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Christian dimensions in healthcare

Vocation in nursing
Ante-natal screening
Prayer at the bedside

'I want to be a nurse'
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editorial:

show God's kindness today

The story of Mephibosheth[1] offers a remarkable parable of God's kindness to us.

After many years as a fugitive David is firmly established as King of Israel. His enemies have melted away and his kingdom is enjoying peace. 'God has been kind to me' argues the King. 'Can I pass that kindness on to someone else?'

The King's thoughts turned to Mephibosheth. He was the son of David's great friend Jonathan, the son of King Saul, who died in battle defending his country. When news arrived that Saul and Jonathan were dead the royal household fled. In the hurry and confusion the nursemaid carrying five year old Mephibosheth dropped him. From that day on he was crippled[2].

'Maybe I could show kindness to Mephibosheth' thought David. So he ordered his servants to search for him and bring him to the palace. When Mephibosheth received David's invitation he was scared. He knew well enough how members of a deposed dynasty could expect to be treated. He may not have wanted to get involved with the new king. But David quietly won his trust. He restored Mephibosheth's lands. He arranged for him to have plenty of farm workers and gave him a suite in the royal palace and a permanent place at the royal table.

This must have been costly for David. It is always costly to have a stranger in one's home for an indefinite period, especially one who is handicapped. Amid all the pressures of state King David set aside time for Mephibosheth to talk about his problems.

David's words offer a model prayer for all of us at the start of a new day: God has been kind to me. He has blessed me in so many ways. He has made me his child and - amazing thought - his heir, with the prospect of living for ever in his palace. This kindness was costly: 'God so loved the world that he gave his one and only Son'[3]; 'the Son of God, who loved me and gave himself for me'[4].

If we accept God's kindness without passing it on, we become like the Dead Sea. It receives water from the Jordan but gives out nothing.

So how can we show our gratitude to God for this kindness? For some time I have had a motto clipped to my desk diary: 'Every day I will praise you, and bless your name for ever and ever'. Now, inspired by the story of David and Mephibosheth, I have added another: 'Is there anyone to whom I can show God's kindness today?'

David Short

References

1. 2 Samuel 9
2. 2 Samuel 4:4
3. John 3:16
4. Galatians 2:20

relic of the bedpan age

Faith Search
Nursing Student
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University of Surbiton

Dear Faith

I was disturbed to hear you have met Angela Plume and am taking this opportunity to warn you against her. I will deal with your queries, but I need to point out that she represents a bygone age which we have fought to eradicate. In her day, service to patients was the purpose of nursing. Nurses talked of having a vocation and ran round getting doctors tea and chocolate biscuits. We have moved on and are now highly qualified professionals. In your course modules you will learn to be autonomous, assertive, empowered, creative and critical. You will learn to use your 'self' therapeutically, and to let the doctors give *you* the biscuits!

So Angela told you the quaint exhortation that nurses learnt in the past: 'Carry that bedpan to the glory of God'. Yes, I know this was how most nurses were inducted into a tradition. How else would anyone be persuaded to carry receptacles filled with urine or vomit, touch caked and slimy dentures, and wash urine-soaked and faeces-speckled skin? We have done away with all that now, leaving those revolting jobs to 'care assistants'. A nurse does not need a diploma or degree to deal in human squalor. I know Angela believes in God but, despite opinion polls to the contrary, remember that no-one else does nowadays. It has long been proved by research that 'God' is used as a prop to justify the expectation that women would do such filthy task-orientated work and call it 'vocation'. As you have surely learnt from your spirituality module, 'God' is one word that causes extreme embarrassment and must be avoided.

Yes, I know Angela quotes recent research that people enter nursing because they want to help people, and use the term 'vocation' rather than 'career', but you must remember to use only those statistics which fit with what you are taught here and ignore all others. By the time nurses have finished their education with us we have changed their minds. They realise the importance of money, status, courses, clip-boards, sharp suits and shoulder pads (if in fashion). Who in their right mind wants to wear a ghastly uniform anyway?

On this question of recruiting nursing students, I too have seen the report by the Qualifications and Curriculum Authority that only 9% of colleges ask for a 'C' in GCSE Maths. Entry requirements are deliberately flexible, a few GCSEs or failing them, entry tests, are quite adequate - we have an extreme shortage of nurses, and many are leaving, so we need to attract people in. I know Angela says that in the old days what she calls 'moral character' was a crucial criterion for recruitment, but thank goodness we no longer ask anything like this.

I refute your point that nurses need to be able to count in order to calculate drugs and use computerised equipment. How many times have you been told in your course modules that nursing is about risk-taking and learning by experience? A few mistakes are part of the learning experience, and patients do understand this. As for the QCA, well they have had their way with education of children and teacher training, and we must in no way allow them to poke their noses into the education of nurses. Let the fact that over the last decade we followed the model of teacher training remain a secret. And keep repeating the myth that nurses in the past were not scientifically developed. We must forget that Doreen Norton's work with pressure sores comes out of that tradition. We did not want to build on the old tradition, we wanted to start afresh. *Vive La Revolution*!

Which reminds me of the report chaired by an educationalist, that was, in my view, quite correct in its scathing reference to the views of the layperson about the move into higher education we proposed. We knew that the public would not want nurses to stop training at the bedside - marching to the drumbeat of service - to become amateur sociologists and psychologists. But I was never too happy with the wording of the statement in the report ridiculing the public's view. It was a mistake to say that the layperson would 'grunt heartfelt approval' to the idea of keeping the apprenticeship. It rather implied we thought the layperson to be a pig. And, whatever the QCA opinion, similar liberal dogma in teaching has been a real boon which has produced quality results in children's learning.

On this point of university education you tell me you are disappointed not to learn more basic biology and that you find the course heavily weighted with psychology and sociology. Recent studies have shown this to be a common criticism from nursing students but they soon grow out of it. You must realise by now that Marx and Freud are far more relevant to patient care than any of the old medical models we had in the past.

If Angela Plume has told you that physicians and surgeons used to teach nurses relevant knowledge in the old days this just goes to

show you how wrong the system was.

Patients should not get diseases or be 'ill'. So called ''illness' is far more likely to respond to massage or counselling. This health-orientated model is surely a great improvement in helping people to be self-caring and not a burden on either the State or nursing. It might even sound the death knell of medicine and an end to the Sir Lancelot Spratts.

You say you are embarrassed because you do not feel competent in techniques; you say you have never been shown how to make beds, take blood pressures, do dressings or even wash patients. You are not alone, as these studies show. But you are wrong to complain. This is victim culture. We are educating you, not training you for irrelevant tasks. You are a professional, it is up to you to direct your learning requirements. Decide for yourself what is *important for you*, then look it up in one of our many nursing journals. True, they may not deal with such basic matters (which care assistants do anyway), but you will learn much about postmodern nursing theory in them. My own study 'Postmodern Concepts of Gender Specific Denture Cleaning' is published in one. I know that when faced with a real situation, such as which dressing to use for a leg ulcer, there may not be time to literature search the relevant evidence and analyse its validity, but your professional code of conduct tells you it's up to you to decide your level of competence.

If Angela Plume gave you the example of a nurse who found a patient having an arrest on her ward, and walked off to the library to look up the procedure only to find the patient dead on her return, this is a myth. Anyway, patients appreciate nurses who feel comfortable with themselves. The purpose of education is to feel more positively about your capabilities. Neither we nor the professional bodies believe in objective measurements, another relic of the past. As we have said many times, this limits creativity and flexibility.

And you must tell Angela that studies show that while many newly registered nurses are not competent practically, they nevertheless impress managers and doctors alike by their ability to be constantly critical of everything they are told; far better than the days when there was authority in hospitals. Now it is free and easy. If you want a quick smoke you just pop off the ward. Nursing students do not need to learn such techniques as you describe anyway, because they will not go near patients apart from supernumerary visits to the ward. Then, they are quite at liberty to refuse jobs they do not want to learn. 'I have given a commode once and do not need to do it again because my learning experience is completed' is all that needs to be said politely.

Most nurses specialise after becoming registered. They go into lecturing, research or management. They call themselves 'practitioners' and generally advise doctors on how patients should be treated. Yes, I know Angela Plume thinks a 'nurse-practitioner' is a non-specific term which may mean anything, but that is part of the mystique that all professions need. The nurse whom you mention, who was appointed a 'pain specialist' but knew nothing about pain, was soon given the know-how by a consultant (though she wisely keeps this quiet). And as I keep on telling you, do you think doctors are any better? And on this matter I am not happy about nurses being trained by doctors to take over their work, becoming anaesthetists, or stripping veins, for example. What kind of laziness is this? We do not expect nurses to become pseudo-doctors, and that is why we ensure their education does not prepare them as such.

Angela has told you her concerns that quality nursing is disappearing. I appreciate her view that all human beings have basic needs which when they are indisposed they cannot meet. But surely, in this technologically advanced society machines should be able to toilet people three hourly, put food in their mouths, wash and dress them, and even prop up their pillows when they are dying? I would not mind myself in the hands of a robot, so long as its mechanical arms were padded. Nurses are now much too overqualified to do this kind of work and we should be looking at alternatives.

As to Angela's musings about whether nurses should surrender the title 'nurse' to care assistants, and perhaps one day even to a machine, I give you a categorical answer: Our image consultant has advised us that the brand name 'nurse' must in no way be lost because the public holds it in great esteem and we can use it in salary bargaining. The 'angel' image may be hateful, but it is the 'aah' factor . . .

Angela Plume is a relic of the bedpan age. The last thing you must do is take her seriously.

With all good wishes

M Powers

Professor M Powers
Department of Health Studies
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The letters of Sister Plume are a series of satirical letters published in the *Nursing Times* during the 1980s and revived in 1997, anonymously written under the pen name 'Sister Angela Plume'. They portray the vocational nurse and nursing tradition as archaic, reactionary and ridiculous. The epithet 'Sister Plume' is now used to stereotype any nurse who dares look back with nostalgia. This letter is written by Ann Bradshaw in this spirit and with apologies to C S Lewis and his *Screwtape Letters*. Ann Bradshaw is a practising nurse and Clinical Fellow at the Royal College of Nursing Institute, Oxford Centre, Radcliffe Infirmary, Oxford

the cradle of the womb

From personal experience, Dr Josephine Treloar asks some probing questions about ante-natal screening tests

I am a GP and mother who has experienced at first hand the desire of ante-natal services to screen out and destroy babies they consider unwanted. They are so keen they will actually screen without the consent or even knowledge of the mother. As Christians we are bound to be concerned about such moves. The joyful time of pregnancy can be harsh and dangerous. Mothers need all the support and knowledge they can get, to withstand some of the destructive pressures now inbuilt within ante-natal care.

Current public policy is increasingly designed to minimise expenditure on the care of the mentally or physically handicapped[1], and the main legal way at present is to prevent them being born alive. The dragnet is designed to be as comprehensive as possible and enrols all parents in screening, even though many of them really only want to see their baby and confirm their dates. Although there are many good obstetricians and midwives who provide excellent care for mothers and their unborn, they are working within a system where if a baby is born with an abnormality which could have been detected (and the baby aborted) they are open to law suits for 'wrongful life'. A court in Britain has already awarded substantial damages to one mother who gave birth to a Down's syndrome child undiagnosed before birth[2].

Tests currently performed

1. Alpha feto-protein

The AFP test has been around for many years as a non-specific marker for conditions such as spina bifida. More recently it has been used in combination with some other blood tests and maternal age to produce a clearer assessment of the mother's 'risk' of carrying a baby with Down's syndrome. Usually performed at about 16 weeks' gestation, with minimal explanation to, and consent from, many mothers, an abnormal result would be followed either by a detailed ultrasound or by amniocentesis. Obviously, more complex investigations usually require more informed consent from the mother, but by now these mothers are very much on the 'seek and destroy' conveyor belt. They are often out of their depth and terrified. I have seen women carried along by the enthusiasm of doctors and midwives and it is hard for them to stand up to pressure in these situations.

2. Nuchal translucency

An additional ultrasound test is being performed in many areas on all mothers at 11-13 weeks to pick up many who show signs of Down's syndrome. It leads on to amniocentesis. Nuchal translucency is however, a remarkably 'soft' sign, associated with a variety of chromosomal defects as well as structural anomalies such as renal dysplasia and exomphalos. When used for population screening only 5% of positive tests are associated with trisomy 21[3]. Nuchal translucency will usually detect for elimination up to 70% of live children with Down's syndrome[4]. All this is done for a condition associated with hardship for parents, but where Down's children are so often specially happy and loved.

3. Amniocentesis

Amniocentesis involves removing fluid from the amniotic sac with a needle and syringe, usually under ultrasound guidance. It can be performed from 11 weeks (after the last period) but because of 'unacceptably high losses' is usually only performed after 16 weeks. The miscarriage rate is 1%, rising to 2% in excess of natural loss when performed as early as 11 weeks (1% of established 16 week pregnancies is actually a very high rate of loss)[5]. Amniocentesis was fairly disastrous for one older mother I knew who had achieved her first pregnancy, was badgered into the test by the registrar, and subsequently lost her baby. Rarer side effects are the formation of silky fibrous bands across the amniotic sac and around which the baby can wrap fingers, toes and even limbs and thus be born without them.

4. Chorion villus sampling

CVS, usually performed from 11 to 14 weeks, aspirates placental tissue for testing, takes 2-3 weeks for a result and causes 1-2% fetal loss.

5. Obstetric ultrasound

Knowledge about gestation can be invaluable if intervention is required for the benefit of mother and/or baby, especially when deciding when to deliver babies around 23-28 weeks. A baby with spina bifida, treatable heart problem or an abdominal wall defect will undoubtedly fare better if delivered in an appropriate unit with specialist paediatric care.

Predictive validity of prenatal diagnosis

Many assume that amniocentesis is the 'gold standard' which gives 100% diagnostic certainty. One interesting report from Denmark questions this statement. Denmark is the only country whose national cytogenetic laboratory follows up testing by analysing the genetics of the baby born, or miscarried, or aborted. They found that one third of babies diagnosed as being chromosomally abnormal with Turner's syndrome who were not aborted, turned out to be normal[6]. Perhaps mosaicism has a part to play in the cause of this[7]. Whatever the reason for this finding, even chromosomal abnormalities on amniocentesis do not mean the child will have the chromosomal syndrome.

Fetal medicine centres

Intrauterine fetal surgery is also able to offer benefits. For example urinary tract obstruction can be treated to save renal function. These more simple procedures have a fetal loss of 8-10% which may sometimes be justifiable. More complex surgical operations which are done between 24 and 30 weeks involve a Caesarean-like delivery, operating on the baby and then returning him/her to the womb. This involves a fetal loss of up to 50% and also has risks for the mother. These latter interventions are still rare and experimental[8]. The centres are high technology specialised places where babies' lives can be saved, but nonetheless hearing the 21 week scan described as an 'anomaly scan', rather than a 'well-being scan' raises concern about the motives of such centres. Reading their literature, I fear they may select out more babies than they save. Much of their expertise was gained by practising on pregnancies due for abortion. Mothers should be well informed if they need to use their services.

Psychological effects of screening

Modern medicine has many benefits and we are fortunate, in wealthy countries, to have access to such care. Such opportunities have their problems as well. Some people may want comprehensive knowledge to prepare themselves for the birth of a child with an abnormality, even though there is rarely any significant medical benefit to be gained. On the other hand the distress and disruption of normal pregnancy by worry is widely recognised. Amniocentesis results take two (worrying) weeks to return. Scans may be happy events, may be worrying, or may be devastating. It does not take much imagination to consider how this affects the unconditional love of parenthood.

'Soft' ultrasonographic markers have been suggested to do more harm than good[9]. Parents undergo testing for reassurance that everything is alright. Doctors screen for abnormality. Medical success in detecting abnormalities leads to severe distress and many have questioned the sense of such tests[10,11]. Worries can be persistent and can damage parental relationships long after birth[12]. An abnormal early scan of a baby with severe structural abnormalities will obviously produce great distress. I have seen a mother in a scan room put in this position. Sometimes interpretation errors occur with the result that normal babies are aborted. Worst case scenarios are often presented along with comments such as 'you must think of the rest of the family'.

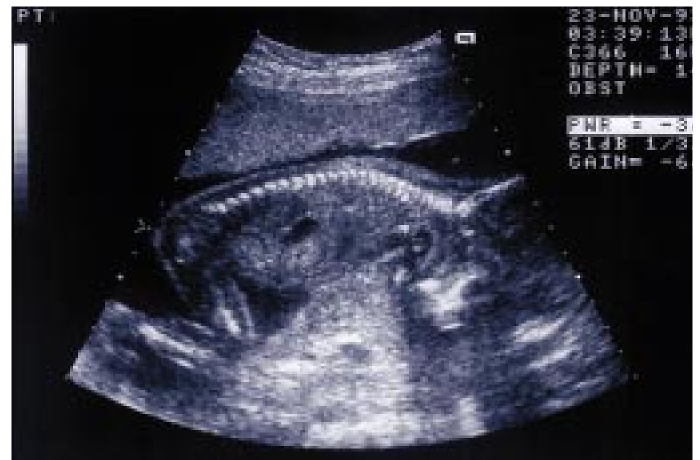
The majority of severely abnormal babies miscarry by the end of the second six months. Kelly[13] has beautifully described how precious short lives can be. 'To me my baby was lovely' said a mother who 24 hours earlier had given birth to a baby with multiple abnormalities and who died 20 minutes after birth. My clinical experience too has suggested that continuing to birth may have great benefits. Women aborting abnormal babies appear to suffer even more than others.

When parents have a disabled child there can sometimes be a sense of embarrassment at the perceived imperfections in the child. How much more so when ante-natal technology claims to be able to spare them such problems? We must remember that children are individuals in their own right who might one day be embarrassed about their own parents. There is no test predictive of adolescent problems or the many other difficulties that parents and children face.

Personal experiences

Perhaps examples from my own experience would be helpful. I trained as a doctor at King's College Hospital which has for many years been in the forefront of ultrasound investigation and research to decrease fetal mortality. As a result, I have been able to understand all the investigations and stages of my pregnancies.

In one pregnancy, during which I had threatened to miscarry several times in the first three months, I was told by the obstetrician that I should have the AFP test. I replied I did not want it. She understood why but still felt the need to press the point. In the end I said she could do it if she wanted to, on condition that I was not to know the result - I had had enough stress by then! She actually realised that the test was probably unnecessary and unreasonable and may well have given a false positive result because of the previous problems.



Ultrasound scan of Gregory John Treloar

In a more recent pregnancy, I was probably one of those investigated in a large multi-centre study to pick up signs of Down's syndrome using ultrasound. I was following the progress of the scan when I noticed the ultrasonographer was spending a lot of time viewing round the back of the baby's head. 'I'm just measuring fluid around the back of the neck' was the not unreasonable response to my question. It was only after the birth of my baby that I was fully informed of what was being studied. I got my answer from the obstetric registrar whom I met in the car park as we were leaving hospital! Realising how close I had unwittingly been to receiving rather non-specific and entirely unconsented information has made me extremely wary of ever attending for an ultrasound test prior to the time when the information gained is of use regarding the baby's well-being.

As a medical student I saw another woman who had spina bifida herself as a child, pressed to have detailed scans of her baby to look for any possible anomaly even though it would not have affected the delivery and even though the mother would not have considered an abortion.

One woman asked me if, by refusing scans, she was really being irresponsible and denying her baby the best chances of being

born healthy. In a previous pregnancy she had lived through the traumas of two-weekly detailed scans at a fetal medicine centre to which she had to travel from mid-pregnancy. This had been a practical hardship as she still had to care for the family but was also a massive disturbance to her serenity. The tests had not made any difference to the management of the pregnancy. The obstetric registrar felt that she should go through this process again and when she refused wrote in huge red felt pen on the front of her notes to the effect that she had refused medical advice and was highly irresponsible. These were the notes she had to endure everyone seeing each time she attended for care - a gross infringement to personal liberty and autonomy. She did have a detailed scan later on with a view to plan for delivery but it would be fascinating to know, had she been in a position to press the registrar, exactly what, other than a process leading to abortion, she was refusing.

I know of many women who now fear ante-natal care. They are afraid that doctors will do tests which will show an anomaly and then press them to have an abortion. These fears are not irrational, but are based upon the experience of earlier pregnancies. Most women simply trust the system, go along, and get swept away when an anomaly is found. Even good Christian women who are against abortion seem to be highly vulnerable to this effect.

The moral nature of ante-natal information

Many would say that ante-natal information is morally neutral and that imparting such information is simply giving parents knowledge upon which they can base their own decisions. In other words, the doctor performing such tests does not become morally part of an abortion if such follows from the test. In one sense this is indeed true. The 'smoking gun' is seen at the time of abortion and not during ante-natal testing. On the other hand tests which serve no purpose other than enabling the destruction of handicapped children may be seen as loading that gun.

The distress and worry which follow on from an abnormal result can be used to propel vulnerable people towards decisions which they would never otherwise have considered. The mere availability of such information appears to have conferred, for many, a duty to have the tests and abort the abnormal babies. Too often I have heard people using financial and emotional arguments to criticise those who opt to keep a baby despite knowing there is handicap. Many talk of the reassurance that normal tests can provide for parents. In fact this is probably a deception. Scans can never identify normality. They can only detect or fail to detect anomaly. The effort that goes into aborting abnormal babies generates a conditionality about pregnancy which implies and persuades mothers that disabled children are less human than others.

Morally therefore, ante-natal testing which is purely for finding anomalies may be illicit. Indeed such tests may be the preparatory work for promoting abortion. As usual knowledge is a mixed blessing.

What should we do?

We cannot ignore the tragedies that are currently occurring as a result of ante-natal screening. There is a real need to support mothers in pregnancy. They are often alone as they deal with these issues on a personal level and need to know of the risks and issues associated with ante-natal testing. They also need to know where to get support and help. We must ensure there are good, well informed pro-life Christian obstetricians and GPs to whom such women can turn for help. We need to be able to do so with the support of a deep faith and spirituality which clearly understands the humanness of the unborn child as well as the humanity of the mother, especially the mother in distress.

Since ancient times men and women have sought to discern their future. Thomas a Kempis, in his 14th century *The Imitation of Christ*, encapsulates the unnecessary disturbance of serenity we undergo by unnecessary enquiry into future conditions for which there is currently neither a moral nor effective remedy:

'What doth solicitude about future accidents bring thee, but only sorrow upon sorrow? Sufficient for the day is the evil thereof (Matt. vi, 34). It is a vain and unprofitable thing to conceive either grief or joy for future things which perhaps will never happen . . . For he (the devil) careth not whether it be with things true or false that he deludeth and deceiveth thee; whether he overthrow thee with the love of things present or the fear of things to come. Let not therefore thy heart be troubled, and let it not fear.'

Josephine Treloar is a GP in Sidcup, Kent

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// Among All Nations
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No. 3
Christian healthcare worldwide

Photo: John Crone/CMS

What are you worth?

It may all have started with a 'big bang' but it would have been a silent bang because sound does not travel through space and there was no human ear to hear it. Creation starts in the 'silence of eternity'. Each life starts silently and unseen. The template for a unique individual is laid down to be shaped by environment, the process overseen by an unseen Creator. That Creator broke the silence when he made man in his own image and gave him freedom of choice. Creation is communication. His message is the value he places on us. He has made us caretakers of his creation and of those made in his image. If we do not understand his purpose in starting the process are we qualified for *safe parenthood*?

'Missionaries are too valuable to lose', but they expose themselves to stress and danger because they believe God sees others as too valuable to lose. The articles in this issue tell of some whom society undervalues - those with leprosy, AIDS, TB. They tell of those who go to the disabled and to children without parents or without education. They tell of those who have risked their lives because some to whom they go misinterpret their message 'my God values you highly' as meaning 'I want to control you'.

Meanwhile they are themselves inadequately supported because others think that God has made too many people in his image. But God may be saying that if we assigned people their true value there would not be too many. 'Look after the pennies and the pounds will look after themselves' may apply to people as well as to money. God in Christ is still in the business of repairing the ruins made by our past mistakes. Time is short if we want to join him before he places a limit on our destructiveness.

Among All Nations is produced in partnership with the **Medical Missionary Association** and **Christians in Health Care** as the international section of *Triple Helix*. They also produce the magazine *Saving Health*, which has more articles on healthcare with mission, and a more comprehensive list of multidisciplinary service opportunities. Details on p15.

Looking forward

~

rebuilding the ruins

North Africa does not get much positive press these days. Algeria seems fixed on self-destruction, caught in the midst of an horrific civil war. Libya is forever portrayed as the haven of Arab terrorism. Mauritania is rarely mentioned - a vast, mainly uninhabited sandy desert. Morocco is infamous as the world's leading exporter of marijuana, and Tunisia is known simply for its dates and tourists. None of these countries has a society or a government favourably disposed towards Christians and yet . . against the odds God is doing something new.

Travelling in the region one is reminded time and again of its rich Christian heritage. The gospel arrived early in North Africa and historians recount how within 100 years of the first Christians becoming martyrs in what is now modern-day Tunisia, half the Roman province of North Africa professed faith in Christ. The evidence of churches, cathedrals and baptistries found in the ruins of Roman and Byzantine towns everywhere is a constant reminder of what God has done in this seemingly impenetrable area. The North African church gave Christendom such figures as Tertullian (160 - 230), Cyprian (200 - 258), and Augustine (354 - 430). By Augustine's death we know there were between 6-7,000 bishops in North Africa alone.

But in the 5th and 6th centuries the church went into decline, and it was not difficult for Islam to take over with the Arab conquest at the end of the 7th century. The crusades of the 11th and 12th centuries were the final death knell to the church, which in some small way had co-existed alongside Islam up to that point. Today there is no visible historic church in any of the countries of North Africa as there is in many countries in the Middle East. And yet in our time God is doing something new!

In the past few years the Christian praying public has begun to intercede with a new depth and fervour for the Muslim world of the '10/40 Window'. North Africa is beginning to feel the effects. Many are listening to Christian radio broadcasts. In the past year, *Sat 7*, a new satellite station for the churches in the Middle East, has been receiving half its responses from North Africa. In ones and twos people are responding in faith. The great challenge of the coming years is to see these brothers and sisters gathered into house-church congregations. The social and political obstacles are considerable but God is doing something new.

Perhaps surprisingly for a region that appears closed to Christian efforts, there are in fact some tremendous opportunities for practical service and ministry, and the need is great for those with gifts in friendship and discipling.

Let's join forces with others, not simply to pray for those whom God is bringing to faith, but also that God would call many more to work with him today in North Africa . . . for God is doing something new, he is rebuilding the ruins!

Healthcare professionals with a vision for service in North Africa are invited to enquire through the MMA office.

Looking back

some ‘working visionaries’

Retired missionary ophthalmologist Henry Backhouse reflects in September 1997 on colleagues he met in the Holy Land

I am reminded that it is 50 years since I first set foot on the Mount of Olives on Ascension Day. It was the beginning of my love for Israel and it also introduced me to some remarkable workers in that land.

Firstly that lover of people, Tom Lambie, the veteran US doctor from Ethiopia who was building his seventh hospital in the Valley of Beracah. He had heart trouble, liver trouble, blood trouble and bleeding when we joined his team six years later, and he had to be carried up into the building to supervise the work. The Muslim sheikhs from Hebron came occasionally and threatened his life if he continued to preach, but the witness went on. He died preparing his sunrise service message, whilst at the Garden Tomb talking of the seven appearances of Christ after his death.

Then there was Dr Eleanor Soltau, his successor as leader of the work. She had already lost half her right lung from TB. She was dismissed by the Mission for her responsible and independent spirit, so she and Aileen Coleman, a young Australian nurse, moved to Jordan, built their sanatorium and began to serve the Bedouin with God’s help from many quarters inside and outside the land.

They allowed no Muslim activities in their compound but served with skill and love, talked freely of the Lord Jesus, saw the *Jesus* video go out in hundreds and saw many come to a living faith, including Franklin Graham, now head of the Billy Graham organisation. We visited them this summer. Despite a severe road accident, Aileen was supervising the hospital whilst Eleanor had retired, and now aged 80 plus was pioneering a work down near Aqaba. There too literature and videos ‘disappeared’, and from time to time she would have to transport a case of TB back to base (at breakneck speed)!

Both were thinking of retiring soon and spending their time visiting their many friends throughout the Middle East, fully equipped with flannelgraphs, books, videos - in case ‘anyone would want to know about Jesus’. Sadly, Eleanor was then fatally burnt in a fire in her house. Her funeral was a gospel celebration, attended by more than 300, mostly Muslims, from the palace to the desert.

Photo: CMS

Jerusalem’s Jaffa Gate

Then there were Ida and Ada, the Mennonite identical twins, whose school in Hebron which they started almost 40 years ago is still functioning as the only Christian witness there. They left the work only when age and loss of sight demanded it. No one knows how many local children had responded to the Lord Jesus through them and their team. I came across one this year.

And there is Florence. She worked in the Lilian Trasher Orphanage in Upper Egypt until made to retire. She came to Jerusalem after 1975 feeling that there was work for her there. She got Government approval for her Church School Service to supply churches throughout the Middle East. Some years ago she had severe trouble with crumbling bones and left to organise support in the USA. She wrote recently ‘I have a broken wrist and painful teeth, but I feel that with a few months rest I shall be fit to carry on again’! Her most recent letter acknowledged that the time had come to retire, at 85! Spiritually, there is no retiring in this war and we are enjoying various ways of serving the Lord. To our joy our children and some of our grandchildren are following on.

Henry Backhouse now lives in Cambridge

It has been well said: ‘If you merely work, and have no vision, you are a drudge; if you have vision, and don’t work, you are a dreamer’. But if you have a vision, and work towards making that vision a reality - then you’re a missionary - wherever you are, at home or abroad.
The late Dr Stanley Browne, in the 1984 Maxwell Memorial Lecture. The world is crying out today for working visionaries.

A.I.D.S. a

Pat Macaulay, Chief Executive of ACET (AIDS Care Education and Training), describes the scene in Africa and Asia

As the millennium approaches and the 20th century becomes part of our history, the sudden and disastrous onslaught of AIDS ranks as one of its great calamities. The statistics speak for themselves. In the UK, government action and effective education leading to behavioural change brought the epidemic under control relatively quickly - though at the cost of 14,000 lives so far.

Elsewhere it is a different story. With over 2 million deaths every year due to AIDS, an estimated 30 million people infected with HIV, and 40 million children losing one or both parents to the disease, the social impact in the worst affected nations is nothing short of devastating.

Africa

The heartland of the HIV/AIDS epidemic today is Africa south of the Sahara. Here it is believed 7% of people aged 15-49, totalling over 20 million, are already infected. Almost 8 million children have been orphaned and in some areas only children and old people are left.

Photo: Mike Webb/Tear Fund

Uganda is one of the countries worst hit. In some urban areas a staggering one in three is HIV-positive. Here, as in most of the world, the main mode of transmission is heterosexual sex. Of particular concern are the rising infection rates in women, and consequently in children. In this mainly male-dominated society, women are often powerless to protect themselves, so, whereas in 1995 there were two HIV-positive men for every infected woman, by the year 2000 the ratio is expected to be six women for every five men. Cultural practices such as polygamy, wife inheritance and ritual circumcision with shared knives accelerate the transmission of the virus.

Nevertheless, Uganda is one of the success stories of the developing world. A highly successful national education campaign is credited with achieving the fall in the number of new HIV cases seen in Ugandan clinics now recorded for two years in succession. One UK-based Christian charity, ACET (AIDS Care Education and Training) has been at the forefront of this campaign, providing AIDS education for over 20,000 students and training over 1,000 community AIDS workers in one year alone.

But according to David Kabiswa, Director of ACET in Uganda, the efforts of the various charities involved would not alone have been sufficient to achieve what has been accomplished. The attitude and approach of the Uganda government has proved crucial. 'The President himself declared open policy on HIV and AIDS' says David. 'An AIDS Commission was set up in the President's Office, and there is an AIDS Officer in every Government ministry.' At the same time an effective surveillance system was established using data from blood banks, hospitals and clinics as well as from academic research and surveys.

Asia

Whilst Africa has borne the brunt for the last ten years, attention is increasingly shifting towards Asia, and to India in particular. With a population exceeding that of the whole African continent, and the early stages of an AIDS epidemic which threatens to be every bit as severe as Africa's, the prospects are bleak. By mid-1996 UNAIDS estimated that 2.5-5 million were already HIV-positive. By the year 2000, the number of HIV infections in India is likely to exceed the current total for the whole of Africa.

With the only effective treatments for HIV prohibitively expensive in the developing world, and with more resistant strains of the virus, effective education is the only hope for truncating the epidemic. But there is no sign as yet of the kind of government intervention which proved so crucial in Uganda.

One strategy for addressing the developing problems in countries like India is to develop successful existing campaigns in neighbouring countries into regional centres of excellence. In neighbouring Thailand for example, at the epicentre of the south-east Asian epidemic, organisations such as ACET have already embarked on education and information programmes in partnership with the Thai government and the European Commission.

Addressing the issue of prejudice is key to implementing a successful programme. Social stigma directed against those with the disease drives it underground, encouraging denial and the avoidance of HIV testing, preventing effective monitoring, and so keeping open the routes of infection.

across the world

Photo: Damian Williams

Sadly, amongst churches in the West, attitudes to homosexual people and the perception of AIDS as mainly a homosexual disease have to some extent hindered a Christian response. A response of unconditional love and care is as appropriate towards those with HIV as towards any other medical condition. A non-judgmental approach, modelled by Christ himself towards the woman at the well and the woman caught in adultery, is the only one which has any hope of winning real trust, and of opening the door for real and positive influence on people's attitudes, lifestyles and behaviour.

With the support of governments and good financial backing, the experience gleaned in the first decade of the AIDS epidemic can be put to good use in areas such as Asia and eastern Europe, where it is still soon enough to make a difference.

Pat Macaulay became Chief Executive of ACET in 1995 after working for 18 years in NHS financial management and six years in the private sector. She visited Uganda and Thailand on behalf of ACET in 1996 and 1997

For further information about ACET please contact **Bruce Townsend** on 0181-780 0400

'The staff actually touched me'

Damian Williams discovered in Thailand that leprosy and AIDS share something in common

Medically speaking leprosy and AIDS are worlds apart. One owes many of its symptoms to an overactive immune response whereas the other is a failure of the immune system. Yet during my elective I saw a very important link.

Manorom Christian Hospital was started 40 years ago in central Thailand. Since then it has provided excellent health care for the local people but most especially has sought to reach out to those with leprosy, people with very real physical need but who are cast out by society, as in the time of the New Testament. Just as Jesus cared for the outcast, so the staff at Manorom have extended Jesus' love to those with leprosy. The results are dramatic. Of the 5,000 patients they have treated and continue to treat, 1,000 have come to faith in Christ. Not only have their physical needs been met but even in a Buddhist country their deepest need has been met. Now there are far fewer patients with active leprosy and it is here that the link with AIDS becomes evident. As leprosy becomes less prominent so AIDS is emerging as a significant problem. Just as 40 years ago leprosy left the person an outcast, so today AIDS has similar devastating consequences.

I shall not forget the day I spent at a hospital in Bangkok. We arrived early for the clinic and so went up to the AIDS ward. I was not sure what to expect. It was perhaps a good thing, as I'm not sure I would have chosen to go if I'd have known what I would see. The ward was just a big room with about 24 beds, back to back, housing both men and women. Words cannot describe the suffering. Young men and women barely had the strength to move or care for themselves. They were without hope, simply waiting for death. Perhaps even worse, many with AIDS know not only physical suffering but also the pain of being rejected by family and friends.

The outpatient clinic heralded even more suffering. One young woman was so ill that she could barely walk. She was covered in sores from head to foot and had severe abdominal pain. She lived alone. She was just one of the 400 people who came to the clinic that day, a clinic that runs every Wednesday. Manorom have now opened their own AIDS ward to provide for the growing need and to continue to show Christ's love to those rejected and broken. A 30-year-old male patient told his story:

'I was always a strong kid, doing all kinds of physical labour and never thinking anything about it. So, when I started to feel weak and tired all the time I knew something was wrong. I went to one hospital in Bangkok where they took some blood for examination. They talked among themselves; they didn't really tell me what was wrong, but said I needn't go back to them again. That seemed strange . . . then I shopped around at several more hospitals in Bangkok. One of them told me I had AIDS but there wasn't anything to do for it right now.

Only my Mum and Dad knew. I was afraid to tell my friends or my fiancée. I knew she'd dump me on the spot! Then a friend told me about Manorom Christian Hospital, up in the boondocks. After I was well enough to know what was going on, I was amazed at the care I received. The staff actually touched me.'

Damian Williams was a medical student in Birmingham when he did his elective in Thailand with the help of an MMA grant

review:

Antony and Maggie Barker - Lives in Tandem

Lives in Tandem Barry Adams. Adams, Long Melford. 1996. 168 pp with 34 photographs in B&W. £10 Pb plus £1 p&p. Obtainable from the author: E B Adams, Fernlea, Hall Street, Long Melford, Suffolk CO10 9HZ

'Travelling until journey's end.' They were both medical students in Birmingham. Maggie, who had previously trained as a nurse, was committed to work for three years with the Society for the Propagation of the Gospel (SPG). Antony 'married into a missionary career'.

After brief service with the Merchant Navy during the war they both went with the SPG to The Charles Johnson Memorial Hospital at Nqutu in Zululand and stayed for 30 years. They built up the hospital on a shoestring to 600 beds but never had a home of their own - up to 15 people met for breakfast in their apartment each morning. They never owned a car.

Their reputation became legendary. They demanded the highest medical standards compatible with the resources in the hospital and developed a community service sensitive to the felt needs of the people without downgrading the hospital.

They had countless visitors from students to academics, such as the author of this book, who was a professor of medicine in the University of Natal. They had their disappointments - Maggie especially that they had no children of their own, and Antony who was invited to apply for a post to establish a Department of Community Medicine in Durban and was then turned down by the state. They would have succeeded anywhere and subsequently ran the Accident and Emergency Service at St George's Hospital in London. However, the fascination of this book is its study of how they worked, lived, entertained and cycled together.

The hospital at Nqutu was a haven of racial harmony at a time when apartheid was becoming its worst. Maggie especially made everyone feel important though she always took the back seat and her influence was not always recognised. When Antony went (on his cycle) to Buckingham Palace to receive his CBE he is reputed to have said to her 'I hope you don't mind about this Mags!' She replied 'No, I don't, so long as you do'. They were not evangelistic verbally but their faith was central to their lives from schooldays on and was seen in their works, their worship and their words. Antony was about to speak to the students in Natal University and they were going to give him a hard time. He announced 'I am what is known as a Jesus freak' and received a hearing.

They had wanted to die together, and this happened on their tandem after celebrating their golden wedding and revisiting the scenes of their honeymoon in the Lake District. Besides multiple injuries the post-mortem revealed subarachnoid bleeding in Antony that may have preceded the accident.

Any would-be surgeon should read Antony's letter to Mrs Theodora Mncube in Appendix 1.

David Clegg

resources:

Barker Memorial Prize

This prize of £250 and a certificate is given by the Trustees of the Barker Memorial Fund to the author of a paper published in *Tropical Doctor* annually. It should be concerned with health and disease among the sort of people for whom the Barkers worked - the dispossessed, or poor urban or rural communities. For further details see *Tropical Doctor* 1997, January or April. Address: Tropical Doctor, 1 Wimpole Street, London W1M 8AE

Mansion Trust (India)

Abbreviated, the purposes are: to provide scholarships to students of Indian origin, who are undertaking courses in medicine, surgery or nursing in India with the intention of serving the people of India . . to provide non-recurring grants of a capital nature for Christian Mission Hospitals in India . . . to assist doctors to establish surgeries or dispensaries in areas of need in India.

All correspondence to: The Secretary, Mansion Trust (India), 101 Queen Victoria Street, London EC4P 4EP, England

MEDAIR

The next 'Crisis Situation Seminar' is July 3-12 1998 in France and will be bilingual. Aims include preparing both short- and long-term candidates to bring assistance in disasters and introducing biblical principles of relief work.

Apply: MEDAIR Personnel Dept, Chemin de la Fauvette, 98, 1012 Lausanne, Switzerland. Tel. +41 21 654 32 30. Fax +41 21 654 32 40. E-mail: medair@compuserve.com

Nurses Christian Fellowship International

Those interested in membership and subscribing to *Christian Nurse International* should contact: NCF International, 18 Buckland Road, Maidstone Kent ME16 0SL

Wallington Missionary Auctions

Jewellery, silver, antiques, oil paintings, porcelain etc needed for auction to support missionary work. You can specify the mission - eg MMA.

Contact V W W Hedderley OBE, 20 Dalmeney Road, Carshalton Surrey SM5 4PP. Tel. 0181-647 8434

RESIDENTIAL REFRESHER COURSE

For Christian Doctors, Nurses and Midwives Working Overseas

June 22-July 3, at Oak Hill College, Southgate, London. Jointly organised by Christian Medical Fellowship and MMA.

Cost: Single from UK or a developing country £240, married couple £380. Single from developed country £350, married couple £600. Brochure and booking form available from:

Dr David Clegg, General Secretary MMA, 157 Waterloo Road, London SE1 8XN. Tel 0171 - 928 4694 Fax 0171 - 620 2453
E-mail 106333.673@compuserve.com

vacancies overseas:

Please note that medical mission posts often require you to raise your own support (though some missions can help with this) and to have the support of your home church.

AFRICA

Benin

Andrew Potter requests a locum ophthalmologist to work in the Protestant Eye Clinic in Cotonou for 3 years so a local doctor can go for further training - enquire CMF/MMA

Burundi

Suitably qualified and experienced medical director/general surgeon required for one year (or longer) from April/May 1998 in a Surgical Unit, Bujumbura. The centre provides a 24 hour emergency service particularly for war-wounded, as well as dealing with planned surgery. Responsible for directing a multi-professional team of about 10 nationalities including 3 part-time surgeons. Apply in writing with CV: Mary Larkum, Health Projects Manager, African Revival Ministries, c/o 32 Salisbury Avenue, Sutton, Surrey SM1 2DJ. Fax: 257-21-72-45 (Bujumbura) or e-mail marylark@cbinf.com

Kenya

Chogoria Hospital (Presbyterian Church of East Africa) requires surgeon (now), physician (from August 1998), paediatrician (from May 1998). Terms of appointment 6 months to 3 years. Includes teaching students, interns and family practitioners. Research encouraged.

Executive Officer for 2 to 3 years. Busy 312-bed hospital with extensive primary health care programme. Enquiries: Rev Ray Gaston, Staffing Secretary, Department of World Mission, Church of Scotland Offices, 121 George Street, Edinburgh EH2 4YN

Uganda

Mildmay International is seeking an Assistant Medical Director for its new AIDS Palliative Care Centre. (A Christian doctor is sought with experience in HIV/AIDS medical care as well as general management.) Involves Christian leadership and general management responsibilities as well as clinical work and teaching. Scope for research into appropriate AIDS care services in resource-limited settings. Contact Mrs Ruth Sims, Chief Executive, Mildmay International. Tel. 01702 394450. Fax 01702 394454. e-mail Mildint@globalnet.co.UK

Kulava Hospital requires a general surgeon for 3 years. Nominal salary. Contact Dr David Morton, Kulava, PO Box 28, Arua, Uganda or e-mail Peter Bewes: cme_ug@starcom.co.ug

ASIA

Bangladesh

Several short term opportunities exist for medical, nursing and physiotherapy staff at the Lamb Hospital. The hospital is primarily for obstetrics although there is some inpatient paediatrics, TB and a little general surgery. The inpatient opportunities are mainly for women staff but there are large outpatient TB and community health projects which would be open to men and women. Enquiries: Interserve, 325 Kennington Road, London SE11 4QH. Tel. 0171-735 8227. Fax 0171-587 5362. E-mail 100014.2566@compuserve.com

Nepal

Baptist Missionary Society seeks a Tutorial Group Teacher at Amp Pipal Hospital from Easter 1998. Enquiries to Dr Helen Johnston, P O Box 126, Kathmandu, Nepal

Pakistan

Urgently required: a Christian ophthalmologist to work short- or long-term at the Gilgit Eye Hospital, a Christian institution in a fairly remote mountainous region in northern Pakistan. Applicants will need their own funding. Enquiries to Dr Stephen Smith, Box 549, Gilgit, Pakistan. E-mail: ssmith@vision.sdnpk.undp.org or to Vision International Healthcare Limited, PO Box 248, Tunbridge Wells, Kent TN2 4YT. Tel. 01892 518358. Fax 01892 518381. E-mail 100142.3521@compuserve.com

EUROPE

Albania

Children in Distress are looking for a doctor to lead a team of British nurses and Albanian staff in a non-acute medical hospital they have opened in the town of Sarandra for a period of 3 months or more. Contact Rev Dr J Walmsley, Thirsk Industrial Park, York Road, Thirsk, N Yorks, YO7 3BX. Tel. 01845 526272. E-Mail info@children-in-distress.org

MIDDLE EAST

Egypt

Specialists needed to spend 2-3 weeks sharing their expertise with staff of a small ex-German Mission Hospital in Aswan, Southern Egypt. There is a small dedicated team of Egyptian doctors who would love to have a specialist in surgery, cardiology, gynaecology, urology or paediatrics share their knowledge with them. Medium is English. Information from Dr John Coleman. Tel. 0181-985 7525. Fax 0181-981 3966. E-mail 100530.620@compuserve.com

WORLDWIDE

African Inland Mission has many opportunities for healthcare professionals including: Chad: nurse midwife. Kenya: doctor/surgeon, pathologist. Lesotho: GP.
Contact AIM, 2 Vorley Road, Archway, London N19 5HE. Tel. 0171-281 1184. E-mail: africa.mission@ukonline.co.uk

Christian Dental Fellowship - for dental opportunities apply for membership to CDF Secretary Anne Hallows, 44 Pool Road, Hartley Witney, Hook RG27 8RD or Tel. Missionary Secretary Mr David Sherwin 01271 812827

The Leprosy Mission (urgent needs). Bangladesh: reconstructive surgeon, rehabilitation specialist. Democratic Republic of Congo: senior administrator. Indonesia: POD consultant. Mozambique: doctor. Nepal: medical officer. Nigeria: physiotherapist/occupational therapist. Contact The Leprosy Mission, Goldhay Way, Orton Goldhay, Peterborough PE2 5GZ. Tel. 01733 370505. E-mail: TLMEW@cityscape.co.uk

Volunteer Missionary Movement. Kenya: doctor for 130-bed Mutomo Mission Hospital, in-service training in minor surgery and tropical medicine. Malawi: Two nurse and/or midwife tutors for St Joseph's Hospital, Limbe, near Blantyre. Tanzania: experienced medical professionals especially surgical desperately needed for Bugando Hospital to join a VMM anaesthetist already there. May suit early retirement. Uganda: experienced surgeon and other medical professionals required for an isolated, challenging (insecure) region in the North. May suit couple. Training given. Apply Monica Pereira, VMM, 1 Stockwell Green, London SW9 9JF

Among All Nations is produced in partnership with the Medical Missionary Association and Christians in Health Care as the international section of *Triple Helix*. They also produce *Saving Health* which has more material on healthcare with mission, and a more comprehensive list of multidisciplinary opportunities for service. This is currently produced two to three times a year, and is available for a minimum donation of £5 per annum (£3 students, missionaries and retired).
MMA has a database of people who would like to be contacted when a suitable opening in a mission or church hospital is notified. Please contact for a form.

Medical Missionary Association
Registered Charity 224636
General Secretary: Dr David Clegg. 157 Waterloo Road, London SE1 8XN. Tel. 0171-928 4694. Fax 0171-620 2453. E-mail 106333.673@compuserve.com

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

a world of *opportunity*

Physiotherapist **Jane Tompsett** helped set up a community based rehabilitation project to empower disabled people in Nigeria

The Evangelical Reformed Church of Christ was founded by the Sudan United Mission in 1916. Today, under national leadership, it is still committed to evangelism and training believers in discipleship, while on the medical side it runs a comprehensive health centre in Alushi with 30 dispensaries, and a training school for community health extension workers.

In 1997 the church launched a community based rehabilitation (CBR) project, following the example of Jesus who sent this message to John the Baptist: 'The blind receive sight, the lame walk, those who have leprosy are cured, the deaf hear, the dead are raised and the good news is preached to the poor'. The project aims to identify disabled people of all ages and to encourage and empower them to take part in the normal life of their family and community. It also aims to share the love and good news of Jesus with them. Priorities include:

- Arranging for the vaccination of children. In Nigeria nationally only 27% of children were receiving polio vaccination, hence the disease is still endemic and is the largest cause of disability in children.

- Providing mobility aids for polio patients who can only crawl. Local craftsmen are trained to make callipers, skateboards to sit on and hand driven bicycles. Parents need motivating to persist with the use of callipers.

- Encouraging parents of disabled children to send them to the local school.

- Supporting teachers who had accepted disabled children into their class. The CBR workers found that only 10 of the 62 disabled children were attending primary school.

- Providing medical eye services and spectacles. Eye problems formed over half the CBR work.

- Encouraging disabled adults to earn a cash income in some way.

Initially we employed Namo Malle, an experienced health worker and a church elder, to supervise the project. He worked alongside me for a year and visited other CBR projects to catch the vision of what could be done, then we employed eight local people as fieldworkers. They were all in their early twenties and had trained at the ERCC School of Health and Technology in Alushi.

Several of these young people have relatives who are disabled, which gives them a natural empathy with their clients. They were given three weeks training on disability issues, especially identifying eye problems, then we sent them to join church outreach teams in the villages. Each fieldworker was given a bicycle to visit disabled clients. Over the first months they all completed a Theological Education by Extension (TEE) course entitled 'Following Jesus'.

I quickly learned that our clients were the experts. Our most important role was to listen. This was brought home to me by one 50-year-old man who had had polio as a child. Despite having to crawl from place to place he earns his living mending shoes. I offered him a skateboard or a bike at 10% of its production cost, but was rebuked: 'What good are they? I have a wife I haven't paid for yet!' Paying for his wife was the priority for him and for his wife's relatives who would no doubt have made him sell any mobility aid he got to pay off his debt.

Photo: Jane Tompsett

Many families had integrated their disabled member into a household routine, but most of the disabled remain underutilised. The teenage girl in the photo was born with club feet and could only bottom shuffle. Her elbows were permanently straight but she could plait other girls' hair and prepare melon seed for cooking. Her mother was teaching her at home but she had never attended school.

Our task was to assess and listen and be a catalyst for positive change, perhaps helping with a wheelchair so she could move out of the compound. Supporting the family would enable this girl to reach her full potential.

Jane Tompsett is a physiotherapist who was employed by Tear Fund to work in central Nigeria with the ERCC from 1994 to 1997. She is now doing an MSc in Community-Based Disability Studies with the help of an MMA grant.

Jonathan Livingston Seagull beats The Bible

In its Christmas edition, the *BMJ* invited suggestions for books to broaden the horizons of the medical profession. The winner was *Jonathan Livingston Seagull*, whose New Age spirituality can be gauged from one voter's describing it as: 'about self transcendence . . . we are all capable of recreating ourselves in the shape of our dreams'. The Bible was in 8th equal place. (Source: *British Medical Journal*, 21 February 1998; 316: 637)

Lords study cannabis risks

A House of Lords Committee will study the risks of taking cannabis for medical and recreational purposes. Its two key questions are: 'How strong is the scientific evidence in favour of permitting medical use?' and 'How strong is the scientific evidence in favour of maintaining prohibition of recreational use?' A call for legalisation is not anticipated. (Source: Anthony Bevins, *The Independent*, 6 March 1998)

Drivers on drugs

16% of 619 people killed in road accidents in a 15-month study had taken illegal drugs, compared with 3% in a 1985-87 study. Drug testing of motorists is planned. Please could their Lordships take note? (Source: *British Medical Journal*, 21 February 1998; 316: 572)

Dolly, Polly, Mr Jefferson

Readers might be forgiven for thinking Eutychus is obsessed with the cloning of animals, but the birth after nuclear transfer of a calf called Mr Jefferson has now been announced. The science is moving fast, as a public consultation about human cloning takes place. And shouldn't the calf have been called Miss Jefferson? (Source: *British Medical Journal*, 28 February 1998; 316: 646)

White witches join animal rights activists

Staying with animals, white witches gathered outside a farm in Oxfordshire where cats are bred for experiments to burn an effigy of the owner, to create 'some good vibrations', and to 'help to dispel any murky black energy around and evoke the Earth Mother'. White witches believe they share an affinity with cats. (Source: Jane Cassidy, *The Big Issue*, February 16-22 1998)

'Jane Roe' now opposes abortion

Norma McCorvey is the real name of the American woman in 'Roe v Wade' who lied that she had been raped and was exploited by pro-choice lawyers to bring legalised abortion to the USA 25 years ago. 35,000,000 abortions later, her story includes the fact that she herself never had the abortion, and that in 1995 through the loving witness of *Operation Rescue* at her abortion clinic in Dallas, she became a Christian. She now campaigns actively to overturn Roe v Wade. (Source: Hugo Gurdon, *The Daily Telegraph*, January 20 1998)

Virgin brides disappear in UK . . .

In the 1950's, 40% of UK women married before they had sex compared with less than 1% now (Source: Jeremy Laurance, *The Independent*, 12 February 1998)

. . . and New Zealand women regret early intercourse

54% of New Zealand women in a study wished they had waited longer before first intercourse, and this rose to 70% for women reporting intercourse before age 16 (Source: *British Medical Journal*, 3 January 1998; 316: 29-33)

Convictions rise for child prostitution

The Children's Society announced in January that the number of children convicted of prostitution offences in England and Wales had more than doubled in one year. Convictions of those aged 17 and under were 210 in 1996 compared with 101 in 1995. (Source: *The Independent*, 30 January 1998)

Two cultures in nursing?

Peter Fisher, Chairman of the National Health Service Consultants' Association, has joined the debate between Faith Search, Angela Plume and Professor Powers elsewhere in this issue. He writes 'Reports of a crisis in nurse recruitment should be heeded . . . there is a sense of two cultures within a hospital. One is traditional, with practical concerns about patient care and how to manage with not enough beds and too few staff on duty, the other occupied with techniques and language imported from the business school.' (Source: Letter to *The Independent*, 29 January 1998)

Credit unions needed for health students?

Responding to the growing problem of student debt, felt most particularly in medicine, Mark Pickering asks about the possibility of a student/doctor credit union where Christian doctors could offer interest-free loans to hard-up Christian students in the local medical school. He writes 'the next generation of medical students will be even worse off'. (Source: *Nucleus*, January 1998, p29)

Muslim requests 'quiet rooms' for hospital staff

Emphasising that 'prayer has a pivotal role in the life of Muslims' requiring formal prayer five times a day, Dr Aziz Sheikh suggests that all hospitals should have a 'quiet room' which would be 'set aside for prayer or meditation or reflection, which is open to those of any faith or indeed no faith'. What do chaplains think? (Source: *British Medical Journal*, 13 December 1997; 315: 1625)

Three score and ten is all we have?

Scientists in the USA have significantly extended the life span of cultured human cells by adding an enzyme called telomerase. There has been no sign of abnormalities. Excitement has been generated - some believe age-related ailments could be controlled, others that the human life span could be extended beyond 120 years. But will the telomerase-positive cells be more prone to cancer? (Source: *British Medical Journal*, 24 January 1998; 316: 247)

Eutychus

prayer at the bedside

Has medical science made prayer for healing out of bounds? asks **David Short**

Dr Martyn Lloyd-Jones, the Welsh physician-cum-preacher, once wrote a monograph titled 'Will Hospital Replace the Church?'[1] He pointed out the unique and vital role of the church in meeting the spiritual needs of hospital patients. Three decades on hardly anyone would argue with his view. Even the Department of Health recognises it[2]. Now the question is: Does the church also have a role in the relief of bodily and mental disease?

It may be argued that health should not be divided up in this way. But there is a real sense in which the answer has to be 'yes'. I like Wilkinson's Bible-based definition of health as 'a state of wholeness and fulfilment of man's being, considered as an undivided entity.'[3] But for clarity of thought I return to the question: Does the church have a role in the relief of physical symptoms? If it does, it must be admitted that on the whole it does little in the way of exercising it. Very little is reported, in the UK at least, of close co-operation between clergy and doctors in hospital practice. The exception seems to be in the work of hospices.

Healing in history

When we turn to the Gospels we see that bodily healing figured prominently in the ministry of Jesus. The Book of Acts describes how it was continued by the apostles, notably Peter and Paul. For centuries the churches exercised a major role in the matter of healing. The church led the way with the founding of hospitals in Western Europe. This involved ministry to both physical and spiritual needs (though, inevitably, the scope for physical help was very limited). In due course this process was repeated further afield. The main impetus for the building of hospitals worldwide has arisen from the concern and activities of Christians[4].

During the last 200 years, however, and particularly the last half-century, medical science has developed and specialised to an extent which earlier ages could never have envisaged. This has become one of the supreme benefits of Western civilisation. Today, not even the most convinced Christian Scientist or faith healer, seriously hurt in a road accident, would be driven past a centre of medical excellence.

Now that science is able to do so much for patients, the church is widely perceived as redundant. It keeps a toe in the door in the person of the hospital chaplain, but this is almost entirely for spiritual ministration. Nevertheless there are still - and always will be - large areas of physical need which medical science cannot meet[5]. The time comes in every illness when nothing more can be done. Often even attempts at alleviation fail. It is a case of 'Guerir quelquefois, soulager souvent'.

In many parts of the world effective medical care is simply not available. What then? Is God now limited to the abilities of medical science? Is he no longer able to do what he did before? Has he ceased to answer prayer? Is prayer for healing out of bounds?

Prayer for healing

No Christian believer can accept that the power of an omnipotent, unchangeable God has declined. Jesus encouraged his disciples to pray about their physical as well as their spiritual needs[6]. The Apostle Paul, when he suffered what he described as 'a thorn in the flesh' did not hesitate to ask God to remove it[7]. The fact that his prayer was not granted was not because it was an improper request, but simply because God had something better for him.

James, the brother of Jesus, positively encouraged Christians to take matters of severe illness (Gk asthenia) to God. 'Is any one of you sick?' he asks. 'He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord. And the prayer of faith will make the sick person well.'[8] For these reasons it never ceases to amaze me both how little we take up God's offer and how little provision there is made for it in hospitals where there are always Christian believers with serious or potentially serious diseases. To what extent are hospital chaplains and patients' ministers involved in the ministry of prayer for bodily healing? Surely, there is a great avenue of blessing here.

There are two caveats which need to be made. One is that we should never go to the extreme of regarding bodily healing as the greatest of God's gifts. The other is that we must never regard prayer as another medicine; worth trying if other prescriptions have failed. Becoming a new creature through faith in Christ and the power of the Holy Spirit is paramount. And we must desire the will of God above everything else, and believe that he hears our prayers and will do what is best for us.

Some might argue that what applied in the first century no longer applies in a society blessed with a skilled and effective medical profession. But, as we have seen, the medical profession is not able to bring relief to all illnesses. More significantly, experience shows that when action is taken along the

lines indicated by the Epistle of James, real blessing has followed.

Experiences of answered prayer

I have been fortunate, in my capacity as an elder in a Brethren church, to be involved in a ministry of Christian healing in response to the exhortation of the Epistle of James. In each case I acted in an ecclesial rather than in a medical capacity, and those ministered to were not my patients. Although no dramatic healing occurred, each patient experienced a definite and lasting improvement in health and well-being.

My earliest experience was in the 1940s, just before the arrival of streptomycin. A young man, the son of the church caretaker, had been ill for months with abdominal tuberculosis. He was deteriorating in spite of the best medical treatment available. The parents asked the elders to come and pray for him and anoint him in accordance with the instruction in the Epistle of James. We did so and within days there was an obvious improvement, though it took some months before he was completely well.

More recently a middle-aged woman with long-standing diabetes and retinopathy started to suffer a severe headache. She was under an excellent physician but he could find no way of giving relief. Nothing happened for a few days after our session of prayer and anointing. However a week later the consultant decided on a new line of treatment which gave rapid, complete and lasting relief.

My third example did not arise from a request from a patient, nor did I use oil. It concerns an 80 year old woman who developed sciatica and this prevented her sleeping. Her GP prescribed tablets without effect. When called again he said there was nothing he could do. I was on holiday and four weeks had passed by the time the problem came to my notice. I went to see her as soon as possible and found her sitting in a chair utterly worn out. I told her son that he must request another visit from the GP.

But before I left the house I committed the old lady to God in prayer, standing beside her with my hand on her shoulder. I simply prayed that God would grant relief from her pain. I envisaged that the GP would come and institute treatment which, with God's blessing, would be effective. Next Sunday the patient was back in church beaming all over her face. She told me that immediately after my prayer her pain was gone and she had her best night's sleep for weeks. There was no return of the pain.

You may say 'There's no big deal, no convincing miracle'. All right. But try telling that to the invalids. And recognise that in each case God was glorified and praised. Nor is God's power limited to relatively minor interventions. Dr Stanley Thomas, who worked as a surgeon in India for 30 years, gave evidence before the BMA Board of Science's working party on alternative therapy. He told of a case of a young man in the last stages of typhoid. To the astonishment of a group who fell on their knees in prayer, he literally sat up and was normal from that moment. This was the only case from his years in India that Dr Thomas was prepared to call a miracle[9].

Prayer in hospital

So can the principles enunciated in the Epistle of James be applied to patients in hospital? I see no reason why church elders should not come together around a hospital bed, especially if the patient is in a single room or screens are drawn around the bed. One obstacle might be the reluctance of the patient to appear to be over-reacting to the illness. At the other extreme the patient may be unconscious. In that case a request may come from a relative.

Another option is involvement of the hospital chaplain. If a chaplain is willing to act in this way it would be valuable for this fact to be stated in the booklet issued to patients on admission. It could say: 'A member of the chaplaincy team would be happy to visit you if you wish, and to pray for God's healing and his blessing on whatever means are advised by the medical and nursing staff. Simply indicate your wish to the nurse in charge of your ward or department.'

If patients who are not church adherents felt inclined to take advantage of this offer, it would give the chaplaincy an opportunity to minister to them. It would need to make clear that prayer is not a magic ritual but simply a humble request to almighty God for mercy and help - either directly, or guiding hospital staff in their treatment. It is important that doctors should encourage chaplains to exercise their specialist role as ministers of the Gospel and not to view themselves as auxiliary social workers.

Three principles in the church's ministry of bodily healing:

1. Healing is not the church's primary task. Its primary task is calling everyone to be a disciple of Christ[10].
2. Prayer should never be regarded as an alternative therapy - something worth trying when all else fails.
3. Intervention by the church should not delay or replace medical help. Both prayer and science are God's provision. John Wesley gave sound advice when he said patients should first seek 'a physician that fears God' and 'above all add to the rest (for it is not labour lost) that old, unfashionable remedy, Prayer; and have faith in God'.[11]

David Short is Emeritus Professor of Clinical Medicine, Aberdeen University

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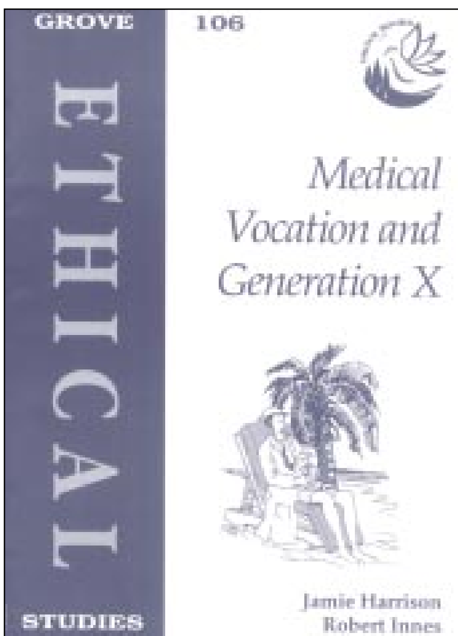
reviews:

Medical Vocation and Generation X

Jamie Harrison and Robert Innes. Grove Books Ltd, Cambridge. 1997. 24pp. £2.25 Pb.

This booklet is a re-examination of the concept of medical vocation in the light of the radical changes which are taking place in the organisation and practice of health-care. The authors, one of whom is medical and the other a theologian, paint a portrait of 'Generation X' - the generation born since 1960 - and emphasise their desire to find fulfilment not just through their work but also in family life, cultural pursuits, friendships, and an inner spiritual life.

They state that the notion of doctor as a 'self-sacrificing parent' cannot be sustained in the modern world. As they put it 'The era of the 24-hour-a-day, 365-days-per-year doctor has gone'. The ethic of unstinting self-sacrifice still persists in the medical profession, but often with unfortunate results - witness the appallingly long hours which were, until recently, tolerated among junior doctors.



As I read through the first four chapters, I thought the authors might be about to conclude that the whole concept of vocation was out of date. Not so. In chapters five and six they spell out the concept of vocation in a new and satisfying way - a way they describe as 3-dimensional, and which includes relaxing and sharing in family life. To find out more about the philosophical and Scriptural basis of this concept, read the booklet and especially the last two chapters for yourself.

David Short
(Emeritus Professor of Clinical Medicine, Aberdeen University)

A Window to Heaven

Diane Komp. Highland Books, Godalming. UK edition 1996. 128pp. £3.99 Pb.

While most of us yearn for a glimpse into heaven, a book about dying children is not what we would readily choose as a gift for ourselves or a friend. However, to pass by this short paperback without a second look would be to miss a little gem. The subtitle 'When children see life in death' summarises a positive view taken of situations most of us would find emotionally difficult and clinically challenging.

Easy to read, the subject matter deals primarily with children's spiritual experiences surrounding death. Diane Komp writes from her own perspective as Professor of Paediatrics at Yale, and tells the stories of children in her specialty of paediatric oncology. It is clear the author has not sought the protection of distancing herself from these situations but has learnt to love her patients, whether their lives are long or short. In so doing, she has been able to learn much from them.

The book also chronicles Professor Komp's own personal journey to faith in the One who holds the answers to life's many difficult questions, and to death's. Like many young doctors she found that the path of medical education (long working hours, the problem of suffering etc) became a journey to disbelief. At the beginning of her specialist career her 'faith began to slip away with each passing child'. As we share in the life stories of her patients, we see how the children were able to 'teach' their professor a number of life-changing truths.

And now the warning! Though the flow of the stories is easy, I did not find the book easy to read. Heartwarming? - yes. Challenging? - yes. Humbling? - yes.The chapter in the book entitled 'Facing Mount Moriah' brought tears to my eyes as I revisited in my thoughts a number of situations where I have 'walked', for a little way, with parents who have been called upon to accompany their child up that steep slope of suffering, knowing they may be expected to give up their beloved offspring.

Their pain is real, but these children's stories add their own evidence that, in Christ, death can be transformed by that touch of love into a window to heaven. Several times while reading this book I was reminded of the phrase 'a little child will lead them' (Isaiah 11:6).

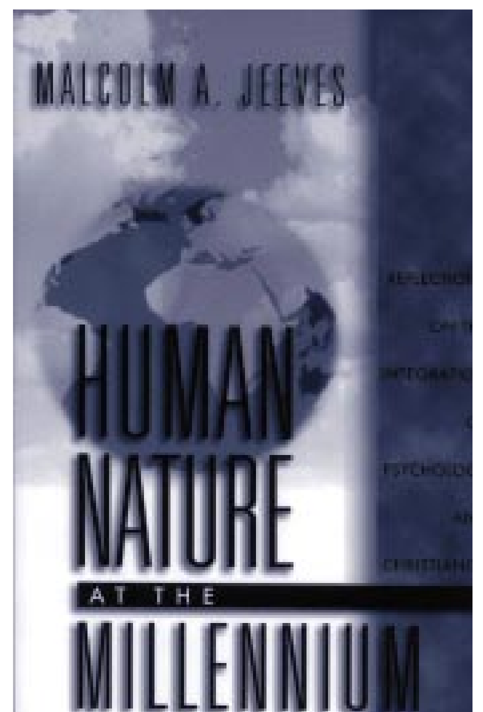
Steve Richardson
(Consultant Paediatrician, Barnstaple)

Human Nature at the Millennium

Reflections on the integration of psychology and Christianity

Malcolm Jeeves. Apollos (IVP), Leicester. 1997. 254pp. £14-99 Pb.

When asked to review a book dealing with psychology and Christianity I confess I groaned inwardly at the thought, not because the subject isn't important but because so many writers have attempted this in the past and produced works which are sadly inadequate.



Christian critiques of psychology have frequently been well intended but have lacked an adequate understanding of what psychology is. Similarly, those psychologists who have commented on matters religious have often done so as outsiders who do not necessarily understand the essential Christian message. This book, I am pleased to say, is different. The author is an eminent psychologist who well understands both his discipline and the teachings of the Christian faith. The work is serious, scholarly and at times challenging. Jeeves addresses issues such as personology, the nature of consciousness and the relationship between brain and mind, drawing extensively on both psychological research and the Bible. It is not an easy read but one which those who are interested in these questions will find rewarding.

The author's emphasis on questions related to neuropsychology no doubt reflects his own academic interest. (He is a former President of the International Neuropsychological Symposium.) While this adds to the depth and scholarship of the work, it can at times leave the practitioner feeling that something is missing. Jeeves' discussion of homosexuality, for example, points out that sexual victimisation of children by adult homosexuals or others is not a factor in the development of a homosexual orientation. This conclusion is well supported by the research evidence, but those of us in clinical or counselling work know only too well the doubts and fears about their sexual orientation that victims of abuse often suffer. His criticism of the 'gay gene' hypothesis and defence of heterosexual monogamy as the only legitimate 'one flesh' experience make more satisfying reading.

In short, this is a timely and helpful text, if a somewhat academic one. It should prove useful to students, teachers and anyone who enjoys having their neurones engaged.

John Steley
(Psychologist, London)

Genetic Ethics

Do the Ends Justify the Genes?

Eds John Kilner, Rebecca Pentz and Frank Young. UK publishers Paternoster Press, Carlisle. 1997. 291pp. £19.99 Pb.

This book tackles from a Christian perspective a number of the ethical issues raised by the rapid developments in human genetics. It confronts most of the common problems but does not address recent controversies such as the debate over cloning whole animals (and potentially humans?) nor the questions surrounding genetically engineered foods. Different emphases are applied by different authors. Dyck for example states that 'one of the major ways in which the concerns of negative eugenics were and are being pursued is through centres for genetic counselling'. The quality genetic counselling described later in the book by Thompson paints a wholly different picture and Anderson states 'genetic counsellors are playing a central role in limiting the reductionism that might otherwise occur and are in a good position to interpret test results back to the individual and wider family'.

Francis Collins portrays the potential medical benefits of the Human Genome Project, whereas Verhey asks 'should we allocate so many resources to the Human Genome Project when we do not have the resources for the poor or the homeless?'

Walters discusses research into the genetic basis of personality traits, IQ, and violent and aggressive behaviour without really questioning its validity or any inherent dangers in these studies. He sees germline gene therapy as acceptable providing scientists can repair or replace the faulty gene, not simply adding a good gene whilst leaving the faulty one in place.

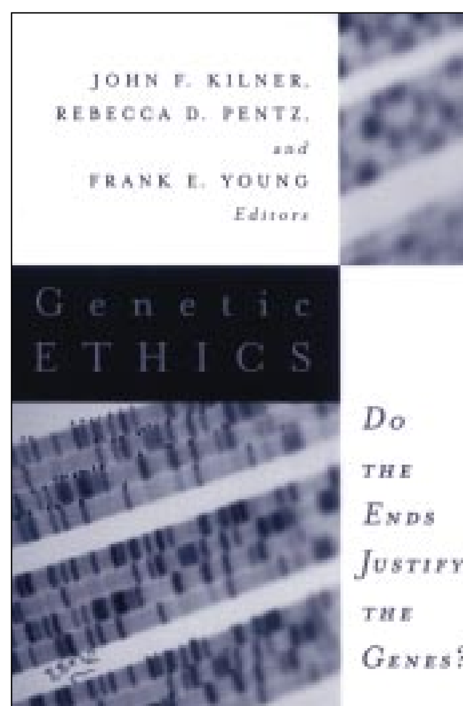
Hook provides a well-balanced review of genetic testing and deals with the issue of confidentiality in relation to other family members including potential spouses, employers, insurers, etc. He argues that confidentiality without exceptions poses ethical problems, commenting that some patients withhold information from relatives for sinful reasons, and that failure to disclose may sometimes endanger life.

Rae is a strong advocate for the rights of the genetically handicapped fetus and argues persuasively against the assumption of abortion if prenatal diagnosis reveals an abnormality. He opposes preimplantation diagnosis as this results in the discarding of abnormal embryos.

Four chapters are devoted to genetic intervention, largely considering the ethics of gene therapy to enhance normal parameters such as height or intelligence, should such things ever become possible. There would undoubtedly be a market for this as conventional therapies are already used for this purpose, eg growth hormone treatment in non-GH deficient short stature.

What approach should be taken? If we can do it, ought we? Sherry argues, in a chapter on patenting laws, that the commercial incentives driving biotechnology research could accelerate developments that are ethically questionable.

How should the church respond? Mitchell urges celebration for some developments, caution that genetic reductionism may result, and outright resistance to other possible outcomes including widespread pre-natal screening (if this becomes possible) and gene-based discrimination.



This American book makes a thoughtful and stimulating read. Because of the variety of views expressed within it, it is important to read the whole book to obtain a full perspective despite the temptation to dip in to certain chapters that capture the imagination. The personal experiences of some families faced with genetic disease which are presented in the introduction are helpful in setting what follows in context.

Alan Fryer
(Consultant Clinical Geneticist, Liverpool)

readers' letters:

Homoeopathy

In Triple Helix No. 1, Eutychus reported that Lambeth, Southwark and Lewisham Health Authority had stopped paying for homoeopathic treatment because there was not enough evidence to support its use. ***Dr Anita Davies****, a Trustee of the Blackie Foundation Trust, writes:*

Thank you for making so much information available in the first issue of *Triple Helix*. It is relevant and interesting for a wide spectrum of health care workers. There may be bias in your choice of items for your roundup of medical news - and I would refer readers interested in homoeopathy to a properly researched review article by Klaus Linde (*Lancet*, 20 September 1997; 350: 834-843) which concluded that:

'The results of our meta-analysis are not compatible with the hypothesis that the clincal effects of homoeopathy are completely due to placebo. However, we found insufficient evidence from these studies that homoeopathy is clearly efficacious for any single clinical condition. Further research on homoepathy is warranted provided it is rigorous and systematic.'

Creation-Evolution Debate

Dr Antony Latham *writes from the Isle of Harris:*

The review in *Triple Helix No. 2* by Denis Alexander of Michael Behe's book *Darwin's Black Box* left me somewhat amazed. My first surprise was that he omitted to mention that Behe has written a beautifully lucid and accessible book about complex biochemistry - written too in the sort of dispassionate and professional way that is badly needed in the debate about creation.

Going then straight to the three so-called 'flaws' that Alexander finds:

Firstly, he finds the term 'irreducibly complex' simply an admission of ignorance. He feels that science will discover the answers to Behe's problems. He gives the discovery of DNA as a good example of how we have unravelled what was once thought to be mystery. In this argument he fails to realise that it is the very discovery of the details of biochemistry such as the DNA molecule which has led people like Behe to find evidence for a creator. The more detail we find about the biochemical processes in the cell (Darwin's black box), the more we see irreducibly complex systems. Behe's parallel example of the simple mousetrap is a good one - the various constituent parts cannot have any role on their own. The systems that Behe describes are far more unlikely to have occurred by chance. Alexander seems to have missed the point here or if not he has failed to give any logical alternative.

Secondly, he criticises Behe as someone putting God into the gaps of our scientific ignorance. He maintains that our God will 'shrink' as we discover more and more to fill these gaps. I find this argument extraordinary from a believing Christian who I assume does think that God somehow created us. Alexander, I assume, is of the Christian school of thought that feels that God had little if anything to with the details of creation once he had set up the laws of the universe at the beginning. If so, then he should say that. Many of us however still hold to a biblical view of God's design and total involvement in our makeup. Behe is challenging the Darwinian world view and is doing so in a credible and very logical way. The sound logic that he uses is in stark contrast to that of celebrated Darwinian writers such as Richard Dawkins, whose books are filled with his own made-up stories of how he thinks we evolved. In contrast to Dawkins, Behe is taking a hard look at the nuts and bolts of the issues. He makes up nothing.

Thirdly, Alexander maintains that design is still possible as a mode of explanation even when we thoroughly understand all the biochemical components. I presume this is his way of saying that he can still believe in God as creator even if all the components of the cell have been shown to have occurred by chance (in other words looking for evidence of design and irreducibly complex systems is unnecessary). I would challenge him to re-examine this and look squarely at the issue. Either God did design us or he did not. If he did, is it surprising that biochemists such as Behe are now finding firm evidence for this? I think Alexander is being vague about this and should say clearly if he believes God designed the details of life or not.

There are other issues which space does not allow me to go into but I would urge readers to go out and buy Behe's book and think for themselves.

Intention

Ipswich GP ***Owen Thurtle*** *finds inconsistency between articles in the second issue:*

I agree with Andrew Fergusson's editorial that the intention of an act is what matters rather than the final outcome. So a large dose of analgesic intended to ease pain is not the same as giving a drug with the primary intention of bringing about death.

However, it is not only the moral philosophers he refers to who have difficulty accepting this distinction, but also contributors to the same issue of *Triple Helix*! On the back page we find Antony Porter protesting at the injustice of calling road deaths 'accidents', just because no-one intended to commit murder.

Another instance where you cannot assess guilt simply by the final outcome.

The Editor welcomes original letters for consideration for publication. They should have both Christian and healthcare content, should not normally exceed 250 words, and if accepted may have to be edited for length.

Write to: *Triple Helix*, 157 Waterloo Road, London SE1 8XN
Fax: 0171-620 2453
e-mail: CMFUK@compuserve.com

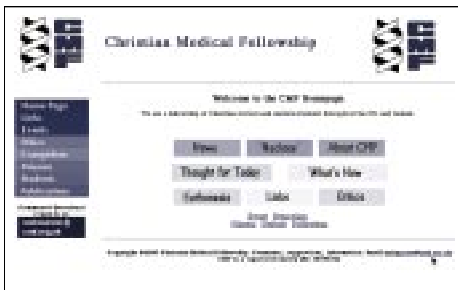
RevieWWWs

with CyberDoc

Christian Medical Fellowship's Website http://www.cmf.org.uk

CMF's site is neat and attractive with many excellent articles on subjects ranging from evangelism to euthanasia. It stands out among Christian medical pages, many of which are basically poster adverts for the organisation.

Navigation around the site is easy. Articles are indexed by both subject and publication. It would be nice, however, to see some links to other sites categorised by subject. For regular users the 'What's New?' page is invaluable. On your first visit to the site, in true 'big brother' style, your e-mail address is automatically accessed in order to send you e-mail updates on the site.



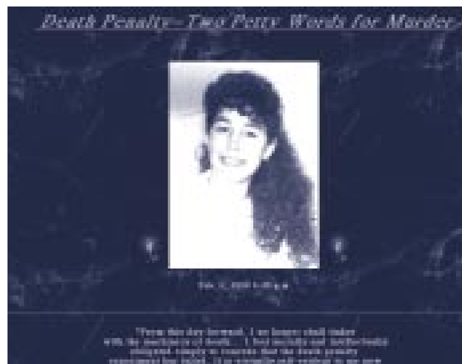
After an early rush of articles, work on these pages seems to have dried up. With no new pages this year the site needs updating quickly or it will soon look out of date. One of the fascinating paradoxes of the Internet is that magazines and newspapers such as *The Times* have put the whole text of their publication on the Internet and found paper sales and web site visits increase. So, hopefully, you will soon be able to browse back issues of *Triple Helix* without needing to put up a new shelf to keep them on.

Ratings (out of five)

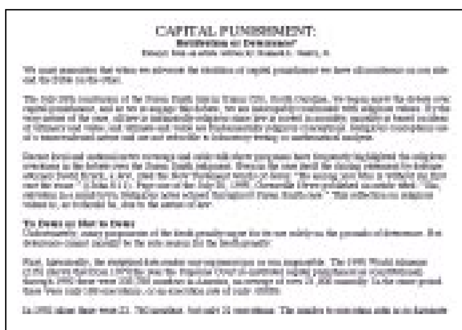
Appearance ****
Content *****
Links to other sites ***
Ease of use ****
Summary: a great site which seems sure to become ever more useful

What the Christian Internet has to say about . . . The Death Penalty

This topical and controversial subject is one that as a Christian health professional you may be asked about. Christians were recently interested in the execution of the American woman Karla Faye Tucker who had apparently become a Christian before her death.



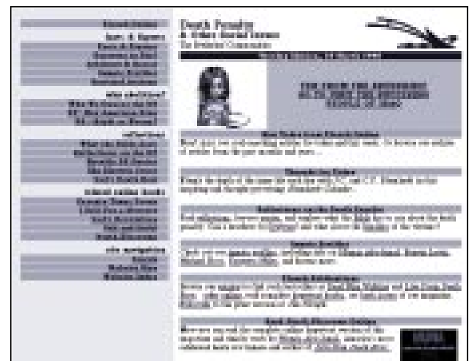
At **http://www.dzn.com/~lhindi/Karla-Faye-Tuckers-Death-Penalty-Executions.html** (yes, I am sorry, you really do have to type out all of that!) is a graphically attractive page written by a Christian. It emotively sets out why Karla should not have been executed and provides several other useful links. It may not be immediately obvious that you need to click on the star next to each link to visit it. One of the links provides a blow by blow account of what was to happen to Karla. The author has not updated this page since her death, which adds to its poignancy. It is as though time is stationary, awaiting the judges' final decision.



CAPITAL PUNISHMENT:

For a page on the opposite side of the spectrum visit **http://www.avision1.com/bwview/v11n9a.html** (again a rather strange address). Here, the biblical case for the death penalty is fearlessly and skilfully portrayed. Don't expect links to other sites though - even the links back to the front didn't work when I tried them!

For a biblical defence of the abolition of the death penalty, and very useful links to background information and statistics to impress your friends with, try **http://www.bruderhof.org/issues/deathpen/index.htm** This well-designed page is well worth a visit.



The text of this and last issue's ***CyberDoc*** articles can be found at **http://www.cmf.org.uk/cyberdoc** where all the sites reviewed are just a point and click away.

CyberDoc is Adrian Warnock, a locum clinical assistant in psychiatry based in London. He runs an Internet site for Christians and is small group leader in his church.

If you have an Internet site or subject that you would like CyberDoc to review he can be e-mailed at **warnock@bigfoot.com**

satisfaction STRESS

Continuing our series on Professionals Under Pressure, Elizabeth Fenney profiles an NHS manager

Roger Thayne OBE is chief executive, Staffordshire Ambulance Service NHS Trust. He joined the army at 15 and worked his way up to the rank of Colonel. During the ambulance dispute of 1989-90, it was his job to co-ordinate military ambulances on the streets. He was a medical planner in the Gulf War, going out at the end of hostilities to bring the hospitals back. He has four grown-up children. Baptised as a Roman Catholic, Roger went to a Methodist Sunday school, and now worships at the local Anglican church.

Trust HQ is on the outskirts of Stafford, and is also the ambulance depot. It's overcrowded, with Portakabins and parking problems. Unlike hospitals, which reduce their staffing at night and at weekends, the ambulance service never stops. Roger's first task in the mornings is to sort out the problems of the past 24 hours. He makes it his business to walk around, talking to crews or control room staff, ensuring that the trust and its 500 staff give the best possible service within the resources available.

There is a high level of satisfaction when everything goes right. 'There aren't many jobs where you can say our organisation has saved one or two lives today.' There is an equally high level of stress. Roger believes this can be dealt with by good organisation. He keeps an eye on staff and expects his managers to do likewise. Stress can be minimised by firm decisions, by giving support, by being polite, by saying thank you, by allowing the odd mistake.

Ambulance personnel can come through horrific experiences, yet be stressed out by a seemingly minor incident. One of the most difficult experiences is comforting an elderly person devastated by the death of their partner. A good ambulance controller can recognise stress from a crew member's voice. 'Get them in off the road, give them a cup of tea, talk to them', says Roger. 'We see life and death in sharp focus and we need to understand the pressures on the staff.'

Roger believes the New Testament is one of the best management text books. 'Leadership is about how to manage people - with honesty, truth, care and compassion. Loving your neighbour as yourself means treating patients and staff as you would wish to be treated.'

The powers that be do not always want their chief executive to be honest with the public. 'But we are a public service; we should tell people what we can do and what we can't, and do our best to deliver what they expect.' The worst element is having to be honest with people who may be in the wrong appointment and have not achieved what they should.

'We in the ambulance service believe very strongly that, with better management and more modern approaches, our colleagues in the health authority or the hospitals could perform to the same response performance as ourselves. We aren't thanked for that. Going out on a limb to do things differently doesn't make you popular.'

The down side of the job is an excess of bureaucracy, meetings and paperwork. Particularly frustrating is the lack of innovative thinking in the service. 'As the professionals in the service, we adopt a paternalistic attitude of thinking we know best. Let's start thinking about what the patient needs and wants, not what we want.'

The enormous dedication of the people on the front line constantly renews Roger's enthusiasm for the job. It shows when paramedics visit someone they have taken to hospital, when staff provide first aid training in their spare time, or take aid to other countries, currently Bulgaria and the former Yugoslavia.

'Belief in Christian principles may make you unpopular at times, but generally people will trust you and will follow you. If we look at the founder of those Christian principles, he's got a massive following and has had over many centuries. It was superb leadership, superb management, against people who were trying to do him down. I am now in my fifties, and have been in management positions since my twenties. I know that New Testament principles really work.'

Elizabeth Fenney is a freelance writer