is self-respect. 'Love your neighbour as yourself' (Matthew 19:19). If Jesus can see the best in the worst sinner, cannot we, his followers?

One of my patients dealt £2,000 of heroin each week in order to feed his habit. He had refused to countenance withdrawal. Suddenly he stopped using and dealing and got a job. Much later I asked him what had changed him. He replied, 'You did. You were the first person in my life who treated me with respect.'

We should not prescribe methadone to our patients *unless* we are prepared to walk that extra mile with them.

John Geater was a GP in Hastings and is now Director of PRIME

What position do you take? Is there a particular issue that you would like featured in Head to Head?

Write in to **rachael.pickering@cmf.org.uk** and join in the debate. In the next issue, we will publish correspondence along with the next Head to Head.

EUTYCHUS

Smacking ban

MPs are to vote on whether or not to ban smacking. A proposed amendment to the Children's Bill, which has its second reading in the House of Lords later this year, would remove the defence of 'reasonable chastisement' and ban the corporal punishment of children by their parents, except in instances where it is necessary to avoid immediate danger or injury to any person, including the child himself. The measure is supported by the *Children are Unbeatable Alliance*, a group of more than 300 organisations and individuals including NSPCC, Barnardo's, NCB and Save the Children. (*The Times* 2004; 15 March:58)

Sex education increases teen pregnancies

A report published by the Family Education Trust has found that explicit sex education in schools has resulted in an increase in the teenage pregnancy rate. Pregnancies have risen by up to 34% in schools that distribute free condoms and offer confidential health checks to girls. Valerie Riches, the former social worker who wrote *Sex Education or Indoctrination* described sex education as a 'manipulative tool to replace the influence of parents with the authority of the state'. (*The Times of London 2004;* 15 March, quoted in *SPUC Digest*)

Reverse Russian Roulette

The NHS is to fund one IVF treatment cycle for sub-fertile women in England under the age of 40, by April next year. This falls short of the three cycles recommended by the National Institute for Clinical Excellence (NICE), which would cost an estimated £85m a year in England and Wales. The chances of a successful birth in a single cycle of IVF are put at around one in four for women under 35 and lower for women in the 35-40 age group; so going for a baby under the new regime will be like playing 'reverse Russian roulette', with chance of success not much better than one in six! (*bbc.co.uk* 2004; 25 February, *Observer* 2004; 22 February)

Italy bans embryo research and donor gametes

A new Italian law banning the use of surrogate mothers and donor eggs and sperm in IVF treatment came into force in March. The law also bans embryo freezing, disposal, experimentation and all pre-implantation genetic testing and restricts treatment to married couples or those in a stable relationship. Senator Elisabetta Alberti Casellati said: 'This law says "enough" to the abuses. It recognises that an embryo is a person and as such must be protected from the point of conception.' (*BBC* 2003; 11 December; *BMJ* 2004; 328:9, 3 January)

'Consumption smoothing'

Young professionals are delaying having children for economic reasons and one in five UK women has not had a baby by the age of 40. According to a report by the Institute of Public Policy Research, 'People have begun to indulge in "consumption smoothing" where they try to accumulate as much wealth as possible to lessen the impact of kids on lifestyle. This has huge implications for UK birth rates and the ageing population and pensions debates that are currently raging.' (*The Daily Telegraph* 2003; 14 November)

Illegal GMC guidance?

Leslie Burke, a 44-year-old Lancaster man with congenital cerebellar ataxia, has challenged the General Medical Council (GMC) on the grounds that its guidance *Withholding and Withdrawing Life-Prolonging Treatments: Good Practice in Decision Making* fails to comply with the European Convention on Human Rights. The verdict in the case was awaited as *Triple Helix* went to press. (*GMC News 2003*; December 2003)

US cuts abortion funding to UNFPA

The US senate has permanently reallocated $59 million away from the UN Population Fund, C-FAM reports. The funds were withheld from UNFPA because of its involvement in coercive abortion in China and have been transferred to programmes that work to improve maternal health and combat sex trafficking. The move comes in spite of efforts by pro-abortion groups such as *'Catholics' for a Free Choice* to draw attention away from UNFPA's role in China. (*C-FAM*, 30 January, quoted in *SPUC Digest*)

Israel rules on post-mortem sperm donation

Israel's attorney general, Elyakim Rubinstein, has issued formal regulations that will allow the removal of sperm from a man's body at the request of his wife or common law wife. Under the new regulations the woman must obtain the permission of a court to use the frozen semen, and the regulations are such that her request is likely to be granted. The new situation in Israel is in direct contrast to the situation in the United Kingdom, where Diane Blood was denied use of her dead husband's sperm on the grounds that he had not given clear permission for its use before he died. She has since had two children after being inseminated by his sperm abroad. (*BMJ* 2003;327:1187, 22 November)

Designer baby case

A landmark legal battle over the creation of so-called 'designer babies' is to be settled in the House of Lords. Opponents will challenge an Appeal Court decision that allowed a couple to use pre-implantation diagnosis to select an embryo whose tissue could save their terminally ill son.

Shahana and Raj Hashmi were granted permission by the Human Fertilisation and Embryology Authority (HFEA) last May to screen the tissue type of their IVF embryos to ensure they had a baby whose stem cells would be compatible with their son Zain, who they claim needs a bone marrow transplant for β-thalassemia. Thus far they have been unsuccessful in producing an appropriate 'saviour sibling', suffering a miscarriage in December last year (*Reuters*, London, 26 January). Last year in Italy, where 13% of Sardinians carry the thalassemia gene, all but 20 of 1,600 fetuses diagnosed prenatally were aborted. (*BMJ* 2004; 328:9, 3 January)

Funding shortage for therapeutic cloning

The European commission, backed by the European Parliament in a November 2003 vote, wanted stem cell work to be funded from the EU's £17.5bn 2002-06 research budget. This has now been overruled. This means that plans for central EU funding for such research will be put off for the foreseeable future. (*Guardian* 2003; 4 December)

LETTERS

Frozen Embryos

***Dave Stevens**, CEO of our US sister organisation CMDA, reports on an exciting initiative.*

It was interesting to read about excess frozen embryos in the UK in your recent review (*Triple Helix* 2004; Winter:12-13). We face a similar situation in the US with an estimated 400,000 human embryos in storage, many thousands of them unclaimed. Working with one of our members, we recently opened the 'National Embryo Donation Centre'. Although we are working with an adoption agency, we have lessened the expense of going through a lengthy adoption process to make it more economically feasible for couples to adopt. There are over 100 couples waiting for adoption and we can serve the UK if there are couples that are willing to donate embryos. See *www.embryodonation.org*

Contraceptive prescribing

*Although he agrees in theory with **Ruth Selwood's** arguments for not prescribing contraceptives for unmarried patients (Triple Helix 2004; Winter:16-17), Chesterfield GP **Neil Ritchie** raises some practical objections.*

Ruth Selwood raises two main ethical considerations. First, is prescribing contraception for unmarried couples 'harm reduction' or is it 'facilitation of sin'? Second, is the 'contraceptive' acting after fertilisation and thereby abortifacient? But the situation can be more complex than this.

Both the combined pill and the IUS can be prescribed for menstrual symptoms alone. However, people can and do change their circumstances, and there is always the risk that people may be tempted to have sex outside marriage (possibly more so, due to the additional contraceptive effect). Therefore prescribing the pill and the IUS for these indications alone, to the unmarried, could be viewed as making it easier for them to sin in the future. With the IUS there is, of course, also the issue of its abortifacient effect on the third party embryo. Where is the line drawn for the responsibility of the prescriber?

It would seem justified to offer the IUS to a married woman with a sterilised husband if she had menorrhagia. However, if she then chose to commit adultery (with a fertile partner), would the prescriber then be held responsible (at least partially) both for facilitating sin and the abortifacient effect?

My view is that some degree of trust seems necessary. I tend to think that perhaps we can only act and take responsibility on the assumption of honesty from the patient and the situation as presented to us now.

These practical issues are important to address, as consistency is vital both for our own peace of mind and also to maintain the respect of our colleagues.

*Retired Somerset GP **Michael Elwin** argues that prevention is better than cure.*

Issues regarding contraception and abortion continue to appear frequently in *Triple Helix*. The problems of sexual immorality are not new, and we find in Scripture a number of examples: Lot's daughters (Genesis 19), David and Bathsheba (2 Samuel 11-12), Amnon and Tamar (2 Samuel 13). But there is little biblical teaching about how to cope with our very powerful sexual feelings, nor how to deal with the consequences of misuse.

The 1967 Abortion Act was made partly to try to stop the dreadful damage illegal back street abortions were causing, and there are some women alive today who would not be were it not for legal safe abortion. This does not make abortion right, but the sin that leads to abortion is not unforgivable. I wonder what Jesus would do if he were a doctor confronted with this problem? He condemned the hard legalism of Pharisees; might he also condemn 'hard-line' Christian doctors?

Control and right use of our sexuality is difficult, perhaps impossible without Christ and the Holy Spirit. Given our diversity of views with respect to the status of life before birth, and especially the early embryo, should we not rather concentrate on helping young people to cope with their sexuality, and encourage marriage and faithfulness, rather than just concentrating on abortion and contraception? It is surely better to try and control the flood at source.

Christian practices

*Lisburn GP **Lloyd Gilpin** asks if business partnerships with non-Christians are biblical.*

I was glad to see the article 'Is a Christian GP best off in a Christian Practice?' (*Triple Helix* 2004; Winter:18) I did feel however that an important point was omitted.

As Christians we should carry out our work to the best of our ability - not seeking to please men but our Lord (which in turn will give best patient care). Surely then, we would not want to be unequally yoked with non-Christian partners (2 Corinthians 6:14) in that task. Being a Christian doctor in today's moral climate is difficult enough without having the pressure to compromise our principles in order to make the practice run more smoothly or profitably.

The advice given to many seeking a partnership is to choose carefully because it is like a marriage - for many reasons! I understand those who like to be kept on their toes by non-Christian partners and the opportunity it affords for witness, but many of these opportunities exist to both employed staff and patients in a 'Christian partnership'.

We may have no say over attached staff, but whom we choose as partners is something we have a definite say over. A business partnership like general practice is more than just a job and I feel Scripture would have us consider carefully who we 'yoke' ourselves with in our service for the best of masters - our Lord Jesus Christ.

HIV/AIDS

***Peter Davies**, Chest Physician in Liverpool takes the editor to task.*

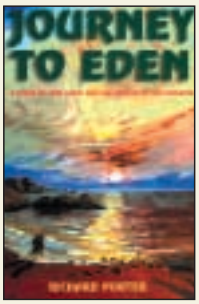
Shame on you for printing a big article on the AIDS Pandemic (*Triple Helix* 2004; Winter:6,7) with not a word about TB. Even Prince Harry knows of the link.

***Keith Sanders**, former General Secretary of CMF, pays tribute to Caroline Collier, who died last December.*

I worked closely with Caroline in the 1980's when she worked with CMF as an AIDS Lecturer and Resource Officer. She wrote one of the first books on the subject, *The 20th Century Plague* (Lion Publishing) and her four-page flyer, *Ten Proposals on AIDS*, was distributed by CMF to all doctors, health authorities and MPs in Britain. Now in 2003, nations are beginning to recognise the realities of what she forecast 20 years ago, and although political correctness still rules the minds of many, where *The Ten Proposals* are being applied, as in Uganda, a way of hope is being demonstrated. Caroline will be fondly remembered for her kindness, integrity, loyalty, intelligence, sparkle of fun, and her persistence in the face of real opposition in seeking to apply the heart and mind of Jesus Christ in all she did.

BOOKS

Journey to Eden



Richard Porter
Ambassador Publications
2003
£12.99 Pb 410 pp
ISBN 1 84030 143 0

Why is this gripping tale of Le Carre style espionage spiced with science fiction being reviewed in *Triple Helix?* The answer is that *Journey to Eden* is a tender story of Christian testimony and also embodies Richard Porter's fascinating hypothesis that reawakens the creation / evolution debate. As a novel it provided one of my most enjoyable (can't put it down) reads. However, the most stimulating aspect is the author's entrepreneurial concept that enlivens the discussion over whether the first few chapters of Genesis are a poetic portrayal of God's creation or are indeed a scientific record.

The fiction is surprisingly realistic with its contemporaneous setting in occupied Iraq. It surrounds a brilliant young Russian-trained Iraqi scientist who develops a satellite-linked 'time probe' which, like H G Wells' time machine, has the potential to see into the recent past and so reveal atrocities of oppressive communist regimes. The plot takes off with the involvement of a young Christian doctor, her geologist husband and both the Russian secret service and the CIA.

Porter goes on to propose that cosmic time, unlike biological time (ie the body clock), has been slowing down since the world was created. He cites over 100 references in support including, for example, the astronomical red shift phenomenon. On this basis he finds it reasonable to propose that the patriarchal fathers of the Old Testament did live for 800 years or more when the Earth was spinning round the Sun more quickly. Equally, as time slowed, it became possible for man to run a 4-minute mile. Records will continue to fall. He says that even carbon dating is susceptible to cosmic time, and asks what basis we have for accepting that time is absolute. From this, he surmises that the world could well be only a few thousand years old.

Professor Porter's considerable lateral thinking ability (known to those who have shared in his clinical research in orthopaedics) combined with his spiritual depth comes to the fore in this dynamic book. It is more than a scientific allegory; it is a rare combination of scientific thesis and good novel writing. However, like all good theses, it provides more questions than answers and so we still have to accept that 'now we see but a poor reflection as in a mirror' (1 Corinthians 13:12).

Michael Edgar is a retired consultant orthopaedic surgeon in London

Healing the Culture: a commonsense philosophy of happiness, freedom and the life issues

Robert Spitzer, Robin Bernhoft, Camille De Blasi
Ignatius Press 2000
£8.96 Pb pp347
ISBN 0 89870 786 2

Those with a materialistic and utilitarian outlook have already demeaned personhood by liberalising life-protecting laws. The writers attribute this to acceptance of the lowest of four possible 'Levels of Happiness'. Although they do not say so, these levels mirror the sequence of conceptual maturation in children.

As with infants, Level 1 offers pleasure through immediate satisfaction. Level 2 is self-centred and competitive, like young children whose inexperience makes them judge by appearances. They squabble over desirable toys, showing how autonomies can conflict when perceived rights exclude responsibilities. Debates about beneficence and non-maleficence conducted at Level 2 are skewed by viewing pain as intolerable, hence promotion of abortion and euthanasia, with no serious regard for alternative but costlier options. Like many in early adolescence, those at Level 3 have ideals beyond self, applying principles (truth, goodness, justice and beauty) which benefit others. Based on supposed 'love', though, the outworking is often materialistic (eg care orders not parentcraft, handouts not hands on). Level 4 brings an eternal perspective to these same principles with God's love inspiring and undergirding their application, thus involving personal self-giving.

It is this common nature, capable of eventual maturity, which the writers see as defining a person. For 'the tyranny of the majority' that seeks to exclude some as non-persons indicates a culture dominated by minds at Levels 1/2. This affects views (and laws) on personal rights, justice, ethics and the common good. Conceptual growth spurts often follow painful crises. Yet 'suffering well' opens up possibilities of developing Level 3/4 humility, empathy, justice and, sometimes, prayer. Competitiveness becomes creative cooperation, whilst the goal of freedom from pain yields to that of freedom for other-centred love. This brings lasting, not ephemeral, comfort and happiness both to carers and cared for.

Those at Levels 3/4 are urged to teach their perceptions about personhood to the more immature. Theoretically, this should be eye-opening, stimulating other-love and thereby bringing about communal and cultural healing. Yet even with the Lord himself as teacher most hearts, ears and eyes remained closed. He indicated that conversion precedes healing (Matthew 13:15). However convincing the philosophy, therefore, education alone is not enough. Informed heads and repentant hearts can be separated by stiff necks.

Janet Goodall is a retired consultant paediatrician in Staffordshire and former CMF President

Johnny Head-In-Air. Memoirs of a Doctor-Journalist

Ronald Winton
Book House 2002
£10, 110 pp
ISBN 1 74018 221 9

Ron Winton, now in his 90th year, was a distinguished editor of the *Medical Journal of Australia* from 1957 to 1977. This gave him the ideal platform for combining his medical training and his love of literature. Every aspect of his life was under girded by his sturdy Christian faith applied in a host of different ways: for 20 years as warden of a hostel for overseas students in Sydney, as chairman of the ethics committee of the World Medical Association and through extensive support of ICMDA with memorable contributions to *Doctors' Life Support.*

In 1977 Douglas Johnson, first General

Secretary of CMF, invited him to be guest speaker at a dinner for leaders of the medical profession in London, hosted by the Archbishop of Canterbury at Lambeth Palace. The subject was as timely then as it is now: 'The future of professional freedom'. This address was subsequently published by CMF and could bear re-reading.

The memoirs are typically unpretentious, but will evoke many memories for the older generation of CMF members and for those who knew Ron Winton. His was a life well spent and an example to follow.

Peter Pattisson is ICMDA Regional Secretary for Europe and the former USSR

Being Me – what it means to be human

Pete Moore
Wiley 2003
£16.99 Pb 277pp
ISBN 0 47085 088 4

'What does it mean to be human?' is a question that has been asked throughout the ages, and definitions are difficult to find. As Pete Moore recognises, 'Any approach to define who I am is doomed from the outset because we will always be more complex than can be catered for by any single definition. It is however, not intractable to investigation once you have broken the subject down into bite-sized pieces, and have admitted that revealing the nature of one aspect of our existence is not the same as describing humanity.'

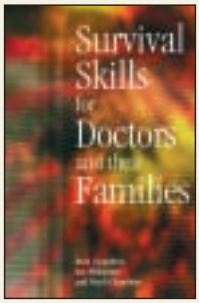
With this in mind, he explores nine different aspects of human existence – embodiment, consciousness, genetics, history, relationship, materiality, spirituality, sexuality and society – by telling the stories of people for whom a single aspect is especially relevant. For embodiment we read about Arthur White, the reigning world champion power lifter, whose physical ability has been a defining feature of his life. A very different experience is seen in the story of David Bird, who was born with a vascular anomaly surrounding one of his eyes that has profoundly affected the way others view him, and consequently his own self-perception and personal development. The importance of our history is considered through the research of David Barker, whose findings show that our health is radically influenced by the diet and environment that our grandmothers experienced whilst pregnant with our mothers.

Some well-known interviewees, such as Rowan Williams and Mary Warnock, are included in the chapter on spirituality. However, it was the stories of everyday people that really drew me in. These provoked consideration of the various environmental, historical and biological factors that have interplayed to make me who I am today, and how changes to any of these might affect my life. It is, perhaps, this kind of reaction that Pete Moore hopes to produce. Modern scientific thought often reduces us to categories that determine who we are, 'there are two branches in particular that are currently making that sort of claim – genetics and neuroscience.' Pete Moore's aim of 'taking a holistic view of our existence' highlights how limited such a view of humanity is.

The content is not specifically Christian, though some of the interviewees express a Christian faith, and it does not detail philosophical arguments on existence. Rather, there are some interesting insights, engaging stories, and useful overviews of current thought – all of which make this an enjoyable and stimulating read.

Jacky Engel is CMF publications and research assistant

Survival Skills for Doctors and their Families



Ruth Chambers, Kay Mohanna and Steph Chambers
Radcliffe Medical Press 2003
£21.95 Pb 140pp
ISBN 1 85775 990 7

Ironically, the only way that I could find time to a review this book was to take it on holiday, a holiday already marred by planning uncertainties at my NHS work which were going to affect me as soon as I returned. So I sat on my hotel balcony and in the airport lounge writing this review and felt guilty since taking work on holiday is definitely one activity which the authors do not applaud!

This is a very good book. The authors are two female academic GPs and a teenage daughter. Their writing is given added weight by being based on survey data and responses. Within an attractively printed paperback, about 100 pages of text are addressed directly to the reader. Both the quotations that are highlighted in text boxes and the well chosen cartoons succeed in breaking up the text, making it a very readable book. The nine chapters cover career-marriage conflict, the team family, stress, surviving time pressures, the importance of listening and talking, taking time off duty, and illness. The final chapter on making a logical plan will appeal to those personalities who like the grid box solution approach to problem solving, but are less useful to intuitives like me.

There is no Christian angle to this book, and in fact the only biblical material is the list of seven deadly sins, curiously unreferenced in an otherwise very well referenced piece of writing. Whilst these are described as strong motivators, the authors clearly do not regard them as desirable ones, although most of them can be observed on a regular basis in the NHS. This book sits very harmoniously alongside biblical teaching, and both Christians and non-Christians will benefit. It is timely since many of us have been forced into a much greater degree of personal reflection about our work and its personal impact as we go through appraisal. In the final chapter the authors state: 'This book is filled with good advice. You will have heard a considerable amount of it before...' They are right, but what makes this book special is the way that knowledge is illustrated and applied.

Who should read it? Any doctor will benefit, but those who need it most are unlikely to choose to read it, at least until they get desperate, have burned out, or their marriages have failed. It would make a superb gift to the newly or recently qualified doctor, which is probably where it will be most effective before attitudes become hardened. It has easily solved the problem of what to give my GP daughter for Christmas! And if I ruled the NHS I would give this book as a free handout to all doctors with their appraisal forms, and then make sure that it was handed on to their literate family members.

Michael Jones is associate specialist, Regional Infectious Diseases Unit, Edinburgh & Director Edinburgh International Health Centre

OPPORTUNITIES ABROAD

Specific Vacancies by Country

Posts usually require you to be **UK-based** with your own **financial** and **prayer** support. The contact details given are to enable you to research the post. For many other current vacancies visit the vacancies page at *www.healthserve.org* which is updated weekly or see previous issues of *Triple Helix.*

Bangladesh

Locum obstetrician/gynaecologist (female) needed from August to late November 2004 at LAMB Hospital, an integrated rural health and development project in NW Bangladesh. This 75-bedded hospital provides medical, paediatric, and obstetric/gynaecological services (2,350 deliveries - 60% complicated in 2003) with both inpatient and outpatient facilities and a community based work. The obstetric team consists of two British obstetricians and four Bangladeshi doctors. **Contact:** Dr Christine Edwards, Medical Director, LAMB Hospital, PO Parbatipur, DT Dinajpur 5250, Bangladesh. Email: *chrise@lambproject.org*

Locum paediatrician (male or female) also needed from December 2004 to late April 2005. Suit a paediatric trainee or GP with special interest. One paediatrician and two Bangladeshi doctors provide a busy newborn service managed with low tech facilities; inpatient and outpatient and rehabilitation services. **Contact:** Dr Ruth Lennox, Head of Paediatrics, LAMB Hospital, PO Parbatipur, DT Dinajpur 5250, Bangladesh. Email: *ruth@lambproject.org*

Burkina Faso

A General Surgeon is needed at the Clinique Medico-Chirurgicale (ONG). The post would suit a retired general surgeon who also has some experience in O&G. The hospital complements the work of a Government run medical centre nearby. The appointee would mainly be dealing with elective surgery - hernias accounting for the majority of cases. French would be a distinct advantage. Accommodation is provided but otherwise the post is self-funding and for three months (negotiable). **Contact:** Dr Hui Tan. Email: *htan@doctors.org.uk*

Egypt

A primary care trainer is needed for the Manouf Hospital (Episcopal Church of Egypt), which is in the Delta area, approx 90 minutes drive from Cairo. It is a busy rural town hospital with 68 beds providing specialist services and with good laboratory and X-ray facilities. It has been selected by the Government to introduce a model of primary health care. Experience will be needed in training other doctors, setting standards and protocols and working with a team. The appointee would be working with the hospital director and other staff, to set in place systems and procedures to ensure efficient use of resources and will have to meet Government standards of operation. Systems of information capture and reporting will be critical to the success of the programme. **Contact:** Mark Bennett, Development Director, PO Box 87, Zamalek, Cairo, Egypt. Email: *markb@refuge-egypt.org*

India

Emmanuel Healthcare (the merged EHA + EMMS) is urgently looking for female obstetricians & gynaecologists, to work in Herbetpur, Satbara, Champa and Alipur. Anaesthetists are needed for Raxaul and Alipur. Postgraduate specialist diploma is required. Accommodation and approved work-related travel expenses will be provided; otherwise self-funding is necessary. Short or longer-term posts are available. **Contact:** Hazel Whiting. Email: *info@eha.org.uk*

Nepal

Doctors are needed (in specialty training grades or fully trained) by **Team Nepal** to work in three rural hospitals (20-50 beds). These posts provide a much-needed service to poor rural communities and offer excellent training opportunities for those specialising in O&G, general surgery, medicine or paediatrics. Contracts of varying length are available from between 1 - 12 months or even longer. **Contact:** Dr Ted MacKinney. Email: *mackinney@bigfoot.com*

Senegal

YWAM need doctors for two projects in this country. The first is in Dakar and involves work at an outpatient clinic offering consultations, vaccinations, prenatal and dental care, plus evangelism and healthcare teaching to street children. The second involves working in a rural area 150 km away, at a training centre for village health workers. A two-year term is envisaged but this is open to negotiation. French, plus the local language would be necessary for longer-term workers. The post is non salaried. **Contact:** Bryan Steele or Beatrice Marceau. Email: *jemclini@sentoo.sn*

Tanzania

Locum needed by a CMF member serving at St Luke's Dispensary in Mpwapwa (Anglican Diocese) from June 2004 to January 2005. The post would suit a general practitioner with some maternity experience but there is no major surgery. The dispensary is situated in a small market town and the work would include overseeing an HIV education project, MCH and family planning Clinics. Swahili would be an advantage but interpreters are available. Knowledge of ultrasound would also be useful. The returning doctor is willing to remain in email contact if need be and a two bedroom house is available. **Contact:** *www.tarlings.com'st_lukes_clinic.htm*

United Arab Emirates

The Oasis Hospital, a well equipped 45 bedded modern hospital in the oasis city of Al Ain, needs an obstetrician (female), anaesthetist, general surgeon with laparascopic skills, paediatrician with neonatal experience and a cardiologist. The multinational staff, of some 150 people, come from 20 different cultures. **Contact:** Dr Larry Liddle. Email: *lliddle@oasis.smart.net*

EVENTS

The Developing Health Course 2004 (previously called the Refresher Course) will be held at Oak Hill College from 5-16 July 2004. Brochures, application form and programme are available from the CMF Office.

ITEMS WANTED

Medical and nursing textbooks (published within the last ten years, exceptions made for anatomy), to assist in stocking the Medical School Library at the University of the Transkei, South Africa. Texts accepted on pre-clinical, clinical, nursing and midwifery subjects at undergraduate and postgraduate levels. If you have books that you could donate **contact:** Mr Peter Willson, Consultant Surgeon, Kingston Hospital, Gallsworthy Road, Kingston, Surrey KT2 QB. Email: *peter.willson@ntlworld.com*

All Nations Christian College offers Refresh for Mission - July 5-9 2004 (same time as the CMF Developing Health course I'm afraid). It aims to provide refreshment of spirit, mind and body for those involved in world mission. *Pause for reflection* July 12-16 is a companion course designed to provide space and time for waiting on God, reflecting on past ministry and future possibilities. **Contact:** *shortcourses@allnations.ac.uk* Web: *www.allnations.ac.uk*

Guard your heart

'Mummy, who attacked Grandad's heart?' My seven-year-old granddaughter was worried when she heard that I had suffered a heart attack. Who indeed? I was a fit non-smoker with no previous ill health. Could it be due to stress, the subtle demon that seems to lie behind so many of today's ills? How had I managed to allow things to get to this state? Three years have passed. With a change of job and a more relaxed environment, I have remained well. Recently, I read a Proverb and the whole experience came back to my mind…

*Above all else, **guard your heart**, for it is the wellspring of life. (Proverbs 4:23)*

This verse led me to Paul's urging of the Philippians…

*Rejoice in the Lord always… Do not be anxious about anything, but in everything, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will **guard your hearts and your minds** in Christ Jesus. Finally, brothers, whatever is true…think about such things. Whatever you have learned or received or heard from me, or seen in me – put it into practice. And the God of peace will be with you. (Philippians 4:4-9)*

This brought another scene to mind. Some years previously in Tanzania, a group of nuns, led by the Mother Superior, appeared in my gynaecology clinic. One of the sisters complained of a number of non-specific symptoms. After examining her, I wrote out a rather unusual prescription and they all left. Minutes later, there was a furious knocking on my door and the nuns all burst back in and demanded that I teach them the chorus that I had prescribed.

All your anxiety, all your care. Bring to the mercy seat, leave it there. Never a burden he cannot bear, never a friend like Jesus. (from All Your Anxiety by EH Joy)

After an impromptu choir practice, I could hear the words echoing round the department as they marched out of the hospital.

What was Paul's advice to those wanting to guard their hearts and minds against the physical, emotional and spiritual onslaughts of this world? What was his prescription for a stressful situation?

- Learn to rejoice and give thanks in every situation.
- Pray into every situation and be thankful.
- Fill your mind with good and excellent things.
- Follow his example and put the things you learn into practice.

He goes on to talk about having learned the secret of contentment 'in any and every situation' and of the fact that he can do all the things that Jesus has asked him to do through the strength he supplies (Philippians 4:12-13).

I was given all sorts of lifestyle advice after my heart attack. Yet, 'above all else', I needed to relearn these spiritual lessons and to know afresh the peace that passes all understanding in my heart. I needed to enter into that rest that is ours in Christ. Perhaps these are lessons that we all need to be relearning continually in the midst of our busy and stressful lives.

I have come to see each day as a gift from God, days that might not have been. We were made with only one heart and are given only one life here on earth. Heed the words of the writer of Proverbs: above all else, guard your heart in order to enjoy the life and work that God has given you to do for him.

Peter Armon is CMF Overseas Support Secretary

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