TRIPLE HELIX

Spring 2005

For today's Christian doctor

NAZI DOCTORS

HPV

CHLAMYDIA

EUTHANASIA

EUGENICS

OSTEOPATHY

COMPUTERS

POVERTY AND HEALTH

OUR PRIVATE LIFE

THE COMFORTING TOUCH

OVERSEAS OPPORTUNITIES

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Cover Dr Karl Brandt receives his death sentence at Nuremberg.

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CONTENTS

NO. 31. SPRING 2005

Editorials 3
Human Papilloma Virus – *Trevor Stammers*
Chlamydia screening at Boots – *Chris Richards*

Euthanasia and autonomy 4-5
Andrew Fergusson

The Nazi Doctors 6-7
Peter Saunders

The return of eugenics? 8-9
Ben Mitchell

Osteopathy 10-11
George Smith

Poverty and health 12-13
Steve Fouch

Imitating Christ in our private life 14
David Short

Records, confidentiality and computers 15
Carl Whitehouse

The comforting touch 16
Janet Goodall

Standing on the shoulders of giants 17
Jes and Jane Bates

Overseas opportunities 18
Peter Armon

Eutychus 19
Clare Cooper, Jacky Engel

Book Reviews 20-21
Janet Goodall, Keith Sanders, Helen Barratt, Charles Foster, Trevor Stammers

Letters 22
Huw Francis, June and Michael Flowers, Charles Foster, Jenny Robinson

Final Thoughts 23
Peter Saunders

EDITORIALS

Human papilloma virus

Department of Health continues to ignore implications

Human papilloma virus (HPV) was back in the news on both sides of the Atlantic early this year. The UK press was euphoric about a new vaccine against HPV which would be available 'within the next five years'.[1] This is indeed good news but predictions of women no longer needing cervical smears seemed a little premature, given that the vaccines have not yet completed clinical trials.

The two vaccines currently being developed are Gardasil, made by Merck, and Cervarix, from GlaxoSmithKline (GSK). Both protect against the HPV-16 and HPV-18 strains, which cause over 70% of cervical cancer cases. Gardasil also protects against some other HPV strains that cause genital warts.[1] The hope is that this will improve take up rates of the vaccine in men. Dr Anne Szarewski, of Cancer Research UK considers both men and women will need to be vaccinated in order to maximise the potential reduction in cervical cancer.[1]

If the vaccine proves to confer long-lasting protection, the developers quite rightly identify the main problem regarding its use will be the ethical dilemma of vaccinating, say twelve year-old girls, against what is essentially a sexually transmitted disease. Prevention is clearly better than cure, but could prevention of this STI induce complacency in sexual behaviour that may cause a rise in the spread of others? Certainly the complacency associated with the increasing availability of ART for AIDS patients[2] does not look encouraging for preventative measures depending on an HPV vaccine alone.

HPV is causing other ethical dilemmas in the USA where a controversial study funded by the National Institutes of Health is proposing to research how HPV is passed from men to their female sexual partners. According to lead researcher, Dr Anna Giuliano of the Moffitt Cancer Center, the aim is to learn whether men should be vaccinated against HPV along with women.[3] Clearly she needs to talk with Dr Szarewski who already seems sure that they should be.

Another issue for Dr Giuliano is that the men in the study, mostly recruited from Mexico and Brazil, won't be told whether they are infected or not. 'There is no treatment for HPV, so we are not doing any harm by not disclosing infections,' Giuliano said. 'There also is no strategy for prevention of transmission to partners,' she said, 'because condoms aren't protective against HPV.' We should perhaps hear more about that in the UK whilst we await the vaccine, as most condom users are blissfully unaware of this.

One further twist in the tale is that Americans were officially unaware that HPV caused cervical cancer until this year. The National Institute of Environmental Health Sciences and the National Toxicology Program, which maintain the official list of carcinogens and update it every two years, only just added HPV, along with Hep B and C, to the list in January 2005.[4]

So now it's official. HPV is a sexually transmitted disease against which the condom offers no protection; it has carcinogenic strains against which there will be no vaccine for at least five years. This surely has implications for sexual health promotion to which the Department of Health continues to turn its back leaving every sexually active man to 'do what seems right in his own eyes'.[5] The outcome now is likely to be no better than it was then.

Trevor Stammers is a General Practitioner in London

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2. Robinson AJ and Gazzard BG. Rising rates of HIV. *BMJ* 2005;330:320-321
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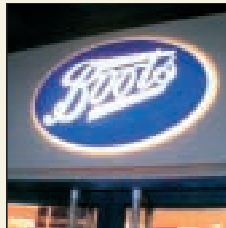
5. Judges 21:25

Chlamydia screening at Boots

De-moralising medicine



Boots the chemist is to offer a screening test and treatment for the UK's most common sexually transmitted infection, chlamydia.[1] This is part of a government-backed national screening strategy[2] aimed at reducing the effects and spread of chlamydia infection which is asymptomatic in the majority of men and women and can produce late infertility in women (and probably men). This latest move is a response to the spiralling chlamydia infection rates increasing by about 8% per year. This epidemic has been caused by a huge rise in both the frequency of extra-marital sex and the number of sexual partners.

Christians should be concerned about the expansion of this programme. Consider first the means. Like many of the other sites for chlamydia screening, the high street chemist has been chosen as a location for its potential to provide a confidential environment 'out of communion', except for contact tracing, with the rest of the patient's clinical care by their GP or specialist. It also replaces the valuable clinician/patient relationship with an advice leaflet. Such confidentiality is designed to increase the uptake of the screening. But this clinical fragmentation and impersonal context threatens our caring for the whole patient.

But it is more than this. Such an approach removes all opportunity for the clinician to warn the patient about the dangers of further extra-marital sexual activity. Such a warning never seems easy to give our patients, because it takes time in a hard-pressed day and it runs counter to the 'non-judgemental' attitude that our society so stridently demands. Yet we need to remember that it is never God's desire for medical care to be given outside of a moral context. He expects Christian doctors to take opportunities in their surgeries and clinics to explain to patients the good things that result from obeying God's commands and the bad things that happen when they don't.

We should also challenge the false creed of the programme's promoters who think that it is really possible to reduce the overall harm of extra-marital sex. Those who attend Boots will have avoided hearing warnings about the dangers of further extra-marital sex. Instead they will be relieved to continue their life-style unrestrained by the fear of spreading infection or creeping infertility and so seemingly avoid the consequences of their sin. However, more extra-marital sex will lead to more STIs and more unwanted pregnancies. Like the 'safe(r) sex' campaign the result will be a worsening rather than improving of the sexual health of our nation.

Chris Richards is a Consultant Paediatrician in Newcastle and Director of Lovewise

1. *news.bbc.co.uk/1/hi/health/4245585.stm*
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Andrew Fergusson argues that euthanasia undermines autonomy

EUTHANASIA - arguments from autonomy

KEY POINTS

'Respect for autonomy' is an increasingly common argument for legalising euthanasia. But a law allowing even voluntary euthanasia would paradoxically undermine rather than support autonomy. Most requests for euthanasia represent a cry for help arising from desperation rather than a serious desire to be killed, but even 'respecting' deliberated requests would inevitably put in danger others who felt pressure, whether real or imagined, to seek early death. Doctors and other health professionals who had a conscientious objection to the practice would almost certainly be excluded from certain specialties. Furthermore experience in the Netherlands has demonstrated that when voluntary euthanasia is made legal, involuntary euthanasia inevitably follows.

There are concerns that the Mental Capacity Bill might let euthanasia in by the back door.[1] Intense interest also surrounds the Report of the House of Lord's Select Committee considering Lord Joffe's *Assisted Dying for the Terminally Ill Bill*,[2] which if ever enacted would allow 'front door' physician assisted suicide with lethal injection back-up for patients incapable of swallowing medication.

Three arguments for euthanasia

Now is the time for all *Triple Helix* readers to have at their fingertips the arguments for and against legalising euthanasia. There are essentially three arguments for:

- ***We want it*** - the autonomy argument
- ***We need it*** - the compassion argument
- ***We can control it*** - the public policy argument

A previous Lords' Select Committee reported on euthanasia in 1994, and unanimously recommended no change in the law. Its Chairman, neurologist Lord Walton of Detchant, later described in Parliament their fear that any such legislation would lead to 'pressure, whether real or imagined, to request early death'.[3] The debate in the 1990s centred on the compassion case, but because of cultural changes and palliative care's success, has moved to arguments based on autonomy.

The word means 'self-determination' and the language now is of choice, control, freedoms and rights. The euthanasia lobby's thrust, as evidenced in Lord Joffe's Bill, has moved from euthanasia as a needed response to symptoms to euthanasia as an autonomous choice by those with, for example, degenerative neurological disease.

The theological case

The biblical case against euthanasia can be stated concisely. No Scripture can be found in favour and the sixth commandment[4] 'You shall not murder' applies. This prohibits the intentional killing of the legally innocent[5] but most practising doctors meet situations where they ask, however momentarily, 'Why does God say that?'

Christians should generally support autonomy because it reflects the unique value of each human being made 'in the image of God'.[6] However, autonomy is not absolute. Four arguments against the autonomy case for euthanasia follow, which are derived from respect for autonomy. There are brief reflections only on the compassion and public policy arguments. These secular answers go some way towards helping us understand the 'No' an infinitely wise and loving God has given us, and interestingly similar points have recently been made by a self-declared atheist![7]

We want it – the autonomy argument

1) Following patient autonomy to the hilt impacts others

Where a patient's autonomy is followed so far that they receive a prescription for lethal medication or are dispatched by injection, the doctor's autonomy is compromised. 'So what? Lord Joffe's Bill has a conscience clause. Objectors need not be involved.' But the conscience clause in the 1967 Abortion Act has only worked partially,[8] and abortion has kept doctors away from obstetrics and gynaecology and from general practice.

While abortion can be avoided as a doctor and still leave considerable career choice, there is no branch of medicine where one can entirely avoid issues of death and dying. What effect might enactment of such legislation have on recruitment and retention of medical staff? Further, the abortion conscience clause has only had limited application to colleagues in some health disciplines and none at all to other members of the team. What impact therefore might euthanasia legislation have throughout the National Health Service on staffing, which is already critical?

And as the award winning pro-euthanasia Spanish film *Mar Adentro* (The Sea Inside) makes so clear, the autonomy of family, friends and others close to the patient is inevitably affected, often with serious long term consequences.

2) Most requests mean something else

Those working with the dying know the (relatively few) who currently ask for euthanasia usually have another question behind their question. This may be physical - a distressing symptom needs palliation; psychosocial - they may want an honest discussion with their family; or spiritual - wanting answers to'Why me?' and 'Why now?'

Osler's old adage counsels 'No treatment without a diagnosis'. If doctors bother to make a real diagnosis and then treat that, requests for euthanasia usually go away. Therefore to prescribe euthanasia, even with the proposed safeguards, would far more often undermine autonomy than underline it.

3) But some requests are deliberated! Why can't they have euthanasia?

Why with controls can't there be a law to accommodate exceptional cases? The answer follows the previous one. For all the reasons hinted at there, and bearing in mind that prognosis is always uncertain, to change the law to allow euthanasia for this small minority within a minority would mean it was performed far more often when it was 'wrong' than when some would see it as 'right'. To protect that majority, the minority forego a right they don't actually have anyway.

This sounds utilitarian but that is how co-existence has to be in complex societies. For example, we all accept limitations on our road traffic 'freedoms' in order to protect vulnerable others, while John Donne's famous words 'no man is an island' evoke the issues of community and relationships always present in the euthanasia debate. Respect for the right of autonomy has to be balanced with the responsibilities that recognise restrictions.

4) 'Voluntary' leads to involuntary

If we change the law to allow voluntary euthanasia for those who are suffering and have the capacity to ask for it, surely we should similarly provide euthanasia on compassion grounds for that patient who is suffering at least as much but has no capacity to request it? This logical slippery slope will follow if society ever gives doctors the power to decide that any patient's life is not worth living.

The progression from voluntary to non-voluntary euthanasia (patient lacks capacity) or involuntary euthanasia (competent patient is not consulted) is well documented in the Netherlands. The Remmelink Report[9] analysed all 129,000 deaths in the Netherlands in 1990. 3% were by euthanasia. Of that 3%, 1 in 3, 1% of all deaths in the Netherlands in 1990, were euthanasia 'without explicit request'. In a mix of non-voluntary and involuntary euthanasia, Dutch doctors in 1990 killed more than 1,000 patients without their request. This is not respect for patient autonomy but doctor paternalism of the very worst kind.

We need it – the compassion argument

This stands or falls on the answer to the question: Do we have to kill the patient to kill the symptoms? Palliative care has answered 'No', though the harder symptoms to deal with (and those more likely to lead to requests for euthanasia) are not positive physical ones but negative ones of loss - the things patients can't do any more. The challenge to healthcare now becomes restoring a sense of dignity and bringing meaning and hope in the face of suffering.

We can control it – the public policy argument

As the Dutch statistics confirm, we cannot. We never could control it, when the key witness is dead.

Conclusion

Nobody has a 'right' to be killed by a doctor, Britain does not need euthanasia, and no society could ever control it. All three arguments are found wanting. Let us take action to prevent the acceptability, practice and legalisation of euthanasia. Let us get on with the task of working for that genuinely 'gentle and easy death' all our patients deserve.

Dr Andrew Fergusson has a portfolio career at the interface of medicine and Christianity which includes being CMF Strategy Advisor on Euthanasia.

BRITAIN DOES NOT NEED EUTHANASIA, AND NO SOCIETY COULD EVER CONTROL IT

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Peter Saunders outlines the history and reflects on lessons learnt

1945: German Reichsmarschall Herman Goering after his capture by Allied forces. Shortly before his uniform was stripped of its insignia and decorations, the leading Nazi cheated the hangman by taking poison after having been given the death sentence at Nuremberg.

Photo: Empics

The Nazi Doctors

Lessons from the Holocaust

Survivors and world leaders recently commemorated the 60th anniversary of the liberation of Auschwitz by the advancing Soviet army on 27 January 1945.[1] Auschwitz was the largest of the Nazi death camps, where 1.1 million people died during the Nazi holocaust. However, very little, if any, of the media coverage dwelt on the role of the medical profession in these events. The Nazi holocaust actually had humble beginnings; in nursing homes, geriatric hospitals and psychiatric institutions all over Germany. When the Nazis arrived, the medical profession was ready and waiting.

'Life unworthy of life'

Germany emerged from the First World War defeated, impoverished and demoralised. Into this vacuum in 1920 Karl Binding, a distinguished lawyer, and Alfred Hoche, a psychiatrist, published a book titled *The granting of permission for the destruction of worthless life. Its extent and form*. In it they coined the term 'life unworthy of life' and argued that in certain cases it was legally justified to kill those suffering from incurable and severely crippling handicaps and injuries. Hoche used the term *ballastexistenzen* ('human ballast') to describe people suffering from various forms of psychiatric disturbance, brain damage and retardation.

By the early 1930s a propaganda barrage had been launched against traditional compassionate 19th century attitudes to the terminally ill and when the Nazi Party came to power in 1933, 6% of doctors were already members of the Nazi Physicians League. In June of that year *Deutsches Arzteblatt*, today still the most respected and widely read platform for medical education and professional politics in Germany, declared on its title page that the medical profession had 'unselfishly devoted its services and resources to the goal of protecting the German nation from biogenetic degeneration'.[2]

Purifying the gene pool

From this eugenic platform, Professor Dr Ernst Rudin, Director of the Kaiser Wilhelm Institute of Psychiatry of Munich, became the principle architect of enforced sterilisation. The profession embarked on the campaign with such enthusiasm, that within four years almost 300,000 patients had been sterilised, at least 50% for failing scientifically designed 'intelligence tests'.[3]

By 1939 (the year the war started), the sterilisation programme was halted and the killing of adult and paediatric patients began. The Nazi regime had received requests for 'mercy killing' from the relatives of severely handicapped children, and in that year an infant with limb abnormalities and congenital blindness (named Knauer) became the first to be put to death, with Hitler's personal authorisation and parental consent.[4]

This 'test-case' paved the way for the registration of all children under three years of age with 'serious hereditary diseases'. This information was then used by a panel of 'experts', including three medical professors (who never saw the patients), to authorise death by injection or starvation of some 6,000 children by the end of the war.[5]

The slippery slope

Adult euthanasia began in September 1939 when an organisation headed by Dr Karl Brandt and Philip Bouhler was set up at *Tiergartenstrasse 4* (T4). The aim was to create 70,000 beds for war casualties and ethnic German repatriates by mid-1941. All state institutions were required to report on patients who had been ill for five years or more and were unable to work, by filling out questionnaires[6] and chosen patients were gassed and incinerated at one of six institutions (Hadamar being the most famous). False death certificates were issued with diagnoses appropriate for age and previous symptoms, and payment for 'treatment and burial' was

collected from surviving relatives.

The programme was stopped in 1941 when the necessary number of beds had been created. By this time the covert operation had become public knowledge. The staff from T4 and the six killing centres was then redeployed for the killing of Jews, Gypsies, Poles, Russians and disloyal Germans. By 1943 there were 24 main death camps (and 350 smaller ones) in operation.

Medical involvement

Throughout this process doctors were involved from the earliest stage in reporting, selection, authorisation, execution, certification and research. They were not ordered, but rather empowered to participate. Leo Alexander, a psychiatrist with the Office of the Chief of Counsel for War Crimes at Nuremberg, described the process:

'The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the attitude, basic in the euthanasia movement that there is such a thing as a life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans.' [7]

The War Crimes Tribunal reported that 'part of the medical profession co-operated consciously and even willingly' with the 'mass killing of sick Germans'. [8] Among their numbers were some of the leading academics and scientists of the day; including professors of the stature of Hallervorden (neuropathology), Pernkopf (anatomy), Rudin (psychiatry/genetics), Schneider (psychiatry), von Verschuer (genetics) and Voss (anatomy). None of these men were ever prosecuted while of the 23 defendants at Nuremberg, only two were internationally recognised academics. [9]

Looking back

It is easy to distance ourselves from the holocaust and those doctors who were involved. However, images of SS butchers engaged in lethal experiments in prison camps don't fit the historical facts; the whole process was orchestrated through the collaboration of internationally respected doctors and the State. Furthermore the thinking that laid the foundation was well-entrenched throughout the Western world of the time. The International Eugenics Congress which elected Ernst Rudin as its president in 1932, met not in Berlin, but New York. [10] The United States had itself sterilised 30,000 mentally ill and criminally insane before the war and within Europe Denmark had beaten Germany to the operating table by four years. [11]

The lessons of history should alert us to similar trends in our own society. What features can we identify?

Deja Vu?

First, **propaganda** campaigns were prominent. Films such as *The Inheritance* degraded and stigmatised handicapped patients; disputing their humanity, inflaming resentment against 'luxury' asylum conditions and advocating the 'natural' elimination of the weak. [12] Others promoted euthanasia as a merciful relase. *I accuse* depicted a woman with multiple sclerosis being killed on request by her husband while a colleague played soft piano music in the next room.

The use of **euphemisms** distorted the facts and added a veneer of respectability to the proceedings. The *Reich Committee for the scientific approach to severe illness due to heredity and constitution* arranged for the killing of handicapped children. *The charitable transport company for the sick* transported adult patients to the killing centres while *The Charitable Foundation for Institutional Care* collected the cost of killings from bereaved relatives. The *SS Xray Battalion* identified TB patients in the general population and then shot them.

An obsession with **cost-benefit analyses** was a third feature. School children were given mathematics problems balancing the cost of housing units for young couples against the costs of looking after 'the crippled, the criminal and the insane'. The killing of 70,000 patients in the T4 programme was calculated to save 245,955.50 Reichsmarks per day. [13] The Germans were diligent gatherers of statistical information. Both the child and adult euthanasia programmes relied on extensive form filling; which became the basis of decisions to kill.

The Nazis' **experiments on human subjects** are well-documented: Hallervorden's collection of brains for his neuropathological collection; radiation and castration for sterilisation; intravenous phenol, gasoline and cyanide; hypothermia and haemorrhage studies. These prompted the drafting of the Nuremberg code in 1947, [14] making informed consent an absolute requirement for research. The ideology which drove the holocaust was utilitarian and Hegelian. The status of certain human beings was denigrated while that of animals was elevated. Ironically, laws restricting research on animals in Nazi Germany were particularly stringent. [15]

The final lesson to learn is the danger of too close a **relationship between medicine and the State**. In June 1933, *Deutsches Arzteblatt* affirmed the medical profession's 'special responsibility to work within the framework of the state on the tasks posed by population politics and racial improvement'. [16]

Conclusion

The Nazi holocaust arose from small beginnings. Such a progression initially required only four factors; favourable public opinion, a handful of willing physicians, economic pressure and no prosecution for those involved. The remaining ingredients were a eugenic social policy and war.

The many similarities between Germany in the 1930s and the direction Western Medicine is moving today should give cause for alarm. The growing acceptance and practice of euthanasia in Australia, the United States and Europe ring familiar bells. All run counter to post-war ethical declarations adopted by the World Medical Association. This coupled with growing health propaganda, specious euphemisms, obsession with cost-benefit analyses, computerised knowledge and a developing intimacy between profession and state leaves Christian doctors no room for complacency.

Peter Saunders is General Secretary of Christian Medical Fellowship

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C Ben Mitchell charts the history of eugenics to the modern day

The return of Eugenics?

Two children with achondroplasia, a genetic condition that causes a form of dwarfism, in which growth of the long bones is restricted during development.

Photo: Wellcome

KEY POINTS

The eugenics movement had its origins in the early 19th century under the leadership of Galton in England and Davenport in the US, both of whom encouraged breeding of 'desirables' and reproductive controls for 'undesirables'. In the US this led to 'fitter families' contests and mandatory eugenic sterilisations. Hitler simply took these ideas further. Now we are seeing the rise of a new eugenics movement armed with genetic technology and using the tools of prenatal selection and abortion, harvesting of egg and sperm from desirable donors and genetic enhancement. It is likely that personal choice, consumerism and legal constraints on reproduction, rather than sterilisation, will fuel eugenics in the future.

Author of the Father Brown mysteries and political essayist, GK Chesterton perceptively said, 'We can be almost certain of being wrong about the future, if we are wrong about the past'. The American eugenics movement is an historical epoch that we can ill afford to be wrong about. Our future may depend upon our right interpretation of its past.

The old eugenics

Eugenics is a compound of two Greek words meaning *good* and *genes*. The eugenics movement began at the turn of the last century in England and the United States. Under the leadership of social engineers Galton and Davenport, it became a remarkably powerful social force.

Francis Galton (1822-1911), a cousin of Charles Darwin, was described as 'a clever and compulsive counter'.[1] Obsessed with numerical patterns, he studied mathematics at Cambridge. As the father of eugenics, Galton felt that social control was necessary to reduce the numbers of 'unfit'. He argued that both Christianity, with its emphasis on the dignity of all human beings, and medical science, with its abilities to keep alive those who might otherwise have died of their physical, mental or moral defects, were holding back the progress of the human race. 'If a twentieth part of the cost and pains were spent in measures for the improvement of the human race that is spent on the improvement of the breed of horses and cattle, what a galaxy of genius might we not create'. So Galton founded eugenics societies to encourage 'desirables' to reproduce and work to prevent 'free propagation of the stock of those who are seriously afflicted by lunacy, feeble-mindedness, habitual criminality, and pauperism'.

PERSONAL CHOICE AND CONSUMERISM ARE MUCH MORE LIKELY TO FUEL EUGENICS TODAY

Over in the United States, biologist Charles Davenport (1866-1944) published *Heredity in Relation to Eugenics*.[2] Under his directorship, The Eugenics Records Office at Cold Spring Harbor served as headquarters for the American eugenics movement. Even president Theodore Roosevelt was enthusiastic: 'I wish very much that the wrong people could be prevented entirely from breeding; and when the evil nature of these people is sufficiently flagrant, this should be done. Criminals should be sterilised and feeble-minded persons forbidden to leave offspring behind them . . . the emphasis should be laid on getting desirable people to breed'.[3]

Fitter Families contests were held across the United States in the 1920s and 1930s. Such families were those with fewest incidences of physical and mental disability, whose ethnic heritage had remained intact. Racial intermarriage disqualified families from entering and fitter families were exclusively Caucasian. Mary T Watts, co-founder of the first contest at the 1920 Kansas Free Fair, said: 'While the stock judges are testing the Holsteins, Jerseys, and whitefaces in the stock pavilion, we are judging the Joneses, Smiths, and Johns'.[4] Each winner's medal proclaimed 'Yea, I Have a Goodly Heritage'.

The eugenics movement did not limit itself to merely breeding better humans. To prevent 'undesirables' from reproducing, mandatory sterilisation laws were enacted. The 'feebleminded', 'indolent', and 'licentious' were sterilised either without their consent or against their wills. 'Eugenical sterilisations' increased from 3,000 in 1907 to over 22,000 in 1935. By the 1930s most states had mandatory sterilisation laws.[5] In one well-known case, a young mentally retarded girl named Carrie Buck was given the choice of being sterilised or being returned to her mental asylum. Because both her mother and grandmother had allegedly been mentally retarded, the famous jurist Oliver Wendall Holmes declared of Carrie Buck, 'Three generations of imbeciles is enough' and mandated that she be sterilised.[6]

Of course, the most infamous use of eugenics was in Nazi Germany. Hitler's racism and American eugenics seemed made for one another. Madison Grant, founder of the racialist movement in America, stated: 'Mistaken regard for what are believed to be divine laws and a sentimental belief in the sanctity of human life tend to prevent both the elimination of defective infants and the sterilisation of such adults as are themselves of no value to the community. The laws of nature require the obliteration of the unfit and human life is valuable only when it is of use to the community or race'.[7] Hitler drank deeply from the well of American eugenics, calling Grant's volume 'his Bible'.[8]

The new eugenics

Today, armed with genetic technology, a new eugenic enthusiasm has emerged. The March of Dimes, an advocacy group dedicated to preventing birth defects, found in a 1993 poll that eleven percent of parents would abort a foetus whose genome was predisposed to obesity; four out of five would abort a foetus if it had a disability; and forty-three percent would use genetic engineering, if available, to enhance their child's appearance.[9]

Increasingly, college-age women are being solicited for their eggs on the basis of their desirable genetic traits. In 2000, the University of Minnesota's student newspaper advertised for egg donors. Preferred donors were women five foot six inches or taller, Caucasian, with high ACT or SAT scores, no genetic illnesses; extra compensation was offered to those with mathematical, musical or athletic abilities. Acceptable donors would be offered as much as $80,000 for their eggs. This is eugenics with a vengeance.

Contemporary culture's emphasis on the genetically 'fit' and difficulty in embracing those who are 'less fit' fuels this new eugenics mindset. The quest for genetic enhancement is the most virulent form of the new eugenics. James Hughes, one of the architects of so-called transhumanism, has argued: 'The right to a custom made child is merely the natural extension of our current discourse of reproductive rights. I see no virtue in the role of chance in conception, and great virtue in expanding choice. If women are to be allowed the "reproductive right" or "choice" to choose the father of their child, with his attendant characteristics, then they should be allowed the right to choose the characteristics from a catalog. It will be considered obsessive and dumb to give your kids only parental genes'.[10]

James Watson, who with Francis Crick discovered the double-helical nature of the DNA molecule, told *The Guardian* in 2003, 'If you really are stupid, I would call that a disease… So I'd like to get rid of that…It seems unfair that some people don't get the same opportunity. Once you have a way in which you can improve our children, no one can stop it. It would be stupid not to use it because someone else will. Those parents who enhance their children, then their children are going to be the ones who dominate the world'.[11]

A truly human future

It may be unlikely in our age of reproductive freedom that the new eugenics will be enforced through mandatory sterilisation. However, there are other, more subtle forms of coercion. Personal choice and consumerism are much more likely to fuel eugenics today. One day, when genetic tests are more widely available, it might even become illegal to bring a child into the world with a genetic disability.

Discrimination against persons because of their race, gender or disabilities is an ugly reality. Discrimination based on genetic identity is even uglier. If we would preserve a truly human future for ourselves and for our children, then we must value individuals for who they are, not for what they can do. The laudable goal of treating human disease and relieving human suffering must not be allowed to become a tool for exercising quality control over our offspring. To do so would be to use the good gift of genetic knowledge for evil ends. Only vigilance on the part of all of us can prevent a bleak genetic future.

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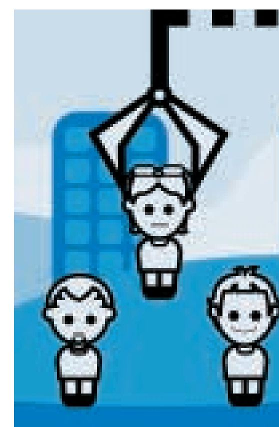

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George Smith explores this hugely popular manipulative therapy

Photo: Wellcome

Osteopathy

KEY POINTS

Osteopathy is a popular and 'respectable' alternative therapy originally developed by Still and based on the idea that physical manipulation directed at 'osteopathic lesions' in the spine initiates holistic self-healing processes. Treatment by contemporary osteopaths includes orthodox advice regarding posture and exercise but concentrates on manipulative techniques for musculoskeletal problems. However, the existence of 'osteopathic lesions' has not been demonstrated clinically nor radiologically and evidence of osteopathy's clinical efficacy is at best sparse and not compelling. From a Christian perspective, Still's involvement in psychic practices, particularly in his diagnostic methods, reinforce the conclusion that osteopathy is not a therapy to be recommended.

Surveys indicate that osteopathy is the most popular alternative therapy in UK with over 3,000 osteopaths providing six million patient consultations a year. Usually perceived as a method of treating musculo-skeletal problems (especially low back pain) by physical methods such as manipulation and massage, it was originally intended to be a complete system of health care.

Definitions

Various definitions of osteopathy give important insight into the aims and aspirations of AT Still, its originator, as well as its present practitioners and teachers:

- *A system, method or science of healing.* (Still, 1893)
- *Osteopathy is a 'whole body' system of health care.* (Sandler, 1989)
- *Osteopathy is a system of medical therapy that employs manipulation of the body, and the spine in particular, to remedy disease – even when the signs and symptoms seemingly have nothing to do with the spine.* [1] (Stanway, 1992)
- *Curative treatment aimed at correcting supposed deformities of the spine as the cause of many diseases.* (Oxford Dictionary, 1996)
- *A form of manual therapy involving massage, mobilisation and spinal manipulation.* (Ernst, 2001)

Origins

Osteopathy was founded by Andrew Taylor Still (1828-1917) of Virginia, USA. He studied at the College of Physicians and Surgeons in Kansas City, USA. Disturbed by the poor medical care of his day and the tragic death of his three children of meningitis, he determined to devise a new system of effective and safe medical care. Believing that bodily functions depended on the structure of the skeleton, particularly the spine, he assumed that malalignment of bones led to deficiency in blood flow, and was the major cause of disease.

Still's diagnostic methods included particular skills of palpation, described by his contemporaries as 'intuitive', 'seeing under the skin' and even as 'psychic or clairvoyant'. They believed he possessed psychic powers, enabling him to foretell future events. Essential to his diagnosis was the recognition of an 'osteopathic lesion', thought to be the common source of disease. He believed that manipulative techniques, directed at these lesions, were the essential factor in treatment, initiating holistic self-healing processes.

After rejection of his theories by orthodox physicians, Still founded the American School of Osteopathy in Kirksville, Missouri in 1893. The British Association of Osteopaths was formed in 1911 and The British School of Osteopathy was founded in 1917 by Dr J F Littlejohn, a former student of Still. Originally osteopathy was not recognised in law or by the medical establishment. Doctors associating with osteopaths ran the risk of removal from the Medical Register.

Osteopathy is now regulated by the Osteopathy Act of 1993. The General Osteopathic Council (GOsC) was formed to regulate training and compile a register of osteopaths. Schools of osteopathy in the UK provide courses leading to a diploma (DO) or a BSc after four years full time or six years part time training. Doctors may fast track osteopathy training in 12 to 18 months.

Present practice

Diagnosis

Many osteopaths today would wish to distance themselves entirely from the suggestion that psychic

powers are involved in osteopathic diagnostic methods. Nevertheless, they do place great significance on the specialised osteopathic skills of diagnostic palpation beyond those normally recognised by orthodox doctors, termed 'palpation awareness' by Sandler. Xrays and laboratory tests would be advised when necessary.

Treatment

Treatment by contemporary osteopaths includes orthodox advice regarding posture and exercise but concentrates on manipulative techniques, including various leverage and thrust procedures, muscle energy techniques, stretching exercises and myofascial release. Some high velocity thrust techniques are accompanied by a crack or pop, said to be produced by millions of tiny carbon dioxide gas bubbles bursting inside certain joints. No evidence is offered for this.[2]

Conditions treated by Still and his successors included eye infections, a gangrenous leg, hip tuberculosis, heart failure, deafness, poliomyelitis, gallstones and stroke. Osteopaths now accept that there are other causes of disease unrelated to the spinal column and its associated vascular and nervous systems. Some, however, maintain that it has validity in treating indigestion, asthma and emphysema, hypertension, angina, migraine and sinusitis. Treatments last from a few sessions to months or even years.

Medical checklist

Does it have a rational, scientific basis?

Identification and resolution of the 'osteopathic lesion' was central to Still's methods but there was no consensus as to its exact nature. It was variously described as restriction in joint mobility, facet locking or spinal joint adhesions. Its existence has not been demonstrated clinically nor visualised radiologically. Identification of specific lesions has become less important and even abandoned by osteopaths today.

Some osteopaths believe that their techniques may influence the autonomic nervous system, situated in ganglia alongside the spine, which control our basic functions. This is the basis for the use of osteopathy for general medical illnesses, apparently unconnected with the spine. Cyriax, former orthopaedic physician at St Thomas's Hospital, was concerned about the osteopathic doctrine of spinal manipulation for general disease, and pointed to the vast mass of authenticated evidence for the orthodox approach to these illnesses, and lack of scientific evidence for osteopathic treatment.[3]

Does it work?

Some studies have suggested that osteopathy may help in acute and sub-acute low back pain.[4] But a comprehensive data review did not demonstrate the effectiveness of manipulation (including osteopathy) for low back pain.[5] A recent larger randomised controlled trial comparing US style osteopathy with standard treatments for low back pain found similar clinical outcomes.[6] After investigating the use of osteopathy in treating non musculo-skeletal conditions, Professor Ernst concluded, '…evidence is sparse and not compelling'.[7] Although the recent UK BEAM report suggests that spinal manipulation may benefit low back pain, treatments by physiotherapists, osteopaths and chiropractors are included as one group, so the trial cannot specifically endorse individual therapies.[8]

Is it safe?

Stiffness, soreness, headache and tiredness may follow osteopathic treatment and occasional cases of stroke, vertebral artery damage and spinal trauma have been recorded. Osteopathy should be avoided in cases of osteoporosis, possible neoplasm, whiplash, bleeding disorders and anticoagulant therapy.

Christian checklist

Can it be recommended with integrity?

Osteopaths may well be caring, trained and dedicated, but the principles and effectiveness of osteopathy have not been validated.

What are its roots?

AT Still considered that osteopathy was truly holistic, referring frequently to inspiration from the Great Wisdom, the Divine Intelligence and the Grand Architect of the Universe; these terms are not characteristic of a Christian's description of a personal Father God. It appears likely that he was involved in spiritualism and the expression Grand Architect is a term more familiar to Freemasons.

Cranial osteopathy or cranio-sacral therapy

This most controversial aspect of contemporary osteopathic practice, devised by William Sutherland (a student of AT Still), emerged in the USA in the 1940s but is only practised by ten to fifteen percent of UK osteopaths. It is not supported by convincing clinical or scientific evidence and '…it cannot be recommended for any condition'.[9]

Conclusion

The popularity and relatively recent statutory regulation of osteopathy have made it appear 'respectable' rather than 'alternative'. As manipulation by orthodox physiotherapists is not widely available, there has been an uncritical and unjustifiable acceptance of osteopathy as an alternative – a therapy without validation of its principles, and unconvincing evidence for its effectiveness.

From a Christian perspective, Still's involvement in psychic practices, particularly in his diagnostic methods, reinforce my conclusion that osteopathy is not a therapy to be recommended.

A good tree bringeth not forth corrupt fruit, neither doth a corrupt tree bring forth good fruit. (Luke 7:43 KJV)

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Steve Fouch identifies practical responses to global poverty

Poverty + health

WE ARE EXHORTED TO SPEAK UP FOR THE POOR, AND ENCOURAGE THOSE IN POWER TO ACT JUSTLY ON THEIR BEHALF

It would be hard to miss the headlines of the first few weeks of 2005. Tony Blair, Gordon Brown and the Vicar of Dibley, all promising that this year was the year to 'Make Poverty History'.[1] Why 2005 in particular? One reason is the pivotal role the UK will be playing in world affairs as it both chairs the G8 (the club of the world's seven biggest economies, plus Russia), and holds (from June) the Presidency of the European Union. It is also the year that Blair's Commission for Africa reports back with strategic recommendations to help that troubled continent.

Tony Blair and Gordon Brown have both made very public their belief that decisive action needs to be taken to tackle global poverty and global warming. Although the UK government's track record on the latter has been widely criticised,[2] there is no doubt that they are trumping up the money on the aid and development side of things – significantly expanding the budget of the Department for International Development (DfID), and committing to debt relief. But the UK's position of influence this year gives the government a chance to put pressure on the other powerful nations to increase their commitment to fighting poverty as well.[3]

The other reason is that 2005 is a third of the way towards the deadline for the achievement of the United Nations eight millennium development goals (MDGs). Endorsed by 189 nations in September 2000, the headline MDG is to halve the number of people living in absolute poverty (currently defined as living on an income of less that US $1 per day) by 2015. The other seven goals[4] include four specific targets related to health:

- Reduce by two thirds the mortality rate among children under five
- Reduce by three quarters the maternal mortality ratio
- Halt and begin to reverse the spread of HIV/AIDS
- Halt and begin to reverse the incidence of malaria and other major infectious diseases

To put this into context, 1.2 billion people barely survive in absolute poverty (half of Africa alone lives in absolute poverty), 800 million are undernourished, AIDS claimed 3 million lives last year, while malaria claims 150,000 lives each month in Africa alone. 1,200 children under five die every hour from treatable or immunisable diseases. One woman a minute dies in childbirth, 95% in developing nations (an African woman has a 1 in 6 chance of dying in childbirth).

So what progress had been made on the MDGs by the start of 2005? According to a recent World Bank Report,[5] most nations are making progress, but not in Sub-Saharan Africa, which is actually slipping backwards in all these areas.

Why is Africa in such a state? The reasons are numerous – internecine conflicts abound (the civil war in the Democratic Republic of Congo alone has caused four million deaths, more than in any other conflict since World War II). AIDS is pandemic – reaching incidences of nearly 40% of the adult population in some Southern African nations – devastating the economically productive population. Corrupt governments filter what wealth is generated

Photo: Empics

from natural resources into their own pockets. Biased trade rules and subsidies on agricultural exports from the US, Japan and the EU mean that Africans cannot trade on anything like a level playing field with the developed world. The chances of building any kind of decent education or health system are severely crippled by AIDS, conflict and the poaching of professionals by the West which leaves too few teachers, doctors, nurses and other skilled people to run essential services.

There is also a great deal of cynicism. Aid and debt relief are not seen to have worked. Despite billions being poured in to the continent over the last few decades, things are worse overall rather than better. It is feared that most aid just finds its way into the pockets of corrupt officials (although large amounts of it also go back to donor governments in trade agreements, consultancies, and other services). Indeed, many Africans and Asians are cynical about aid because they see it being tied to conditions that ultimately benefit the donor's interests rather than meeting the real needs of the poor. Similar concerns abound over the misuse of money released by debt relief.[6]

Yet, as a Malawian doctor recently told a colleague of mine, if Africa is to be saved from poverty, it will require Africans finding African solutions. The West can give aid, alleviate the debt burden and not load the trade tables so unevenly, but it will be Africans who turn things around for their continent.

In this, a great biblical truth is echoed. Scripture urges us to respond to the needs of the poor. Jesus' much misquoted saying 'the poor you will always have with you'[7] is actually taken from Deuteronomy 15:11, the second half of which says, 'Therefore I command you to be open-handed towards your brother and towards the poor and needy in your land'. The New Testament also exhorts us to care for the needs of our brothers in poverty and need.[8] It could be argued that this does not relate to those in other nations, but rather near neighbours, but then again we are exhorted to care for the whole Body of Christ,[9] and it's clear that a huge proportion of those suffering in Africa are Christians. Furthermore, Jesus made a strong point that our neighbour was anyone in need, of any nation, tribe, creed or tongue.[10]

Yet at the same time, giving money, sending Christian health professionals and other forms of aid are not enough. Such aid helps in the short-term, but in the long-term it fosters dependency and feeds corruption. The Levitical Law encouraged generosity to the poor, but the aid given was to help that person be able to make his own living again. The laws required that debts be cancelled and land restored to its original owners on regular cycles,[11] ensuring that the means of living were not concentrated in one set of hands for too long, and that people could feed and clothe themselves rather than depend indefinitely on the goodwill of their neighbours.

There is above all a call for us to pursue justice as believers.[12] Poverty may be always with us, and some degree of inequality is inevitable, and not necessarily unjust, but the degree of extreme poverty and inequality that we see today is not acceptable, especially as so many of the causes are due to injustice. That is why we are exhorted to speak up for the poor, and encourage those in power to act justly on their behalf.

What does this mean for us here and now in 2005? The Make Poverty History campaign is lobbying for the government to follow through its pledge on tackling poverty.[13] There is now a global campaign spearheaded by the World Evangelical Alliance and the Micah Network for Integral Mission that is gearing up to raise the voice of Christians worldwide to tackle poverty. Known as the Micah Challenge,[14] this campaign is set to be a significant voice globally in advocating for the poor over the coming decade, to see increase in aid, cancellation of debts and fairer trade rules, and above all to support our brothers and sisters in Christ as they seek to influence their own nations for the better. Both are campaigns with which we as Christians can and should be engaged.

Ultimately, if we are to act justly, love mercy and walk humbly with our God[15] we need to consider how we live and prioritise our time, gifts, money and other resources in the service of God and his people around the world. This does not start or stop in 2005. This year merely highlights that something can be done to fight poverty and injustice, and that we are called by God to play our part.

Steve Fouch is CMF Allied Professions Secretary

KEY POINTS

The UK's chairmanship of the G8 and presidency of the European Union have made health improvement through alleviating poverty a major political priority this year. But whilst much of the world is making progress towards fulfilling the UN's millennium development goals (MDGs), Africa lags behind as a result of war, the AIDS pandemic, corrupt governments, unjust trade practices and the migration of skilled professsionals.

A Christian response must include generous giving of money, aid and health professionals but alone this will merely foster dependency unless coupled with restoring justice through debt cancellation, fair trade practices and support for good national leadership. The Micah Challenge is a good international best practice Christian model.

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David Short points to Jesus' personal walk with the Father

IMITATING CHRIST
in our private life

Having a pattern to follow is not our only need as healthcare workers. Attempts to follow Christ's example inevitably fail unless they are energised by his supernatural power. The Gospels record how constantly and critically Jesus was watched,[1,2] and the same is true of those who profess to follow him. A public life lived to the glory of God must be founded upon a personal and private life lived in communion with God and empowered by the Holy Spirit. When a person's public life crashes, there is invariably found to have been a preceding period of hidden erosion of the foundation. Jesus is an example to us both in the purity of his life – sinless in thought, word and deed - and in the closeness of his walk with the Father.

Jesus' communion with his Father is reflected in his **prayer life**. Luke records that 'Jesus often withdrew to lonely places and prayed'.[3] His Gospel contains no less than 17 references to Jesus' prayer life. He spent time in prayer early in the morning,[4] and at significant life events such as his baptism, which inaugurated his public ministry.[5] He spent a whole night in prayer before choosing his disciples,[6] reminding us of the importance of prayer before making staff appointments. One doctor likened Jesus' prayer life to a discussion with an experienced colleague.[7]

There is no doubt that Jesus also spent time in **meditation on the Word of God**. His mind was saturated with the Scriptures. He used them in his arguments with the religious leaders, to instruct his disciples, in his lonely conflict with Satan in the wilderness, and in his time of suffering on the cross. Additionally, Jesus made a habit of **church attendance**,[8] dull and uninspiring though the synagogue services may sometimes have been.

Application

Healthcare workers, with their busy lives of service cannot be excused the need to spend time with God - the busier we are, the more we need to *set aside* time for God. As Professor Henry Drummond noted, 'Ten minutes spent in Christ's society every day - aye two minutes if it be face to face and heart to heart - will make the whole of life different.' Starting the day with God is good preparation for keeping in touch with him throughout the busy hours of the day; taking problems and duties to him as they arise. It is not enough to store isolated texts in our memory. We need, like Jesus, a deep and balanced understanding of God's Word,[9] and our knowledge of the Bible must be accompanied by obedience to its teaching. It is meaningless to talk of 'loving Jesus' if we do not seek to obey his words.[10]

Jesus' private life is a powerful example to us. Do we put God first in the day, and practise the presence of God throughout the week? It is a wonderful relief to be able to put aside all non-essential work, and just spend time with God. I try to read a few verses from one of the gospels every day. We may not have time for more than a short daily Bible reading during the working week, but Sunday can be an oasis in the desert.

Conclusion

We need to keep the example of the Lord Jesus always before us. One used to see bracelets with the initials WWJD: What would Jesus do? It is a good motto. However, we cannot become Christ-like simply by our own efforts in the way that budding musicians polish their performance by continual practice. We need the grace of God and the power of the indwelling Holy Spirit. We must also accept the moulding effect of the trials of life. The apostle James says: 'The testing of your faith produces endurance.'[11] He adds: 'Let endurance have its full effect so that you may be mature and complete, lacking nothing.'[12]

In the light of the example of Christ, I challenge myself and my readers to answer the following questions:

- Am I developing the mental and spiritual patterns necessary for discerning the will of God and doing it in life's daily choices?
- Do my personal relationships, my marriage and family values, my study and thinking material, and my recreational habits and choices reflect the goal of pleasing God?
- How would my definition of success differ from that of my colleagues?[13]

We must be able to justify all we do on the ground of serving God and pleasing him. In this, there is a profound element of noble obligation: 'Love so amazing, so divine, Demands my soul, my life, my all!'

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Carl Whitehouse reflects on the National Programme for IT in the NHS

Records, Confidentiality and Computers

Over the next few years there will be a revolution in the way personal information about patients is managed in the NHS. We are told that: '…every patient's medical and care records will be held electronically and will eventually be available securely online. The information will be safely and easily accessible to healthcare professionals and patients, whenever and wherever it is needed.'[1] There is intended to be a central spine, a national electronic record for each individual, containing summary information such as allergies and major ongoing conditions. This will be available anywhere in the country, whilst more detailed information will continue to be held locally. The specifications are complex and aimed to deal with many concerns about security and confidentiality: information will only be available on a need to know basis, there will be 'patient sealed envelopes' containing sensitive information only accessible with permission from patients, all access will be monitored and there will even be an 'alarm' system alerting the Caldicott Guardian of any unauthorised attempts to access sealed envelopes.

There is every reason to believe the level of confidentiality will be greater than with existing systems, whether paper or computer. However, concern has been expressed about the extent of information that will be centralised and the use to which it might be put. Coupled to this is an anxiety that patients may be less likely to trust the care-giver and provide necessary information if they are unsure who might access that information, even in the distant future.

Christian caregivers need to respond to this changing situation with a mixture of support and vigilance.

The health care situation of biblical times was vastly different from that of the 21st century, but we cannot claim scriptural justification for a total ban on centrally held information or for absolute confidentiality between caregiver and patient. Censuses, with centralisation of personal information, were acceptable[2] although not if the information was being gathered for the wrong reasons.[3] Leviticus delineates a responsibility to report many diseases to central authorities,[4] a rule which Jesus himself accepted.[5] Loving concern for neighbours will make us anxious to avoid damage through inappropriate sharing of information, but modern health care means there are many more situations where communication is right. We have to remember the greater mobility of people, increasingly individuals do not remain with one practice and/or hospital for all their medical care. Health and care problems are increasingly complex, requiring an ever-larger team to manage them - secondary care episodes are no longer contained within a single unit and the primary health care team often extends well beyond a single surgery premises. All this requires sharing of information. This is brought out in the specification, which states that consumers of care services should 'feel confident that information about them and their history of care is accurate and *easily accessible* to any other professional involved with their care and with a need to know, except where the patient has expressed a view to the contrary'[6] (emphasis added) before any mention of security.

There is a strong assumption that patients will feel more confident if all caregivers have access to appropriate information without the need to tell the same story. Where patients may need help and vigilance is in ensuring that the information available is appropriate and not likely to cause more harm than good. We may have to think much more clearly what information may be considered redundant and therefore need pruning or putting into sealed envelopes.

Over recent years there has been strong pressure to strengthen individual patient rights. The pendulum is now swinging towards a more communal ethic. This comes out in the early pronouncements of the Ethics Advisory Group of the Care Record Development Board (responsible for developing the new system). Their statement of ethical principles emphasises our responsibilities as citizens as much as individuals' personal interests. They talk of finding an appropriate balance and emphasise that 'in accordance with the Human Rights Act 1998, public interests should only prevail over individual interests when it is necessary that they should do so in order to achieve a legitimate aim in a proportionate manner', but they are in no doubt of the importance of public interest.

Perhaps there is a need, whilst ensuring that we can give the right care to individuals, to also encourage and teach our patients to be more open and freer in sharing information, working to reduce the stigma of sickness. A reading of Paul's letters will soon remind us that he did not consider confidentiality about his state of health 'something to be grasped', but rather was prepared to share with others in order to bring them comfort.[7]

We need watchfulness as this progresses. The Care Record Development Board, its action groups and ethical advisory group are only just beginning work. They welcome input, and perhaps now is the time to consult their website[8] and contribute our thoughts on these complex issues.

Carl Whitehouse is Professor of Teaching medicine in the Community in Manchester

CHRISTIAN CAREGIVERS NEED TO RESPOND WITH A MIXTURE OF SUPPORT AND VIGILANCE

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Is political correctness getting in the way of good child care? asks **Janet Goodall**

The Comforting Touch

'*People were bringing little children to Jesus to have him touch them, but the disciples rebuked them*' (Mark 10:13). Most people know that tiny babies thrive better for personal contact. Ill and dying people are often comforted by a hug or handclasp. Intensive medical care is no longer like Thai dancing - high in skill but low in touch. Aural and tactile stimulation is routine even for unconscious patients. Yet in educational and other professional settings, the idea of touching a child has become so loaded with anxiety. Why?

Today, would Jesus be allowed to express his tender feelings for children without some busybody reporting him? Would his ministry need to be vetted before he could meet and greet any of them? Mark's Gospel tells us that people brought their little children to Jesus especially 'to have him touch them'. He did not disappoint them. No doubt some had special needs which no-one else cared about. Jesus frequently touched and healed untouchables, an example for Christians ever since.

Publicity surrounding isolated cases of child abuse by professionals has contributed to serious over-reaction.[1] A researcher from Manchester (UK) has found care workers reluctant to put a plaster on a child's hurt knee. One mother objected to playgroup staff wiping the soiled bottom of her three year old. Fear and suspicion are spoiling trustful relationships between adults. It is leaving the children for whom they all genuinely care deprived of sympathetic contact. Some could feel rejected and unloved - which is itself a form of child abuse.

Public confidence would improve if it were more widely known that the trustworthiness of those who work with children must now be officially documented. Childcare workers have to undergo checks before they can be employed. There is ever increasing vigilance designed to debar any with a questionable past record. Moreover, most young children themselves have instincts that help them know when adult actions are comforting or uncomfortable. Most will make their concerns known. If parental opposition persists there might be a deeper reason for it than is always apparent (see box).

Necessary discomfort, as for the gentle bathing of a scraped knee, is unlikely to be greeted favourably by the owner of the knee. A simple explanation, of the dangers of rust, for example, and afterwards commending the child for being brave in the face of the pain involved, should communicate kindly intent. In turn it will affect the pain threshold. A family member may or may not be more demonstrative, but for a nursery nurse or teacher to hold a hurt child's hand or offer a comforting hug is unlikely to be misinterpreted either by the child or an impartial observer. Any misunderstanding should be calmly and patiently cleared up in person. A health worker might need to point out that a child who has just endured a venepuncture, for example, will indeed be left feeling abused unless the professional's body language is allowed to express sympathy as well as the sometimes cold comfort of mere words.

Sadly, Mark reports how the disciples themselves tried to thwart the Lord's compassionate, healing touch for children. Jesus indignantly told them that the eagerness to trust him, which was being shown by carers and children alike, was the kind of faith needed to gain a passport into his kingdom. The disciples' antipathy was acting on the families much as the threat of deportation affects genuine asylum seekers. No wonder he was upset. (Mark 10: 13-15)

As his followers, we must not allow political correctness or officious officialdom to deflect from properly appropriate child care. Complaints should be met with grace, backed by sweet reason. Carers have been given legal authority as well as having moral responsibility to conduct their care properly, but implicit in this is to speak up fearlessly for the voiceless. Children are not just bodies to be given professional treatment at arm's length. Proper care of the whole person reaches beyond the technical and, as with our Lord, involves a healing touch and comforting word - even when others hold back. Obvious compassion and frank, though sympathetic, discussion can change fear and suspicion to trust. Commonsense must not be allowed to remain the least common of the senses.

Parental Opposition and its Roots

The widowed mother of a chronically sick primary school child became hostile towards all treatments being offered, whether invasive or oral, and abusive to the staff trying to give them. The child picked up the atmosphere and was outspokenly uncooperative, especially about intravenous therapy. The request for transfer to another doctor was not immediately acted upon as it was clear that the problem would be transferred, too. Instead, doctor and mother sat down together for such a homely chat that the woman suddenly said, 'Do you know, doctor, I have just realised that you're a human being like myself.' She then told how, as a small girl, she had sustained a bad cut at play and was then held down forcibly by nurses whilst, ignoring her screams, the doctor stitched up the wound, apparently without local anesthetic and certainly without any memorable warning or comfort. Not unreasonably, she had been antipathetic towards both professions ever since, antipathy made worse by the death of her husband and the child's need for constant medical surveillance. With barricades lowered, she accepted a fresh explanation of the illness and the inescapable need for the proffered treatment. Being a forthright woman, she conveyed this to her daughter who was quick to observe the changed attitude. This, together with the customary anesthetic cream for venepunctures and the unflagging support of her medical team, helped her (for *most* of the time...) to become a calmer and much more cooperative little girl.

Janet Goodall is Emeritus Consultant Paediatrician in Stoke-on-Trent

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Role models can have an enormous influence on students and young doctors, as **Jane and Jes Bates** recall

Standing on the shoulders of giants

Over the years we discover how much our paths and perspectives are shaped by people who have gone before. As a medical student involved with ICMDA I met some remarkable medical role models: great people of God like Paul Brand, Keith Sanders and Dennis Burkitt to name a few. All dedicated some of their best years to work overseas.

Paul Brand was a gentle, humble man of great wisdom and intelligence who pioneered reconstructive surgery in leprosy. He loved and respected his wife Margaret and they worked closely together as a team. He was prepared to live simply. At one planning meeting for the ICMDA World Congress he made it clear that he wasn't comfortable with the divide created between delegates. Until then people from poorer countries attending the congress stayed in a hostel whilst richer doctors booked into 5 star hotels. Paul suggested all should rather stay together in the hostel to learn from one another for the sake of Christ's fellowship.

He once told a story that is like a modern parable. After some years he and his wife moved from India to the US. While walking in their neighbourhood they often saw rubbish lying around. At first they grumbled, feeling thoroughly smug about how they wouldn't do such a thing. Then one day they felt Jesus telling them to collect up the rubbish themselves. They resisted for a while but then they began to see afresh how Jesus had already cleared up the 'rubbish' from their lives and they were humbled. I was touched by the way prominent Christian people make their lives subject to him even in this small, practical way.

My husband Jes and I realised with increasing conviction from these early days that God was calling us to work overseas. It was an important shared vision for our life together. We made various short term trips and joined prayerful mission minded churches. However it takes time to prepare. After qualifying, Jes spent four years in basic surgical training. I did a variety of SHO jobs including spells in anaesthetics, and obstetrics and gynaecology, plus my GP registrar year and MRCGP.

In 1998 we went to the ICMDA World Congress in Durban and six months later returned South Africa, working at Ngwelezane hospital in KwaZulu Natal as a trial period for work overseas. Jes was an orthopaedic trainee and at night was on call for anything surgical with a lot of gun shot wounds and other trauma. I spent time in anaesthetics, community health and paediatrics, with the dawning realisation that we were working in one of the world epicentres for HIV/AIDS. This work became my passion.

Spiritual dryness is an issue for doctors. For 2-3 years Jes wasn't really praying or reading the Bible. We went to church but it seemed like just going through the motions. What kept him going was that he believed God had a plan and had called us to work overseas. There came a point, however, where we needed to take stock and time out from work to focus on 'getting back to God'. We wanted to build a firmer foundation in our faith alongside our professional knowledge. So after two years in South Africa we applied to All Nations Christian College to do the Certificate in Biblical and Cross Cultural Studies.

WITH MY WORK IN HIV/AIDS I FEEL LIKE THE BOY WHO GAVE HIS LOAVES AND FISHES TO JESUS WHO THEN DID AMAZING THINGS WITH THEM

People are often key to the next step. We had imagined we would work with a mission organisation such as Interserve. However, after praying over one Christmas holiday, we contacted Jim Harrison, an orthopaedic surgeon and friend already working in Malawi. When we arrived Jes found he could complete postgraduate training within the region. The vision for HIV care that God began to show me in South Africa is now becoming a reality. Through our work in the government teaching hospital we seek to make God's love known.

What we have done has meant stepping out of the standard UK career path. Being away from family, especially taking grandchildren far away, is hard at times but compared to stories from previous centuries we have the advantages of rapid communication - phone, email, and even texting - but the miles still exist.

With my work in HIV/AIDS I sometimes feel like the boy who gave his loaves and fishes to Jesus who then did amazing things with the small offering. Early on we learnt that to work overseas did not require 'super-spiritual' people, but obedience and openness to God if that was his call. From those who have gone before we can see that God is faithful to provide for all our needs even at the end of a career overseas.

It may be that in the 21st century it is difficult to hear God's call amidst the many voices which clamour for our attention, but it is exciting to follow him, and definitely not to be missed

Jes and Jane Bates are medical missionaries in Malawi

OPPORTUNITIES ABROAD

The vacancies listed on this page are only a small part of available openings. Visit our website at www.healthserve.org for a more detailed list or contact some of the agencies themselves for details of other vacant posts.

Agencies usually require you to be a UK based national with your own financial and prayer support. The contact details given here are to enable you to research the post.

If you want to be kept abreast of needs as we hear of them, log on to www.healthserve.org and sign up for email alerts to be sent to you as new vacancies go on line.

Short Term Medical Teams (Two week trips)

BMS World Mission will be taking a multidisciplinary capacity building medical team to the Christian Hospital at Chandraghona in Bangladesh for 2 weeks in the Autumn 2005 and are also planning to take a community based team to Uganda in 2006.

CMF members have been involved in these teams. They are highly recommended

Contact: Ruth Robinson,
Tel: 01235 517654
Email: *rrobinson@bmsworldmission.org*
Web: *www.bmsworldmission.org*

SIM are planning a 2 week field trip to observe and experience healthcare in a cross cultural setting at Mseleni Hospital, Kwazulu Natal, South Africa in mid August. The team will be lead by a CMF member, Peter Jackson and his wife Ruth. Recently retired, they have had mission experience in West Africa.

Contact: Tel: 01449 766464
Email: *lizlegg@sim.co.uk*
Web: *www.sim.co.uk*

For other such short term opportunities: Visit the HealthServe Pages at *www.healthserve.org*

Locum Surgeon needed urgently in Bangladesh (4 -5 weeks)

One of our members overseas, Mark Pietroni writes: LAMB Hospital, Bangladesh, is looking for cover for its surgeon who will be on leave from late July to late August 2005

Contact: Dr Mark Pietroni,
Email: *markp@lambproject.org*

Tsunami Response (3 months)

The **Church Mission Society (CMS)** is looking for Doctors, particularly Psychiatrists willing to work for 3 months+ in **India, Indonesia**, **Sri Lanka** and **Thailand**. Team and Individual placements identified by partner churches in the region. Self funded welcome, but finance should not be a barrier, accommodation and flights provided.

Contact: Stuart Buchanan, CMS, Partnership House, 157 Waterloo Road, London, SE1 8UU, United Kingdom. Tel: 020 7803 3348
Email: *stuart.buchanan@cms-uk.org*

Pakistan (3 years)

A female **Obstetrician & Gynaecologist** and a **General Surgeon** (either sex) are urgently needed by the **Diocese of Hyderabad, Church of Pakistan** to work at Kunri Christian Hospital on a 3 years contract (negotiable). A female Surgeon must be willing and able to cover O&G and the Obstetrician & Gynaecologist be willing to undertake some general surgery. Accommodation provided otherwise self supporting

Contact: Dr Jacob Zahiruddin, Kunri Christian Hospital District, District of Mirpurkhas, Pakistan. Tel: +02382 78488
Email: *jacoobz@yahoo.com*

South Africa (1 year or more)

A Doctor is needed as part of the team at **Ingwavuma Orphan Care** for one year or longer. The work includes support and supervision for the lay home based carers: daily village visiting and provision of basic medical care. '*We believe in holistic care which includes prayer and planning for care of the children after the parent has died*'. With ARVs round the corner, the project will need to adapt also to provide treatment support for those who take these drugs. Knowledge of palliative care and HIV/AIDS an advantage. Basic salary provided. Zulu can be learnt on the Job!

Contact: Dr Ann Barnard.
Tel: +27 35 5910793 Email: *ioc2@lantic.net*

Uganda (2-3 years)

Doctor is required at **Rugarama Health Centre** on a 2-3 year contract from June 2005. He/she will head a team of 39 medical and 29 non-medical staff, assisted by 4 Clinical Officers (nurse practitioners). Suggested 5 years post-graduate experience, preferably with GP training and some tropical medicine and surgical experience are needed.

Free housing but utilities will be paid for by the occupant. It is hoped that an expatriate doctor would be able to raise their own funds from supporting church and individuals.

Contact: Dr Rachelle Sanderson, Rugarama Health Centre, Diocese of Kigezi, PO Box 3, Kabale, Uganda. Tel: +256 77 333 580
Email: *sanderson@infocom.co.ug*

Urgent need of Ophthalmic Equipment

A member knows of a national doctor training in ophthalmology, planning to set up a mobile Eye Clinic work based at Galmi Hospital, Niger and in need of equipment to do so – new or secondhand - to purchase or as donations. If you can help or advise,

Contact: Dr Jessica Whitworth.
Email: *thunder_rod23@hotmail.com*

Events and Courses

- **Serving God overseas as a Healthcare Professional - Saturday 9th July 2005**

A day Conference at Oak Hill College in North London, for those thinking about working overseas, looking at the practical issues in modern healthcare and medical mission.

- **Developing Health Course, 3rd-15th July 2005 also at Oak Hill College**

CMF's highly recommended two week residential course for those already working overseas - to refresh and update their skills and for those preparing to go abroad who want to acquire new skills relevant to working in a resource poor environment.

Details of both events and application forms can be found at *www.healthserve.org* under Developing Health Course and Other Courses and Events.

- **The use of medicinal plants in the tropics - 9-11th September 2005**

Run by **Action for Natural Medicine (Anamed)** at Barnes Close Conference Centre, Worcester. Cost £90. One of the facilitators, Simon Challand, is a CMF member recently returned from Tanzania.

The seminars will be practical and interactive, covering such topics as: The scientific and cultural basis for the use of medicinal plants; Self reliance in health, using medicinal plants; Treatment of common health problems including malaria, diarrhoea, burns and HIV.

EUTYCHUS

Class difference in disease and survival

Men and women living in the poorest areas of England not only die younger than those living in more affluent districts, they also spend twice as many years in poor health, says a report in *Health Statistics Quarterly*. Conclusions are based on 1994-1999 data from the annual health survey for England, which each year asks about 20,000 people to rate their health on a five point scale from 'very good' to 'very bad'. On average, men in England spend 59.1 years in good health and 15.9 years in poor health, while women spend 61.4 years in good health and 18.6 years in poor health. It is in the poorest areas that long years of ill health are most common. Men's healthy life expectancy was 66.2 years in the richest tenth but only 49.4 years in the poorest tenth. *Health Statistics Quarterly* (2005;No 25:19-27) is available online at *www.statistics.gov.uk/downloads/theme_health/HSQ25.pdf* (*BMJ* 2005;330:498)

WHO tobacco control treaty

The World Health Organisation's tobacco control treaty came into force on 27 February. 57 countries, including the UK, have ratified the treaty, which aims to reduce the number of smokers worldwide. Under the treaty, governments must:

- ban tobacco advertising, sponsorship and promotion, where constitutions allow, within five years
- include health warnings on tobacco packets that cover at least 30% of the packaging, within three years
- introduce measures to protect people from second-hand tobacco smoke in public places
- draw up strategies to combat smuggling
- adopt tax policies which discourage smoking

Some of the world's largest tobacco growers - India, Japan, Pakistan, Thailand and Turkey – have ratified the treaty. However, more than two thirds of WHO countries have not agreed to be bound by its restrictions. (*bbc.co.uk* 2005; 27 February)

Kenyan boys castrated for AIDS potion

Late last year two teenage boys from the remote northern region of Bungoma, had all or part of their genitals cut off to be sold for the making of an HIV/AIDS potion. A six-year-old was also attacked in a similar way. Both older boys were taken to Bungoma hospital, where they came to the attention of Spanish doctor Pedro Cavadas, who was on a surgical trip in Kenya. The older boys have since been taken to Spain and had reconstructive treatment at the Levante Rehabilitation Centre in Valencia; the six year old is expected there later this year. The boys are expected to make a full recovery. (*bbc.co.uk* 2005; 3 February)

Deaths from assisted suicide

40 people from the UK have ended their lives at the Swiss assisted suicide clinic run by Dignitas. Michael Irwin of Friends at the End (FATE), a Scottish group that openly assists people in going to Switzerland, said that nine out of ten Britons he has helped to join Dignitas have committed suicide. Dignitas is thought to have some 800 British members. (*Sunday Times* 2005; 13 March) 37 people from Oregon also died via physician-assisted suicides last year according to official reports. Psychiatric evaluation was performed in only five per cent of cases. (*CWNews* 2005; 14 March)

NZ study links cannabis to psychosis

Researchers from Christchurch School of Medicine, New Zealand, have found that smoking cannabis nearly doubles the risk of developing mental illness. Over 1,000 young adults were interviewed. The study took into account factors such as family history, mental illness and other substance abuse, and whether illness encouraged more cannabis use. Nevertheless there was an increase in rates of psychotic symptoms with regular cannabis use. They note the findings add to the growing body of evidence which suggest heavy cannabis use may lead to increased risk of psychotic symptoms and disease in susceptible individuals. (*Addiction* 2005;100;3:354. Reported in *Doctor* 2005; 8 March 2005)

NICE withdraws Alzheimer's drugs from NHS

New NICE guidance advise that certain Alzheimer's drugs should no longer be prescribed on the NHS, having reviewed the latest evidence on efficacy and cost effectiveness. Comments on the proposals were taken until 21 March, and final guidance is expected in July. The NICE assessment group says that although the anticholinesterase inhibitors donepezil, rivastigmine and galantamine have proved gains in cognitive and global scales compared with placebo in people with mild to moderate Alzheimer's disease, there is 'limited and largely inconclusive' evidence on outcomes that are important to patients and carers, such as quality of life and time to admission to a nursing home. (*BMJ* 2005;330:495)

New pre-eclampsia clue

A research team at Imperial College, London has found higher levels of antibodies to *Chlamydia pneumoniae* in women with pre-eclampsia. Their report in the *British Journal of Obstetrics and Gynaecology* says the infection could be a factor contributing to the development of pre-eclampsia in a small number of women predisposed to it. 91 pregnant women were included in the study. If further studies support these findings it may be advisable to screen women in early pregnancy and treat them if indicated. The research is seen as a promising development in the prevention and management of pre-eclampsia. *C. pneumoniae*, a cause of atypical pneumonia, is a different type of chlamydia to that which is sexually transmitted. (*bbc.co.uk* 2005; 28 February)

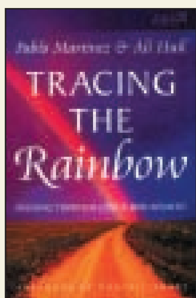
UN adopts human cloning ban

The UN General Assembly has voted to accept a declaration supporting a total ban on all forms of human cloning. The declaration urges member states to outlaw all cloning practices 'as they are incompatible with human dignity and the protection of human life'. The General Assembly voted 84-34 with 37 abstentions to accept an earlier report against cloning. The non-binding declaration was put to the vote after the UN had failed to reach agreement on a binding ban. (*bbc.co.uk* 2005; 5 March) Richard Gardner, chairman of the working group on stem cell research and cloning at the Royal Society, said that the declaration would have no effect on 'promising' research into therapeutic cloning in the United Kingdom. He commented, 'The voting shows a divided UN and fails to send out a clear message to maverick scientists that reproductive cloning is unacceptable'. (*BMJ* 2005;330:496) The UK government voted against the proposal. Health Secretary John Reid said the UK stem cell research industry remained 'open for business'.

BOOKS

Tracing the rainbow

Walking through loss and bereavement



Pablo Martinez and Ali Hull
Spring Harvest, Milton Keynes 2004
£7.99 Pb 171pp
ISBN 1 85078 487 6

A Christian psychiatrist and journalist here explore the nature of grief after death or divorce, offering telling personal histories to illustrate their points together with practical wisdom and spiritual consolation.

The authors remind us how grief is the other side of love. Its duration matters less than its direction, which is normally towards resolution. The different feelings occur in waves, switching between denial, intense longing and depression before there can be a coming to terms with the loss. Sustained grief often follows the loss of a child or partner (this especially after divorce). Medication should not be used routinely, even when the supporters of those who mourn wish that they would move on more quickly. Intending helpers should start where people are, not where we think they should be. The diagnosis of chronic grief should *only* be made by a specialist.

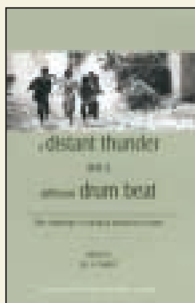
Helpful consideration is given to the roots and recognition of abnormal grief as well as the ways in which intending comforters can help or hinder recovery. Bereavement in childhood is given special mention. Whatever the age, most people numbed by grief appreciate a sensitive supporter who stands firm as reality strikes and emotions flare. Reinvestment of emotional energy takes time, but practical help along the way means much to those feeling so drained. A prayerful, loving and supportive church can be a great help throughout, but 'we are called to listen, not to preach'.

A whole chapter is given to discussion of the painful bereavement entailed in divorce, including the feelings of the affected children. Recovery is messy and complicated, bringing confusion, loneliness and isolation before probable readjustment. Understandable anger will slowly resolve as forgiveness takes over. Family, friends and church members should avoid judgmentalism and exercise grace.

Research indicates that faith significantly helps the progress of grief. The last chapter is devoted to the specific comfort offered by the Christian faith, and its crucial role in readjustment. Despite some unanswerable questions, Christ's defeat of death offers hope -the rainbow of the title. This is an invaluable little book for sufferers and their supporters alike.

Janet Goodall is Emeritus Consultant Paediatrician in Stoke-on-Trent

A distant thunder and a different drum beat



Edited by V Philip
EMFI 2002 50pp
Available free of charge from www.healthserve.org or contact emfi@vsnl.com for a copy

Throughout the world the ways through which Christian faith influences healthcare services have changed radically and continue to change. This booklet is an analysis of a workshop run by the Evangelical Medical Fellowship of India and the Emmanuel Hospital Association on the changes in India over the past 50 years, and how Christian sponsored healthcare may be most beneficial to Indian communities in the future.

In the past Christian hospitals in India were the major providers of quality healthcare in rural areas. Many have closed as government policies have changed and support from overseas has diminished. Private and corporate healthcare providers have increased. The ability to maintain the old-style mission hospital with its wide community influence has become tenuous.

The challenge in this booklet is how to keep a Christian influence in a society which is looking away from traditional Christian services. Increasing non-Christian influence in healthcare is the distant thunder. To counter such a threat of storm requires an assessment of which drum beat today's Christian soldiers should march to.

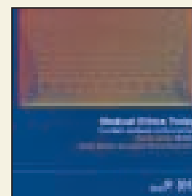
The booklet presents an objective critique of the positive and negative sides of healthcare which apply in any country. Statistical evidence is given of the relevance of poverty in ill health. The 'drum beat' response to this is holistic primary healthcare. Nothing new you might say. But do we truly promote and practise primary and preventive care?

The 'drum beat' is not just about such facts. We are challenged to consider why curative services dominate the preventive when clearly the latter can benefit many more and at far less cost. The answer lies in the application of moral principles to questions of healthcare. How and when is technology relevant? Is healthcare primarily a business? Why should treating diseases of affluence be more profitable than preventing them? Do we know for certain what we are aiming for? 'Where there is no vision, people perish and institutions follow'. While this concise booklet aims to define the challenges and pitfalls of medical mission in India, it similarly confronts all who seek to apply the mind and will of our Creator to the many aspects of healthcare. Medical mission involves all those who seek first the kingdom of God, whether in state, private or mission context.

Keith Sanders is a former General Secretary of CMF and medical missionary in India

Medical ethics today

The BMA's handbook of ethics and law (CD-ROM)



British Medical Association Ethics Department
BMJ Books 2003
ISBN 0 72791 829 X

The 1974 edition of the British Medical Association's (BMA) ethics handbook provided guidance on important matters such as whether a consultant or a GP should enter the room first when both visited a patient. Times have changed significantly, and medical ethics with them, and the new edition of the handbook, *Medical Ethics Today* weighs in at over 800 pages. All the book's content is available on this CD-ROM as a PDF eBook.

The BMA receives thousands of ethical enquiries each year and the content of these forms the main focus of *Medical Ethics Today*, which has been put together under the direction of the association's Medical Ethics Committee. It consists of 21 chapters assessing everything from consent and confidentiality, to emergency treatment and research ethics. I was interested to read the sections on 'classic' bioethics topics like care at the end of life, but also found the chapter on education useful.

The text includes a lot of background

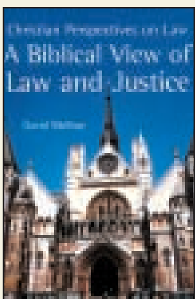
information relevant to each issue and the boxed summaries of key legal cases are particularly helpful. However, the CD-ROM is difficult to navigate as it contains the index of the original book, and the page numbers listed here bear little resemblance to those of the electronic text. There is a search function, but this is painfully slow.

Medical Ethics Today has a dual purpose: to equip readers with both skills in ethical reasoning and an understanding of the law and professional guidance. It perhaps succeeds with the latter, but it's difficult to see how it enables readers to formulate their own conclusions particularly when, like many ethics texts, it seeks to satisfy everybody by only appealing to mid-level principles such as autonomy. The authors mainly outline the BMA's position, at the expense of other viewpoints, and there is a worrying tendency to sweeping statements about the views of 'society as a whole'.

The book doesn't provide any easy answers, and a lot of it sits uncomfortably with a biblical bioethic. However it does represent a useful reference work about the state of medical ethics and law in the UK today.

Helen Barratt is a final year medical student at Imperial College, London

A Biblical View of Law and Justice



David McIlroy
Paternoster 2004
£17.99 Pb 238 pp
ISBN 1 84227 267 5

Christian doctors often rage at the laws which set the ethical pace of their profession. This book is an important inquiry into the legitimacy of that rage, and a lexicon of the words in which the rage can properly be articulated.

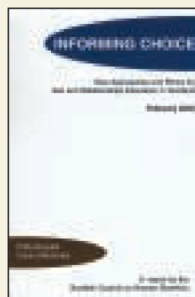
The Bible is full of laws. They sometimes seem to be at war with grace. McIlroy helps to broker a peace. God seems to like order: his first recorded act was to subdue chaos. Although the Fall twisted things so that the originally ordained model of societal harmony has never been visible, he continued to want humans to live in a regulated way with one another and with himself. Laws for an Israelite theocracy are one thing; laws for a Kingdom which is not of this world are another. There is an apparent dissonance between what the Old and the New Testament say about the demands of the law in a civilized society. All this is the stuff of McIlroy's book. It is immaculately researched and highly readable. It is important reading not only for jaded lawyers, but also for anyone who takes the obligations of citizenship seriously.

I have some quibbles. Most of them boil down to saying that the book is too short. That necessarily means that mere assertion triumphs over argument. Sometimes, though, the unargued assertions become central pillars of later arguments, and those later arguments are unstable as a result. It is frustrating, too, that McIlroy does not grapple head on with some of the urgent contemporary questions which his thesis raises. Yes, we should, within limits, submit to rulers, but who, in a Britain whose policies are dictated to a significant extent by the US and the EU, is my ruler? The dissolution of the boundaries of nation states makes dubious the application of theologies designed for nation states. It would have been exciting, too, to see an able intellectual matador like McIlroy take firmly by the horns some of the dangerous historical bulls which stampede through any Christian philosophy of law. Theocracies have historically been vile: secular states have generally done a good deal better. I think I know what McIlroy would say about this, but I would have liked to hear him say it.

But this is unfair. It is criticising a book for not being the book that it does not purport to be. McIlroy has produced a fine work of biblical scholarship. It is a compliment to him that I want him to develop and apply his thesis further.

Charles Foster is a Barrister in London

Informing Choice
New approaches and ethics for sex and relationships education in Scotland



Philip Boydell and Calum MacKellar
Scottish Council on Human Bioethics 2004
£15.00 88 pp
ISBN 0 95468 300 5
www.schb.org.uk for full contents

This is a highly useful resource for anyone interested in sex education, whether or not they are working in Scotland. Within its mere 88 pages of densely packed text, it covers a wide range of topics.

Consisting of two parts, the first summarises the sexual health scene in Scotland and then looks at the biological, psychological and social factors influencing the initiation of teenage sexual activity. The social factors examined include family systems, peer pressure, the media and socio-economics. There then follows a fascinating comparison and contrast of sex education in the Netherlands, USA and Uganda, applying lessons from successes in these countries to future policy in Scotland.

The second half of the book considers the often neglected area of the ethics of sex education, firstly using the well-known ethical principles of autonomy, beneficence, non-maleficence and best interests and then looking at the effect of the UN Convention on the Rights of the Child. 19 recommendations to the Scottish Executive (the Scottish parliament) conclude the book. I have no doubt that if even half of these were adopted, sexual health in Scotland would be transformed for the better. The recommendations include giving information on the effectiveness of condoms in preventing STIs; giving information on sex within the context of love and relationships; promotion of programmes that encourage young people to have educational goals; promotion of communication between parents and children regarding sex and relationships; promotion of delay and abstinence until a young person is older and more able to make informed decisions.

There are a few little irritations which betray the 'in-house' nature of this publication. Testosterone is given a capital 'T' in mid-sentence and there are some printing failures in the bar charts. The high price probably reflects the production costs (the shiny paper feels expensive) and limited expected circulation. It is a great pity that this well-researched and helpful book which must have taken months of work to put together, has had so little marketing. Though published in February 2004, I had not heard of it until my review copy arrived in December 2004! It is a real goldmine of useful information however with nine pages of references and is well worth ordering even in 2005. I hope the Scottish Executive have all had copies.

Trevor Stammers is a General Practitioner in West London

LETTERS

Smacking children

Readers have added their comments and insights to this debate (Triple Helix 2005; Winter:16-17).

***Huw Francis** argues that prevention is better than cure.*

I am sure readers of *Triple Helix* will have been surprised at Dr Rhona Knight's comment on the legitimacy of smacking a child approaching danger in the home. Care to ensure that the home environment is appropriate and safe for children, and intelligent anticipation of the likely behaviour, can head off trouble and reduce the number of occasions on which punishment of any kind has to be considered.

*Leeds members **June and Michael Flowers** give principles from experience.*

We found the contribution from Rhona Knight thoughtful and wise. We have had five children. First, we found that as a result of occasionally finding it necessary to smack the oldest, and most defiant, a spin-off was the deterrent effect on the other children. Second, each child was different. Three of them were never smacked, and the fourth rarely. That is why there will be many families where smacking will never be used, but it is foolish to refuse such flexibility to others. Before the age of six or seven some children will need this particular sanction in order to learn where the boundaries are that responsible parents draw. Third, we learned not to smack in anger - we are not talking here about parents losing their temper, are we? Fourth we already knew that *verbal* violence can be, in contrast, significantly harmful compared with a smack, and we needed to be vigilant never to allow disapproval to cause a seeming withdrawal of affection.

*Discipline is part of God's compassion, says West Lothian GP **Rob Proudlove.***

Why is this debate occurring today amongst Christians? Is it because of a better understanding of scripture than our forefathers, or because of the pressure of liberal humanism? Bishop Ryle, I believe, used to urge the acceptance of the 'plain reading' of the Bible - are we shying away from this in embarrassment?

The abuse of something valuable may require to be severely dealt with, but is not in itself a reason to abandon it; anymore than the murderous abuse of diamorphine by Dr Shipman means that the profession must cease its compassionate use of that drug in the relief of suffering.

Who is wiser or more compassionate than our God? Yet he is prepared in his loving purpose to use discipline -'No discipline seems pleasant at the time, but painful. Later on, however, it produces a harvest of righteousness and peace for those who have been trained by it'. (Hebrews 12:11)

Leslie Burke v the GMC

***Charles Foster**, a Barrister in London, argues that the pro-life lobby has scored an own goal in the High Court ruling in favour of Leslie Burke. Mr Burke has a progressive neurological condition and brought a legal challenge against GMC medical guidance setting out circumstances in which food and fluids could be withdrawn from patients without the courts' consent. He feared that his life could one day be ended (Triple Helix 2004; Autumn:4)*

Leslie Burke was technically successful in his judicial review of the GMC's guidelines on withdrawing and withholding treatment, and Christians greeted that success enthusiastically. Sadly their enthusiasm was ill-founded. The *Burke* case is a setback for the pro-life lobby.

The case was unnecessary. As the judge found, the NHS has an obligation to provide basic care. The GMC guidelines should reflect this obligation more obviously, but Leslie Burke was never in any danger of having basic care withdrawn. The old law gave perfectly adequate protection, but Leslie Burke was not satisfied. He invited the judge to say that the principle of autonomy, enshrined in Articles 3 and 8 of the European Convention on Human Rights, demanded provision of basic care to a competent patient who wished to stay alive. The result was tragically predictable. Of course Articles 3 and 8 had that effect: no one ever doubted it. But the judge, having been invited to sing a hymn to autonomy, duly did. Here it is:

'*…The personal autonomy which is protected by Article 8 embraces such matters as how one chooses to pass the closing days and moments of one's life and how one manages one's death…. The dignity interests protected by the Convention include, under Article 8, the preservation of mental stability and, under Article 3, the right to die with dignity and the right to be protected from treatment, or from a lack of treatment, which will result in one dying in avoidably distressing circumstances… Important as the sanctity of life is, it has to take second place to personal autonomy; and it may have to take second place to human dignity…*'

The Voluntary Euthanasia Society rejoiced. We need to be careful about which cases to support.

The euthanasia bandwagon

*Retired doctor **Jenny Robinson** draws a link between abortion and euthanasia with reference to the editorial on the Mental Capacity Bill and the Assisted Dying for the Terminally Ill Bill (Triple Helix 2005; Winter:3)*

I am one of a few Christian doctors who stood outside the DHSS in 1967, protesting just before the Abortion Act became law. Shortly after I saw Francis Schaeffer's film series, *Whatever Happened to the Human Race*, which made clear that if we accepted the killing of unborn babies then we would eventually countenance the killing of the old, the vulnerable and the sick. Since 1967, it must have been hard for Christian gynaecologists and anaesthetists to stand up and be counted. Many did. Some allegedly lost their promotion prospects, others their jobs. This though will be different. If or when these provisions become law every medical professional in almost every branch of medicine will become involved in making or carrying out these life or death decisions. Non-Christians will be looking to see if we Christian doctors will be indistinguishable from the others or whether we will say, like many Catholic Christians, Jews and Muslims, 'I am not going to co-operate consciously or unconsciously in the killing of patients.'

Some may say it is easy for me to speak out, because I will not be involved. That is true, but I do not want to see our profession involved as Nazi doctors were.

Paragraph six of the editorial could read:

'Had the medical profession taken a strong stand against the mass killing of unborn babies in 1967 it is conceivable that the entire idea of *The Mental Capacity Bill* and *Assisted Dying for the Terminally Ill Bill* would not have materialised'.

Peter Saunders reflects on our attitudes to those with special needs

Photo is posed by a model and does not refer to the article
Photo: Down's Syndrome Association

Bearing burdens

When I was a final year medical student, a baby was admitted onto the paediatric surgical ward with duodenal atresia. A relatively straightforward operation would have saved her but, because she had Down's Syndrome, her parents opted not to treat. She was left alone in a side room, given large doses of morphine and effectively starved and dehydrated to death.

Some years later, when I was a senior registrar in general surgery, a woman in her 50s (again with Down's Syndrome) presented with obstructive jaundice secondary to a tumour of the Ampulla of Vater. The necessary Whipple's procedure, which involves removing duodenum, gall bladder, bile duct and half the pancreas, was a major undertaking, but there was no question in the minds of her family that she should receive the best care available. In fact she tolerated the procedure well and made an excellent recovery.

I have often reflected on these two cases and the different attitudes of the families involved. But treatment decisions like these may be consigned to history very shortly if current trends continue.

The number of Down's Syndrome pregnancies is increasing. There were 1,067 in England and Wales in 1989 but by 2002 this had risen to 1,433, mainly due to the fact that women are delaying having children until an age when the risk of having a child with this condition is higher. But despite this the number of Down's Syndrome babies *born alive* each year has actually *fallen* from 750 to around 600 over the same period. This is because our society is increasingly taking the view that it is better if children with this condition are not born at all. In 2002 around 800 Down's Syndrome babies, 56% of the total, were aborted. But the number would have been much higher if more had been diagnosed before birth.[1]

Prenatal screening by ultrasound or maternal blood tests can raise suspicion of Down's Syndrome, but a firm diagnosis can only be made through tissue diagnosis, either at 10-12 weeks by chorionic villus sampling (CVS), or at 16-20 weeks by amniocentesis. Currently 92% of all Down's Syndrome babies diagnosed before birth are aborted, but the government has plans under a new Human Genetics Commission consultation called *Choosing the Future*[2] to make prenatal screening much more widely available. If it concludes as anticipated, we can expect the number of children born with Down's Syndrome each year to fall to well less than 100. We can also expect to see fewer children born with a large range of other genetic abnormalities.

There is no doubt that bringing up a child with special needs involves substantial emotional and financial cost, and yet at the very heart of the Christian gospel is the Lord Jesus who chose to lay down his life to meet our own 'special needs'. The Apostle Paul tells us that Christ died for us 'when we were powerless' (Romans 5:6) and that 'bearing one another's burdens' is at the very heart of Christian morality (Galatians 6:1). For Christian doctors bearing burdens involves not only providing the best medical care for the most vulnerable members of our society, but also supporting their families in the long haul, being prepared to speak out when they are being treated unjustly and doing what we can to oppose unjust and discriminatory legislation and health policy.

On 17 April 2005 I will be part of a small team running the London marathon to support those with Down's Syndrome and their families.[3] But all of us are part of a much larger team called in a whole variety of ways to engage in the fight for these very special people and others in a similar position of vulnerability. Let's pray that we fight these battles well.

Peter Saunders is General Secretary of Christian Medical Fellowship

1. *www.smd.qmul.ac.uk/wolfson/ndscr/NDCSRreport.pdf*
2. Saunders P. Choosing the Future. *Triple Helix* 2005; Winter:4
3. See *www.justgiving.com/petersaunders*

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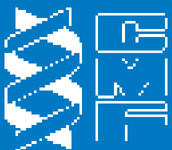

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