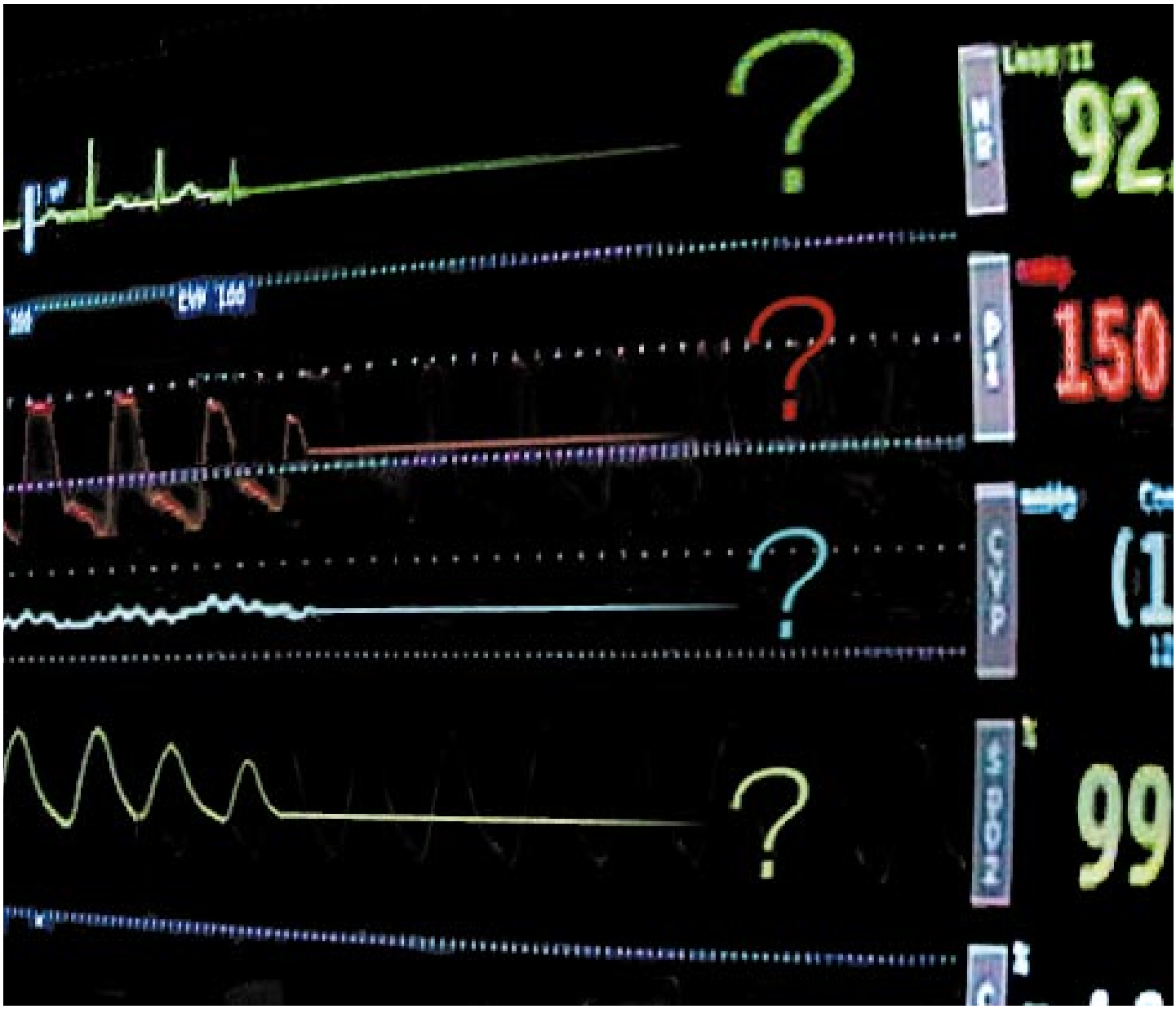
Triple Helix

Christian dimensions in healthcare

Brainstem death
Tubes or not?
A worldwide Cinderella



Transplants: are the donors really *really* dead?

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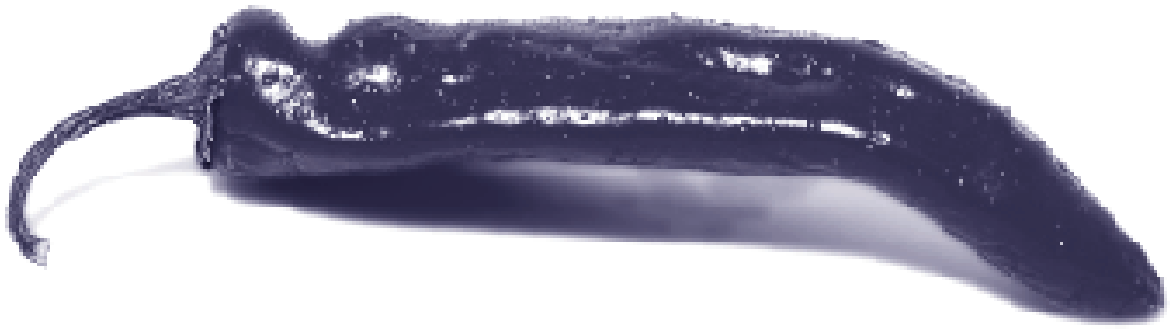


editorial:

'Frankenstein foods'

'You shall not allow your animals to breed with a different kind, nor sow your field with two kinds of seed' (Leviticus 19: 19)

These perhaps obscure Old Testament words carry a contemporary resonance. Public debate about genetically modified food rages. The spectre of 'Frankenstein foods' stalks the popular imagination, the latest episode being fears about how far pollen from trials of GM crops can travel and what it might affect.

So did the authors of the Pentateuch know something our generation has forgotten or overlooked? I'm not sure. Leviticus 19: 19 is essentially a piece of common sense. It did not necessarily rule out breeding of mules (a cross between a horse and a donkey) since later on the Hebrew kings would ride a mule on ceremonial occasions. For ordinary people there simply were more economic benefits from breeding donkeys or horses than mules because mules cannot reproduce. Likewise, mixing varieties of seed wheat or corn invites 'throwbacks', weeds and even crop failure.

Selective breeding to produce new strains of animals and plants has been commonplace for millennia. There are even hints of it in the Book of Genesis. As a farmer's son I hail the benefits of sustained experiment and research: higher yielding crops, fine wools, wonderful wines, an ever-bigger array of nutritious cereals and fruits, better meats.

Genetic modification of food represents a further step. There are no proven health hazards yet, and it could bring benefits - it could improve quality and introducing drought resistant crops to barren parts of the world could ensure global food security. But there is no reason to hurry GM foods into general use. The world's food security problems are as much due to distribution failure as shortages. We can afford to wait as long as is necessary to ensure that these foods are completely safe.

Meanwhile we could benefit from a wider-ranging debate about the underlying crisis in world farming. A handful of companies, among them some of the strongest advocates of GM foods, hold virtual monopolies and make mega-profits. In contrast small family farms the world over struggle to survive. Millions of small farmers caught in a cycle of falling prices try to compensate by producing more and more, for which the cash returns diminish all the time. The result: environmental devastation, increasing debt and bankruptcies, and inevitable mountains of unwanted food.

John Martin

Transplants
are the donors really *really* dead?

Is 'brainstem death' diagnostic of death or merely prognostic? And does it matter? *Triple Helix* interviews consultant anaesthetist **David Hill**

David, tell us about yourself. Give us a brief CV.
I did my preclinicals at King's College and my clinical training at the old Westminster Hospital. I qualified in 1954 and did housejobs with a view to going into general practice, but doing anaesthesia as an SHO I realised I had a particular interest and facility for that. I eventually became a consultant anaesthetist at Addenbrooke's Hospital, Cambridge, but before that I was a senior registrar at King's College Hospital and I mention that because I was there at an early stage of kidney transplantation procedures.

We're going to be talking about organ transplantation and associated issues. Do you accept that transplantation per se is ethical?
Yes I do. I would have no objection myself to my organs being used, particularly corneas and even kidneys, provided they were taken at a time after my death.

Death has obviously got spiritual, philosophical, ethical, legal and medical aspects to it. It's a big subject. Can you tell us how the law in the UK defines death?
There is no legal definition of death. Basically you are dead when a doctor says you're dead.

How then historically have British doctors defined death?
Death has been diagnosed on the basis of there being no respiration and no heartbeat and no circulation and that has been the standard way of assessing death.

When did that change?
It began to change in the late 1960s and early 1970s when intensive care became established and one of the results of that was we found ourselves in the position sometimes of prolonging the deaths of patients rather than prolonging their lives. Decisions had to be made about discontinuing treatment in order to allow a person to die.

So one of the reasons for the development of the new concept of 'brain death' was the inappropriate ventilation of dying people?
I don't know that I'd say 'inappropriate'; we were able to sustain for much longer people who would have died. Of course many of the people in intensive care who would otherwise have died survived, but a proportion of them who would have died still did die, but it turned out in retrospect we were just prolonging the dying process.

Was there any other reason for the development of the concept of brain death?
I think that was initially what it was. At that time there was no question of assuming that the people who were on what is generally called 'life support' were dead - they clearly were not dead but we were maintaining life over and beyond the time for which it seemed reasonable.

What has this new concept of death involved? Tell us about brain death.
It was formalised in this country in 1976 by the Conference of Royal Colleges and their Faculties[1] who determined that, following preconditions and allowing that we knew the cause of a coma, if certain tests were fulfilled then a patient would have no hope of recovery. Those tests were valuable because we had found ourselves having to discontinue treatment and they did formalise that and give one the backing of the Conference. But again there was no question at that stage of saying those patients were dead; it was simply a series of tests to assess whether there was any reasonable chance of the patient ever recovering. It was very much a prognostic test we were carrying out.

When and how did that change?
It changed very suddenly in 1979 and I think we must remember this was the time when organ transplantation was

extending beyond corneas and kidneys to other solid organs and even to lungs and pancreas and bowel. There was a Memorandum[2] in 1979 from the same Committee. They determined that these same tests which they had previously used in prognostic terms (that the patient would not recover) should be used equally as diagnostic terms (that the patient was already dead). Quoting from the Memorandum, this was because by then 'all functions of the brain have permanently and irreversibly ceased'.

Now that's talking about 'all functions of the brain' but haven't we moved on again to use the language of 'brainstem death'?

The tests which were made were of brainstem activity so what was in fact being tested for was brainstem death, but there was a mistake in terminology which was only corrected in 1995[3] that this should not be called 'brain death' but should be called 'brainstem death'. The important point is that the assumption in the 1979 Memorandum equating this condition with death was that all functions of the brain had totally and irreversibly ceased, whereas it has been shown in many papers there is residual brain activity in these patients.

So the language was of 'the whole brain' but in practice it was the brainstem?

Yes. In *ABC of Brainstem Death*[4] Christopher Pallis describes his idiosyncratic view of death, that if 'these few cubic centimetres of tissue' in the brainstem were tested, that was all one needed to establish whether a person was alive or dead, and he disregarded all the activity in the higher parts of the brain[5,6].

Let me pick you up on that word 'idiosyncratic'. Christopher Pallis, who is regarded as Britain's if not the world's leading authority, defines death as 'the irreversible loss of the capacity for consciousness and the capacity to breathe' and he cites the centre of both those capacities as the brainstem. Now, everybody's agreed with him, so why do you call it 'idiosyncratic'?

Consciousness is subjective so there's no external test one can make for consciousness, and there is no way Pallis or anybody else can say there's no consciousness if we can show by electrical or other means that there is brain activity. Also, regarding the capacity to breathe - what he means is the capacity to breathe spontaneously - there are many occasions clinically where people unable to breathe spontaneously can maintain a virtually normal life. I'm thinking of people with polio or paralysis or some demyelinating diseases who are being ventilated.

The 'Further Reading' list cites[1] these various tests for brainstem death which you have criticised, but doesn't the consensus of British medicine regard them as adequate?

I don't think there is a consensus. There is a small group of experts who make the rules and there is a large majority of doctors who really have little understanding of the processes.

Pallis says that any activity in the higher parts of the brain is irrelevant in the presence of brainstem death. How do you respond to that?

I'd like to ask how he knows? Another thing he says is that none of these patients recover, and the only way one could know whether a patient with activity in the higher brain had any consciousness at that time would be by asking them if they recovered. They don't recover, because the only purpose for doing these tests is either to discontinue treatment and allow them to die, or to remove their organs in which case they will die.

But hasn't Pallis in his book got statistics of people maintained on ventilation who die naturally on the ventilator?

He has a phrase which is quite insubstantial and that is that all these patients who have the condition diagnosed as brainstem death 'will die within a matter of hours or days' and this is simply not true. It is based on a retrospective paper in 1981[7] but the patients who died were diagnosed as 'brain dead' on other criteria than the 1976 brainstem tests. There is a recent paper[8] looking at 175 patients who had the diagnosis of brainstem death made and they did not die in common terms for long periods - I think 40% survived a matter of weeks, another 20% survived a matter of months, and one or two survived many months. The other opposing evidence for Pallis' claims that all these patients will die is the number of recorded cases of pregnant women who have suffered some cerebral catastrophe and have been diagnosed as brainstem dead and have been maintained sometimes for many months in order that the fetus may mature and be delivered.

You've commented elsewhere on the extent of responsiveness of brainstem dead people during the process of organ donation. Donors being operated on show a number of physiological responses. What's the significance of that to you?

As an anaesthetist I am horrified that any of these patients are operated on without proper anaesthesia. You would think such an important issue would be well-documented and debated in anaesthetic literature. In fact I've been able to find precious little about it. There are some statements that anaesthesia is not needed but nevertheless should be given[4], there are some statements that it should be given 'just in case'.

Just in case what?

Just in case, I presume, there is any possibility of residual sensibility or life.

But aren't those physiological responses just a consequence of spinal reflexes below a dead brainstem?
This is what the transplant team will attribute them to, but again there is no evidence in man that an acute transection of the cord (which is what they're referring to) produces these exaggerated responses and nearly all of the patients who are operated on for organ removal without anaesthesia show a rise in pulse and blood pressure at the beginning of surgery, which lasts sometimes 20-25 minutes unless they're given anaesthetics in which case they subside to a normal level[9].

You've also drawn attention to concerns in the literature about removing fears of 'residual sentience'. Do you think it is possible the patients might therefore be feeling something?
I don't think one can exclude that as a possibility[10].

Summing up your concerns so far, you recognise that people who are brainstem dead go on to die eventually by classical criteria but you are saying that 'brainstem death' is talking about a prognosis and not a diagnosis.
Yes.

Moving on from there, please take us through the transplant procedure. The donor is taken down to theatre, the ventilator is turned off, respiration stops, the heartbeat stops, circulation stops, they're dead by anybody's criteria, and the operation begins. Is that right?
That's completely wrong. That is certainly the impression which is given, whether deliberately or not, but that is not the situation. It used to be the situation when we were transplanting only kidneys because the kidneys will survive a period after the person has died. Other organs - heart, lung, liver, pancreas - will not function under those circumstances. The earliest liver transplants were from patients who were treated in the way you describe but they failed, so it became necessary - it was seen to be necessary - to take organs at an earlier stage. It was at that time that the Royal Colleges changed their opinion so that fulfilment of the brainstem tests would diagnose death rather than say that it will happen eventually.

Let's be quite clear. At what point is the ventilator turned off?
The ventilator is not turned off until all the organs that are needed have been removed. The patient comes to the operating theatre with sometimes even more intensive treatment going on than they were receiving in the ICU, they may need blood transfusion, they are treated intensively and they look like any other patient. As I've said, at the beginning of surgery they respond physiologically like any other patient.

What has been your experience of health professionals observing transplant operations? How have they reacted?
The number of people involved is very small and most of them are committed to the procedures. While I was working at Addenbrooke's I did over a period of four years or so see many entries in the Operating Register which gave the time the patient came into the theatre but also recorded the time of death as being some hours after that. Clearly the person filling in the Register, usually a nurse, had not regarded the patient as dead when they came into theatre but had subsequently recorded the time of death when the heart and respiration stopped.

But we've agreed in law you're dead when a doctor says so according to accepted criteria and writes a death certificate, so is that not just a conflict, some confusion, between the two disciplines of medicine and nursing?
No, I don't think so, I think it's a difference between theory and practice, between what we'd like to see and what we actually do see.

The Department of Health has recently had a big campaign encouraging the signing of donor cards, going onto the Register, being willing to have your organs taken after death. The literature they've released to health professionals suggests that relatives don't want to know the sorts of details you were describing earlier. Isn't that fair? Surely the public's ignorance of the detail doesn't matter?
I think it matters tremendously. Relatives are being asked to give consent to a procedure without being given adequate information on which they can base that consent.

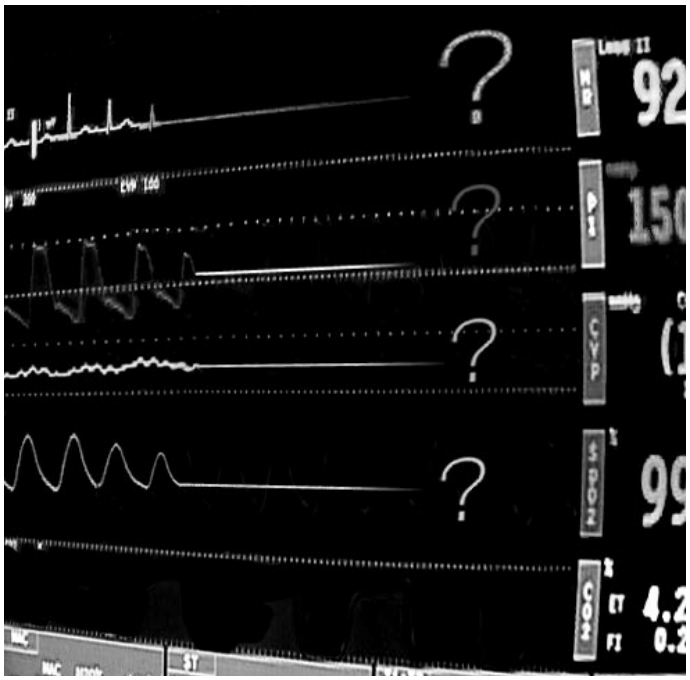
What about relatives' emotional state at that time? Is it fair to burden them emotionally?
Frankly, I think it's not. The condition of mind of relatives at that time is enough in itself to invalidate any consent.

It also says in the DoH promotional literature that 'two doctors working independently' who 'confirm brainstem death . . . are not part of the transplant team and . . . have no connection with organ donation'. Isn't that enough of a safeguard?
No it isn't. Two points: one is that it requires four opinions (two doctors on two occasions) as to whether somebody's dead and that does imply a degree of doubt[11]; secondly, doctors who are asked to confirm death on those criteria are very much part of the transplant team. If the doctors were not willing to confirm death they would not be asked. That was my own observation - I was never asked to confirm death because I would not sign a death certificate under those circumstances.

Aren't you just being semantic? Pallis claims that nobody who repeatedly fulfils UK brainstem death criteria ever survives.

Surely they're as good as dead?

Well, he's right that as far as we can tell they will not survive, but there is a world of difference between being dead and being as good as dead. I'm afraid the perceived urgency for transplanting organs has blurred that difference.



Have your views had any influence on your own career? How did your colleagues at Addenbrooke's react?

I was initially involved with transplants when we did switch off the ventilator before proceeding to remove organs and I was initially involved when we were using beating-heart donors, but I was appalled at that stage at what we were doing. Fortunately, we had a big enough anaesthetics department so that not everybody had to be involved and I was able to withdraw from it without any detriment.

Do you know of doctors with views like your own who've had problems?

I know of doctors who've had to search their consciences about what they're doing but I'm not aware of any anaesthetists who've had their career jeopardised. I do know of one cardiologist who was pressured into early retirement.

Quite recently we've had suggestions that Britain should join several other European countries and have an 'opting-out' system; in other words, somebody whose medical condition following injury or illness makes them a potential organ donor will be presumed to have opted into organ donation unless they're carrying a card confirming they've opted out. What's your reaction to that?

This is even less valid as a consent. Presumed consent is not informed consent under any circumstances.

At the end of the day, deep down aren't you fundamentally opposed to transplantation and just looking for fine print semantic niggles to justify your views?

I've seen the transplant scene develop, I've participated in it at an early stage with as much enthusiasm as everybody else, and it was only when the subsequent change was made that I have been unable to participate. It's not transplantation per se; it's the lack of information and the deceit and increasingly in my mind the lack of anaesthesia for the donors which make me so hostile to current procedures.

So can we sum up your objections?

There are four:

1. We are removing organs from people before we would declare them dead for any other purpose.

2. We are deliberately concealing this from would-be donors and their relatives.

3. We are failing to obtain properly informed consent - the donor card is inadequate.

4. We are failing to offer anaesthesia for the operation.

Thank you, David.

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David Hill was a consultant anaesthetist at Addenbrooke's Hospital, Cambridge and since retirement now works for much of each year in Nepal

Fiendishly clever creams

Specialists in London tested 11 Chinese herbal creams used to treat skin conditions and found eight illegally contained dexamethasone. In addition to the potential health risks of this 'alternative medicine' the authors discuss 'the ethical issue arising from giving steroids to patients who, disillusioned with conventional treatment, believe they are taking herbal medications that do not contain steroids'. (Source: *British Medical Journal*, 27 February 1999; 318: 563-564)

Brits opposed to human cloning . . .

Even among groups who may benefit from the technique, there is virtually no public support in the UK for reproductive cloning. All but four of the 79 lay people recruited to a Wellcome Trust study 'rejected the idea of human cloning outright'. Many were concerned about the therapeutic use of embryos and did not trust scientists to regulate themselves. (Source: *Public Perspectives on Human Cloning*, available free from 0171-611 7221 and at www.wellcome.ac.uk/publications)

. . . though organised crime thinks there's money in it

The head of a new research unit at the National Criminal Intelligence Service has warned that illegal trade in human body parts and genetically engineered children is a future market for organised crime. 'By 2020, 95% of human body parts could be replaceable by laboratory-grown organs' predicts Robert Hall, expecting this to stimulate criminal entrepreneurs. Crime groups are involved already in the international sale of transplant organs. (Source: *The Independent*, 3 March 1999)

The Dead Citizens Charter

Eutychus wondered initially whether this headline was a spoof, then whether this charter was right to take patient's rights beyond the grave, but studying this statement from the National Funerals College concluded it was an excellent contribution to the College's aim of 'improving the uniformly dismal standard of funerals'. (Source: *Bulletin of Medical Ethics*, January 1999, p10-11)

Recycle the dead to help the living

argues Professor John Harris. In a response to the shortage of donor organs (and his case deserves study) this secular bioethicist says all organs from dead bodies should be automatically available at death without any consent being required. Wonder what the British public and the National Funerals College think? (Source: *The Independent*, 19 February 1999)

Men could bear children

Another high-profile 'ethics expert', Professor Lord Winston of IVF fame, says in a forthcoming book that an embryo could be implanted in a man's abdomen, with the placenta attached to an internal organ such as the bowel, and the baby later delivered by Caesarean section. The technique could be another way of allowing homosexual couples to have children. Eutychus doesn't fancy this gender bender distender. (Source: *The Independent*, 22 February 1999)

Suicide kills more young men than RTAs

in some parts of Britain and is one of the country's biggest public health problems. Badly educated young men hit by unemployment are at greatest risk, with those in social class V four times more likely to kill themselves than those in social class I. Meanwhile, the fastest growing contact method for the Samaritans is e-mail: 'The messages that come via e-mail are much starker. Directness is part of the method.' (Source: *The Independent*, 24 February 1999)

Abortion rise blamed on Pill scare

There were 179,700 abortions in England and Wales in 1997, compared with 177,500 in 1996 and 163,600 in 1995. Just under 21% of all pregnancies are now ended by abortion. *Health Statistics Quarterly* editor Karen Dunnell said 'there is a general feeling that the Pill scare caused a crisis of confidence among women in methods of contraception . . . it may be one of the reasons that larger numbers of women are deciding to use abortion rather than the Pill'. (Source: *The Times*, 17 February 1999)

Abortion: legalised in Northern Ireland?

The all-party Parliamentary group on population, development and reproductive health called in December for abortion in Northern Ireland to be placed on the same legal basis as elsewhere in the UK. A backbench motion which might have government support is anticipated, yet more than almost any other issue, opposition to liberal abortion unites politicians in Northern Ireland. (Source: *The Independent*, 10 December 1998)

'Jerusalem syndrome' and the millennium

Mental health services in Israel are preparing for a major outbreak of the 'Jerusalem syndrome' with the expected increase in visitors to the Holy Land from the turn of the millennium. The temporary psychiatric condition has been known to Israeli psychiatrists for decades - patients believe they have become biblical figures such as Moses, John the Baptist or Jesus. (Source: *British Medical Journal*, 20 February 1999; 318: 484)

Tissue engineered bladders

Returning to the organ theme, animal experiments have shown that bladders grown in the laboratory with tissue engineering techniques can be successfully implanted. Researchers at Boston and Harvard used dogs and urodynamic studies showed that those receiving implants regained 95% of original bladder capacity, were continent, and voided normally. Human trials could begin within two years and the technique might help babies with congenital bladder conditions and adults who've lost bladders through cancer or trauma. (Source: *Nature Biotechnology*, 1999; 17: 140-155)

Doctor/clergy co-operation - better in US than UK

Eutychus found most of the above pretty depressing this quarter, but was cheered by reports of clergy and doctors working together more effectively. American family doctors though are more likely than British GPs to refer patients to a clergyman for advice, counselling or spiritual healing. (Source: *Archives of Family Medicine*, 1998; 7: 548-553)

Among All Nations

Spring 1999
No. 7

Christian healthcare worldwide

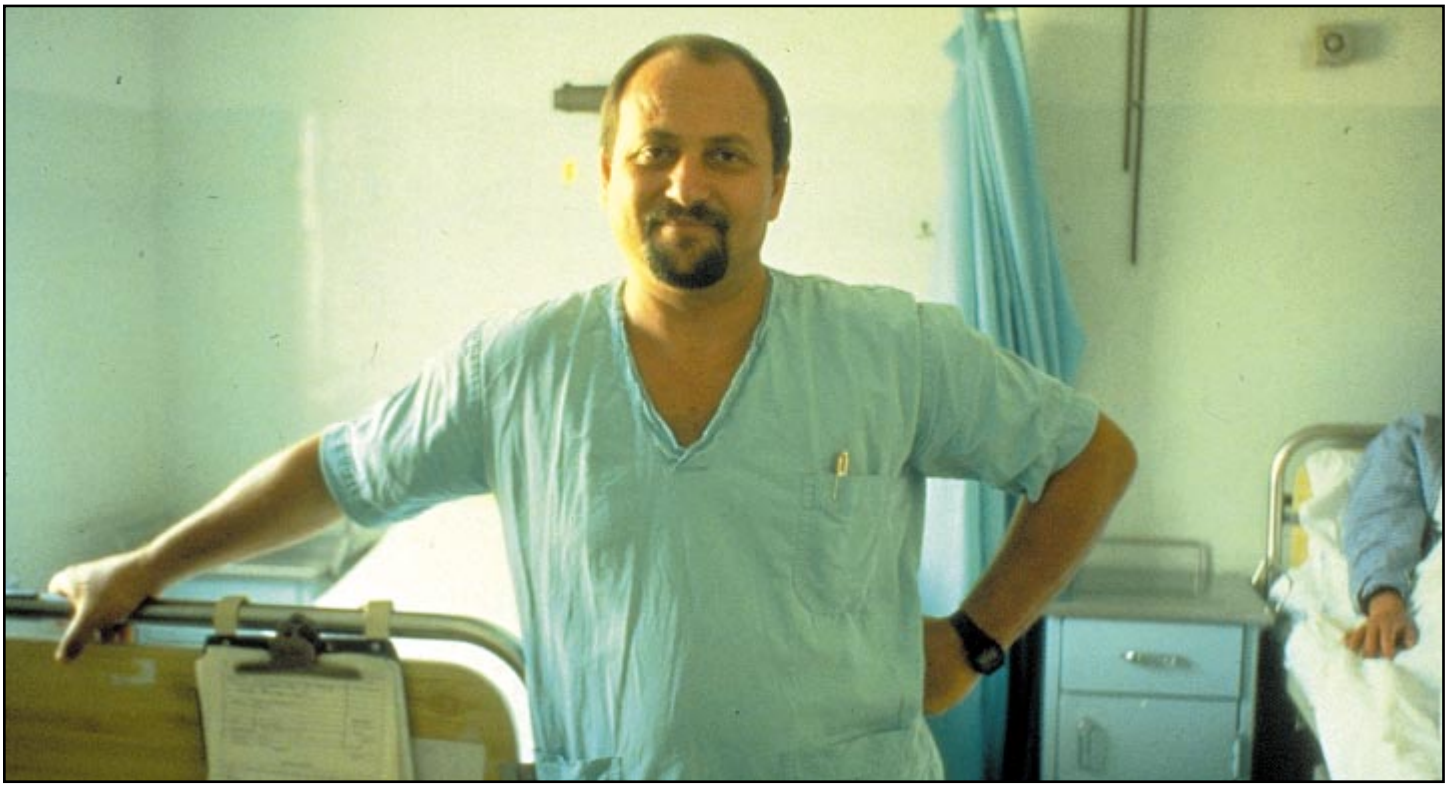


Photo: EMMS

What makes a doctor tick?

Increasing effort is being put into selecting, training, and controlling doctors while public confidence in them is declining, litigation is increasing and the media are reporting more failures in healthcare. The profession is pressed for more objectivity by a society that is increasingly driven by its feelings. We have objective selection of medical students, objective examinations, continuing professional development, evidence based medicine, management protocols and clinical governance. Doctors are to be re-accredited at intervals throughout their careers.

This pattern of control works well in business and industry. For medicine the ingredient lacking is motivation. Only 1% of recent medical graduates feel medicine is a vocation. The 99% are not be blamed - doctors are not a breed apart, genetically engineered for the task (at least not yet). They are the product of the culture and society for whose health they are responsible. When we point a finger at a doctor who has failed we point three fingers back at ourselves.

The personnel secretary of a Christian mission reported it was a privilege to interview medical candidates: 'they are looking for the opportunity to express their faith in the work they do'. They are people centred because they belong to a culture centred on the God who sent his Son to care for those he made to be like him.

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.

medical missions *look to the future*

John Martin reflects on the second 'Summit Meeting', arguably the biggest gathering of medical missions since the famous 1910 Edinburgh Missionary Conference

Top of the agenda at the meeting in London on 18th February was putting flesh on a framework document, product of the first 'summit' held a year ago. That meeting proposed creating a new umbrella organisation to bring new impetus to medical missions. Within weeks we can expect to see the birth of 'HealthServe'. Funding for its first year is already in place, and a Director is being sought - see p14.

The changing scene

Everyone agrees the mission scene is changing. The biggest change of all is that 'mission' is no longer 'the West reaching out to the rest'. Over a century and a half the modern missionary movement planted the Christian church in some form on every continent. In the last two generations what were once 'mission fields' have become churches in their own right. Most are led by their own people. Few depend financially on the West for day to day operational costs. It is widely recognised, moreover, that the West is now itself a 'mission field'.

Many third world churches are now missionary-senders. Dr David Barrett, author of the *World Christian Encyclopaedia*, believes that early in the new millennium the numbers of third world 'missionaries' will eclipse those from the West. It is estimated there are currently more than 1,500 third world missionaries working in Britain. If there was a major flaw in the blueprint for the 1999 Medical Missions Summit it was that the voice of the third world was nowhere to be heard directly.

Why medical missions?

All this change raises particular questions for medical missions. With political independence, many third world governments aspired to something approaching the British National Health Service. Missions were asked to hand over many of their hospitals and medical facilities. Soon, however, governments discovered that running these institutions was beyond their resources. In some places the outcome was an 'on-again off-again' relationship between non-governmental organisations, missions and government.

Now there are places where NGOs and missions effectively provide the only health service. It is a good question, however, whether this can be funded indefinitely. Moreover, money can be a source of tension. A Westerner suggesting a 'low tech' or low cost solution may sometimes be accused of seeking to deprive third world people of 'the best . . . which they are surely entitled to receive'. While some work reflects the character of mission work of earlier years, it is not always possible to maintain a distinctly Christian ethos. So where and how does the 'mission' part of it fit in the picture?

New questions

There are other factors in play. Are hospitals always the best base possible for medical mission work? A doctor-medical missionary based in Uganda told me recently: 'I could spend all my time at this hospital, doing operations, and prescribing treatment and medicines. But none of that addresses the root causes of why people get sick with illnesses that could be prevented.'

He is a keen convert to community-based healthcare, run in partnership with a team of local workers. What is certain is that it is often only Christ-like motivation that can lead a health professional with a family to accept the deprivations of working in an isolated third world situation rather than in an institution which as well as everything else confers status and prestige.

The spectre of AIDS carries an enormous threat to health care as we know it in the third world. It prompted one respected former missionary doctor to tell me: 'The AIDS epidemic could easily wipe out completely every semblance of third world healthcare'.

There have been times when Western-style healthcare, administered in an arrogant way, has received its come-uppance. In Nigeria in the 1920s some medical missions confidently told people there was no value in traditional remedies, or use of touch or prayer for healing. But then a virulent influenza epidemic defied even their ministrations. Out of the crisis came a breakaway African church that practises a combination of Western-style medicine and prayer for healing in a local form.

What is health anyway?

Experiences such as these have prompted some medical missions to engage in dialogue with local people about the nature of health itself. It is very easy for Western health professionals to arrive on a scene and immediately pronounce on what needs to be done. Some find themselves bewildered to discover that patients still die despite receiving the 'right' treatment.

Healthcare is both a science and an art. This is why, even in the West, a good GP will sometimes ask a patient 'How are you in yourself?' Sometimes third world patients are unable to conceive that they can be brought back to health without a 'touch' or even being prayed over. Can we learn something here from how Jesus worked with the sick?

Theological foundations

One issue somewhat absent at the Summit was consideration of the theological basis for medical missions. HealthServe is

rightly seeking balance between pragmatism and principle. Healthcare professionals are essentially practical people. Doctrinal statements can easily become a distraction or a source of unnecessary disagreement. So HealthServe, with a short doctrinal affirmation, is seeking to travel light. Nevertheless it recognises the need for sources of thoughtful reflection to help Christian health professionals, for example:

- to articulate cogent reasons for what they are doing, including the meaning of Christian 'witness' in day to day work, or in situations where formal Christian activities are restricted, even by the law of the land.
- to think through the ethical dimensions of the questions confronting Christian health professionals in their work, including how to adapt to another culture.

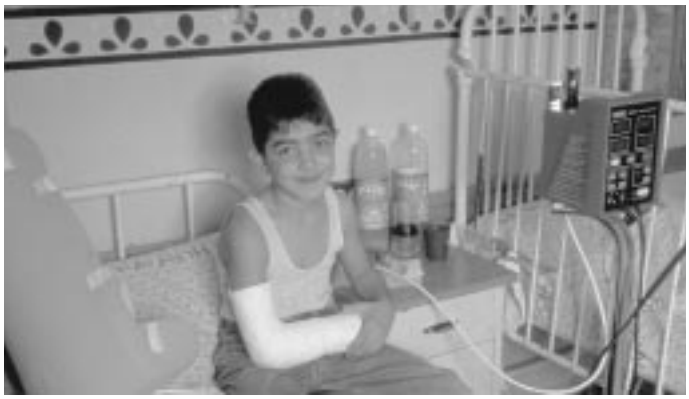


Photo: EMMS

Some key concepts

I would humbly offer the following as key concepts that underpin what medical mission is all about.

1. 'Incarnation'. Christ is the message. And he is the supreme model for what Christians seek to do in his name. When God in Jesus took human form he immersed himself completely in the life of a family, a community, a nation, and (even) a religion. 'That which he could not become he could not redeem' (Irenaus). Here is a radical vision for what mission is about and how it is done.

2. 'What Jesus did'. We get Jesus wrong if we think his work was fully accomplished over a long weekend (his death and resurrection). His life and ministry are important too. Sometimes the Gospels speak of the healing acts of Jesus as 'signs' of the coming rule of God. Sometimes Jesus heals out of the sheer goodness of his heart with nothing more said. People engaged in healthcare mission will sometimes be given opportunities to explain their motivation and it is worth having a ready answer. Equally the ministry of Jesus suggests that acts of healing, generosity and compassion can often be left to speak for themselves.

3. 'General revelation'. We do not 'take' Christ with us. He is already present as the creator and sustainer of all things, present in all that is good, and present by his Spirit, in his Church, and at work in the lives of God-fearers.

4. 'Presence'. This takes on special significance in places where opportunities to speak openly are restricted. Presence in other cultures is in itself beneficial. Third world Christians say that the presence of missionaries and 'tentmakers' reminds them of the missionary origins of their churches and that the mandate for mission never ends. Presence in the West of third world Christians often challenges timidity in witness and the tendency to 'privatise' matters of faith.

5. The 'Great Commission' (Matthew 28:19-20). This has often been misinterpreted by enthusiastic apologists for missions. In the Greek the imperative is not 'go', but 'make disciples'. The declaration assumes that followers of Jesus are a people on the move: 'As you go, make disciples'.

Conclusion

The emergence of HealthServe is a highly important development. Moreover it is good news for the UK scene for at least two reasons:

- More and more health professionals are being encouraged to seek out opportunities for electives overseas as part of their training and development. Without necessarily competing with other agencies HealthServe will be an important clearing house, identifying opportunities and helping those who go to be fully prepared.
- Christian health professionals are almost invisible. A major developmental job is needed to identify the Christian health professionals in this country and to discover what sort of support they need.

It all points to the need to find new approaches. HealthServe's first priority will be to enlist the help of churches to identify Christian health professionals, and link them up in interesting new ways. I wish it every success.

John Martin has broad experience of mission and is Associate Editor of *Triple Helix*

What can your church do?

You may be surprised how many healthcare professionals belong to your church. At my former church our mission committee identified the world of work as a key area of witness and ran a series of 'World of Work Seminars'. I shouldn't have been surprised that the biggest single sub-grouping was health professionals. But there were two sources of surprise. Several had hardly any contacts in the church at all and these seminars brought them 'out of the woodwork'. Worse, perhaps, was that some did not know that people they sat with in church week after week worked in healthcare.

1. Urge your church to plan a special service or event for *Health Care Sunday* (17th October). Make an effort to identify all the health professionals in your church. Have a special lunch or supper. Invite one or two to tell the entire congregation about the stresses and opportunities that form part of their everyday work. Pray regularly for them.

2. If a health professional from your church has worked overseas either on a short or long term basis, on their return gather other health professionals for a welcome home party. Before festivities start update the person on developments in the NHS and all the different professions.

Mental Health: Cinderel

In the first week of December 1998 a groundbreaking international workshop was held at High Leigh Conference Centre, run jointly by the Overseas Health Care Advisory Forum of the Churches' Commission on Mission and by the Evangelical Missionary Alliance. Of the 88 participants 52 were overseas nationals and several others were expatriates with overseas experience. John Lowther reports.

Photo: John Lowther

When the madness goes to the market place

A bright wintry sun poured through the windows as we met for the final session of the workshop. In prayer time, Peter Green chose the story of the healing of Legion and my thoughts went back not only to my patients who have exhibited similar excessive and destructive strength but also to our first session three nights before. Participants from a number of African countries, India and Nepal highlighted the breadth of the problems of mental illness in their countries, the few facilities and the valiant efforts of family to cope with the ill relative. But when 'the madness goes to the market place' their coping mechanisms fail. With violence and aggression or a 'David' dancing naked in public places, and in the absence of freely available anti-psychotic drugs, many patients end up as vagrants.

Photo: John Lowther

Church based projects

Examples of 'up and running' church based projects in Nepal, Malawi and Nigeria captured the imagination. I found particularly interesting the very innovative Nigerian project helping vagrant, chronic psychotic patients arriving at a village settlement. There they are able to come and go as they please, living and working side by side with mentally healthy compatriots. Because they are enabled to have treatment, many are eventually rehabilitated back into their families. As a result other families ask for their mentally ill relatives, still within the family fold, to be admitted for treatment. This has led to a community based service funded by national and local government sources but organised by the same Christian group.

Changes required

The workshop was a good blend of academic learning and participants' contributions of their own experiences. Professor Andrew Sims reviewed the changes in practice and advances in treatment which make it even more incumbent on Christians to provide for the care and treatment of people with mental illness. This will need efforts to change attitudes inside and outside the Church and programmes to train local staff in the variety of disciplines which need to co-operate in the care of the mentally ill. With the shortage of national professionals this still needs expatriate help.

Professional assessment: community choice

From her experience in Nepal Dr Christine Wright spoke of the necessity for a professional approach to assessing the needs of a population, and letting the local community give priority to those needs. One community considered an alcohol service essential and that led to a whole

lla in the developing world

series of rehabilitation measures and social changes. The professionals would have chosen a different priority! Dr Ewan Wilkinson - ex Malawi and with a public health background - gave valuable practical advice on the collection of data to optimise the usefulness of such assessments.

A biblical framework

From Singapore, Robert Solomon - doctor, theologian and pastor - brought a wealth of practical experience and academic learning as he discussed 'A biblical framework for mental health care'. He started with the Christian belief that we are:

- created in God's image which requires us to give to all the dignity we owe to God
- social beings made to live in community
- embodied beings - made of clay into whom God has breathed; bodies to be temples of God, not prisons

He then developed the implications of these beliefs for the Christian practice of mental health care and for the churches' support.

Traditional healers

Then came the necessity of acknowledging the role of the many types of traditional healers, who in Africa and Asia are the first line of treatment for the vast majority of the population. How do we co-operate with them and where do we draw the line? The issue is different for Westerners whose cultures largely ignore the spirit world - even though we acknowledge its existence Sunday by Sunday in our worship - but for colleagues in Africa and elsewhere the spirit world is an ever-present reality for the vast majority of their compatriots. The tensions of this dilemma for African Christians were obvious as delegates discussed the subject.

Photo: John Lowther

Of great help in assessing where to draw the line was the paper 'Challenge and opportunity - traditional medicine and a Christian response' by Brother Raphael Ngong Teh. Traditional medicine has so many components from straightforward herbalism to witchcraft. The debate is similar to the Western one about alternative medicine and its New Age connections.

Physical, mental, social and spiritual factors

Other speakers outlined ways of weeding out from general medical clinics patients with mental illness presenting with physical symptoms. Professor Ager quoted research findings from Israel showing that the support from a self-help group reduced the mental symptoms in women undergoing continuing severe stresses. He also raised the subject of the effect of such stressful experience on expatriates working in the developing world. We were warned of the danger of seeing mental illness solely in the context of the science of psychiatry and neglecting the role of global developments, local cultural understandings, and the input of Christian faith.

The global burden of mental disorder

- 12% of the global burden of disease in 14-44 year olds is caused by mental health problems
- 40 million worldwide suffer from severe mental disorder
- By the year 2000 there will be 23 million people with schizophrenia in the developing countries

Mental and physical health problems cause or complicate each other. No longer can healthcare afford to ignore this large slice of global health practice. Neither can the Church. Whether clinicians, administrators or other involved professionals we are all challenged to mediate God's presence to this unfortunate group of humanity.

John Lowther has mission experience, was a consultant psychiatrist and is now medical adviser to the Salvation Army International Headquarters

Director of HealthServe

HealthServe (see pp 10-11) is an exciting new initiative dedicated to healthcare mission. It has been set up under the auspices of the Medical Missionary Association with the key objective of establishing a Resource Centre to serve Christian churches, organisations and healthcare professionals.

The Resource Centre will initially be based in central London. Its activities will include: developing a database of Christian healthcare professionals; organising conferences and workshops; commissioning high quality research on healthcare mission; maintaining a website; publishing a quarterly newsletter; dialogue with aid agencies; and involvement in national initiatives such as Health Care Sunday. We wish to appoint an exceptional individual to establish the Resource Centre and lead its development. Candidates probably in the age range of 30-45 should be evangelical Christians with a heart for mission. They should have experience of the healthcare sector and must be able to demonstrate strong communication skills and ideally computer literacy. An understanding of marketing or fundraising in a large charity could be useful.

Salary will be commensurate with the responsibilities of the position and experience of the successful candidate. A copy of the Job Description and an application pack can be obtained from Sir Timothy Hoare, Career Plan Limited, 33 John's Mews, London WC1N 2NS. Tel. 0171-242 5775. Fax 0171-831 7623

Introducing ICTHES

Editors! Writers! Proof readers!

Do you have the time and energy to contribute to publications prepared for healthcare personnel in developing countries? We are looking for Christians with experience of service overseas in medical and educational fields.

A new charity is about to be registered. ICTHES (International Community Trust for Health and Educational Services) will have close links with the MMA and CMF (three of the trustees of ICTHES are on the MMA Council).

The inspiration for this vision has been the 'success' of the *Journal of Community Eye Health* which peaked at a free circulation of 27,000 to 188 countries. Now we invite subscriptions from the West. The idea for this 16 page journal was originally given in Afghanistan where the lack of information for health workers in deprived and isolated areas of the world became apparent. We now believe the time is right to expand into other medical and educational areas. Other educational materials have also been developed, such as teaching slide sets, videos, a CD-ROM, manuals etc. These are presently housed in the International Resource Centre for the Prevention of Blindness in London.

It is likely that our first new journal will be the *Journal of Injury and Reconstructive Surgery*. We have discussed a possible ENT Journal. Other journals and teaching materials may follow. The options are many and varied, depending on the recognised needs and the available resources and personnel.

If you can help us in any way with ideas or support please let us know. Please pray with us as we seek to fulfil this programme and vision. Contact Murray McGavin, Canniesburn, 71 Brickhill Drive, Bedford MK41 7QE

Christian Medical Service Teams

There are many opportunities to join teams of health professionals visiting countries to teach, learn and share in professional activities. Such visits may lead to longer term service which will usually involve learning a language.

Central Asia

Medical Ministry International. Contact Stephen Wallace, Frontiers, PO Box 7, Northampton NN1 5AF. Tel. 01604 233535

Elam Ministries want doctors and nurses to join team of 14 to serve in a short term medical mission, May 1-21. Must be self supported. Contact Chrish Jayasuriya at 'Grenville', Grenville Road, Shackleford, Godalming, Surrey GU8 6AX. Tel. 01483 427778/9. Fax 01483 427707. E-mail Chrishj@aol.com

China

Medical Services International (see centre pages last edition) issue a challenging invitation to health professionals in the UK to partner hospital and healthcare services at Chongqing. The Second Affiliated Hospital of Chongqing University of Medical Sciences provides healthcare and is a centre for teaching and scientific research. It grew out of the hospital founded in 1892 by Methodist Missions. There are departments in medicine, surgery, orthopaedics, O&G, paediatrics and other associated clinical services. Special research is carried out into liver diseases, gastroenterology, cardiology, and radiology and ultrasound techniques.

International exchange and communication in clinical care and research is welcomed. Short term visits for teaching and exchange of specialist information can be arranged through MSI.

Professional expertise in therapy, clinical and nursing care, particularly in intensive care, is needed for teaching and demonstration seminars. For village healthcare, short and long term training and planning programmes in prevention and healthcare delivery can be arranged. Other MSI associated programmes include teaching English at the Medical School, management and accountancy courses and partnership in livestock care at village level.

Contact: MSI, 42 Telston Lane, Otford, Sevenoaks TN14 5JX.
E-mail 113720.362@compuserve.com

Jian Hua Foundation has been recruiting Christian professionals to work in China since 1981 and is registered with the Chinese State Bureau of Foreign Experts. Stephen and Denise Wang supervise JHF medical work and personnel. Current projects include:

Medical teams to visit two counties in Qinghai Province in North West China.

Children's rehabilitation in Tianjin, North East China. Long and short term volunteers including trained therapists and special needs teachers needed to help in a centre for children aged 3-17 with severe mental and physical disabilities.

Student electives - through contacts they have around China.

Contact c/o Doug Plummer, 77 Southcliffe Road, Carlton, Nottingham NG4 1ES. E-mail DougPlummer@compuserve.com

vacancies overseas:

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. A much longer list of Opportunities for Service mostly through UK-based mission societies is available in the MMA magazine *Saving Health* (see below).

AFRICA

Tanzania

Retail pharmacist required for important and busy shop in Dodoma for at least 3 years until national available. Would need to learn Kiswahili, be involved in daily prayers and with local community of believers. Accommodation, transport, schools and local salary available. Contact Rt Rev G Mdimi Mhogolo, Bishop of Central Tanganyika, PO Box 15, Dodoma, Tanzania. Tel. 255-61-324050. Fax 255-61-320004. E-mail Mhogolo@MAF.org

Doctor urgently needed for team caring for 40,000 Congolese refugees in western Tanzania. Short term positions possible for those with previous overseas experience. Situation available immediately. Contact CORD (Christian Outreach - Relief and Development), New Street, Leamington Spa, Warwickshire CV31 1HP. Tel. 01926 315301. Fax 01926 885786. E-mail corduk@compuserve.com

Uganda

Kisiizi Hospital needs senior Medical Officer, 3-4 year contract: 'Clinical and hospital management duties, supervision of primary care activities in newly established health sub-district. Able to start mid 1999.' Also general surgeon to head surgical department including supervision and training of interns. Contract 2-4 years from January 2001. Contact Dr Lionel Mills, Kisiizi Hospital, PO Box 109, Kabale, Uganda. Fax 00871 761 587 166 or Chris Hindley, Mid Africa Ministry, 157 Waterloo Road, London SE1 8UU

Zimbabwe

Island Hospice Service. Home based service with professional team of nurses and social workers and busy part time medical director needs full time medical officer. Developing hospital support team, 17 branches throughout the country. No funding but a grant might be sourced. Contact Carla Lamadora, Cambridge Road, Avondale, Harare. E-mail island@mango.zw

ASIA

Cambodia

Community health manager, doctor and nurse/midwife for community health focusing on primary and preventive care in under-served rural areas. Other opportunities in broad-based community development. Contact John Heard, Southeast Asian Outreach, 90 Windmill Street, Gravesend, Kent DA12 1LH

Central Asia

Operation Mobilisation are looking for physiotherapists but also doctors and other health professionals - Personnel Department, Operation Mobilisation, The Quinta, Weston Rhyn, Oswestry, Shropshire SY10 7LT. Tel. 01691 773388

Nepal

Health services partnership director (working in close co-operation with government in health services development in Midwest and West regions). Finance director developing financial policy. Medical director (senior technical representative at national and international level). Project director for leprosy relief, AIDS prevention and drugs education programmes. Contact John Reynolds, International Nepal Fellowship, 69 Wentworth Road, Harborne, Birmingham B17 9SS. Tel. 0121-427 8833 or e-mail jreynolds@inf.org.uk

AUSTRALASIA/PACIFIC OCEAN

Papua New Guinea

Anglican Church Health Service: two newly established Medical Officer posts in rural areas. Both postholders expected to provide inpatient and outpatient services at the health centre but strong emphasis on public health and health promotion. Applicants should have right of entry to UK. Contact PNG Church Partnership, 157 Waterloo Road, London SE1 8XA. Tel. 0171-928 8681. Fax 0171-928 2371

Solomon Islands

Helena Goldie Hospital. Dr John Low writes from this hospital frequently visited by UK elective students. He is helping out in the absence of other medical staff. The United Church of the Solomon Islands is looking for Medical Superintendent and Medical Officer. The hospital has 55 beds and serves 38 touring sites. Family accommodation and salaries at least equal to local ones. Contact Council for Mission and Ecumenical Co-operation, Box 21395, Christchurch, New Zealand or Medical Superintendent, Helena Goldie Hospital, PO Box 166, Munda, Solomon Islands. Office Tel. 00 (677) 61121. Fax 00 (677) 61258

EUROPE

Gibraltar

O&G consultant Peter Armon is looking for locums: PO Box 878, Gibraltar. Tel. 350 42552. E-mail 106277.333@compuserve.com

INTERNATIONAL

Project Managers required for various health programmes by:

Tear Fund International personnel team. Tel. 0181-943 7888. E-mail rns@tearfund.dircon.co.uk

World Vision International seek health manager for Sierra Leone and health officer for Liberia for health and nutrition programmes. Must have degree in medicine or nursing. Also a southern African nutritional project technical adviser to be based in Malawi. Tel. 01908 841000 or e-mail cliff.eaton@worldvision.org.uk

Among All Nations (AAN) is produced by the **Medical Missionary Association** (MMA) and **Christians in Healthcare** (CHC) in partnership with the Christian Medical Fellowship (CMF) as the international section of the CMF publication *Triple Helix*. The MMA also publishes its own magazine *Saving Health* (SH) which is designed for those wishing to know more about, pray for, give to and take part in medical mission. *Saving Health* is currently produced about once a year and a newsletter twice a year. *SH* and/or *AAN* are sent to MMA supporters who donate £5 or more a year (£3 for students and missionaries). MMA is building up a database of those based in the UK wishing to hear of specific types of service opportunities in medical mission and who may be available as locums at short notice. Please ask for a database 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. Websites: www.cmf.org.uk/mma/home.htm and www.healthserve.org

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

Nazareth Hospital: a unique mix

Medical student Rebekah Price on her elective in Israel:

The Nazareth Hospital was founded in 1861 and continues to be sponsored by The Edinburgh Medical Missionary Society. At the end of the British Mandate in 1956, over one million Palestinians became refugees and Nazareth became home for thousands of them.

In 1986 the hospital was recognised by the Israeli Ministry of Health and now all the Heads of Department have to be Israeli citizens or permanent residents in Israel. There are still expatriate staff and volunteers including the Hospital Director and Head of the Nursing School. The hospital continues to grow and a new Emergency Room is planned in 1999. It is reserved as a centre for casualties in the event of war.

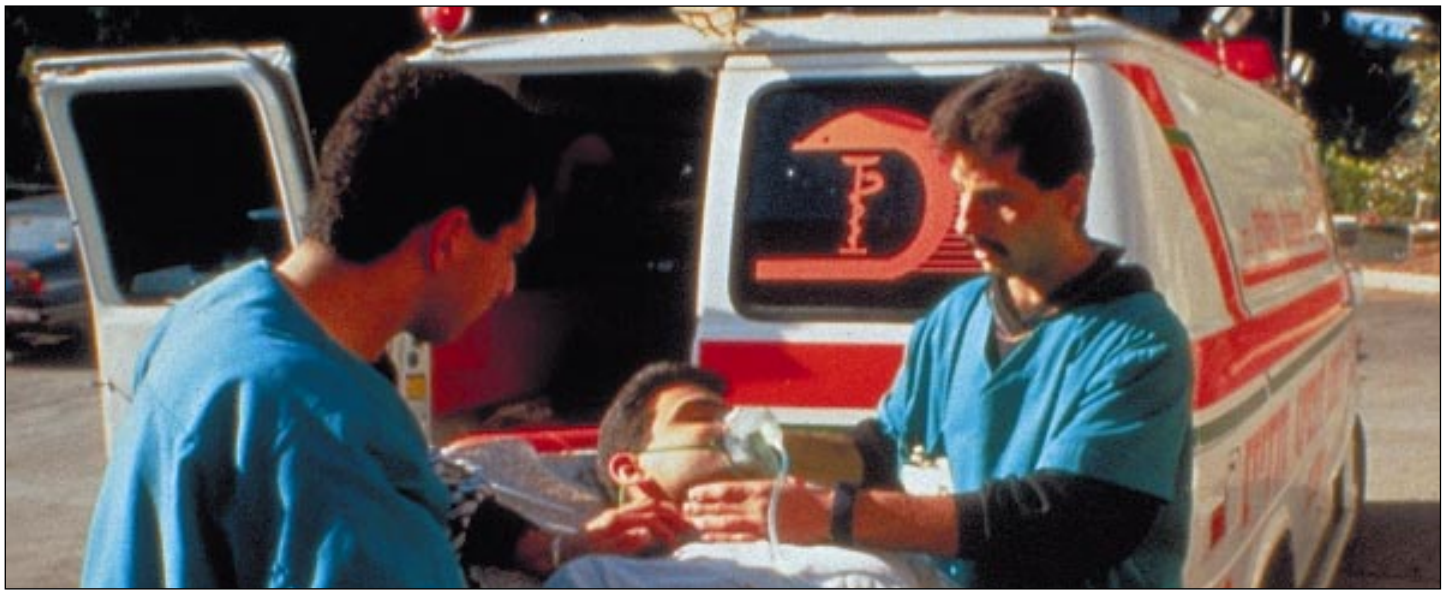


Photo: EMMS

The majority of the patients are Palestinian Arabs but Jews also visit the hospital from the newly built town of Nazareth Illit, a sharp contrast from the dusty, noisy maze of old Nazareth. The staff includes Christians, Muslims and Jews, including a number of immigrant Jewish doctors from Eastern Europe. Such a mixture of cultures working together in equality is unique in Israel and I felt privileged to be part of this working environment. Many of the Christian staff are Israeli citizens. There are worship services in the hospital chapel and weekly Bible studies.

I learnt much about this culture from observing the doctors and patients. Both Israelis and Arabs have an aggressive manner but patients seem very passive and untroubled by this. I was surprised at the medicalisation of childbirth - most mothers receive episiotomies, do not handle their babies after delivery, and seldom have their husbands present during labour and never at delivery. Afterwards the women were overjoyed to show me their infant and insisted I went away with pockets full of sticky sweet cakes, Arabic chocolate or pieces of fruit.

On the buses seats were filled with sleepy members of the Israeli Defence Force. The majority were in their late teens and the female contingent looked extremely glamorous in their figure-hugging khakis with an Uzi submachine gun slung over a shoulder.

We cycled up the Mount of Beatitudes and halfway around Lake Galilee, relishing in a freshwater swim in the lake to refresh us in the overbearing heat. We stayed in Jerusalem's Old City and soaked up the incredible atmosphere of this place, which has an almost tangible sense of destiny, visited Jericho, and swam in the Dead Sea - an extremely painful experience.

As we sought out in Bethlehem the site of the manger, it was no place of 'deep and dreamless sleep' because soldiers were guarding barriers on the road after the shooting of a young man.

Exploring the *souk* was a favourite activity in the early evening when the aromas of nuts, spices and coffee filled the cooling twilight air. One afternoon amongst the narrow cobbled streets and down stone steps I found the ancient synagogue. It is a simple building. Sitting inside I remembered a passage from Luke 4 where Jesus spoke in the synagogue at Nazareth about his priorities: not simply to stand and preach but to give the needy what they needed.

Rebekah Price was a final year medical student at Cardiff when she did her elective in summer 1998 with the help of an MMA grant

RevieWWWs

Following recent controversy, CyberDoc reviews websites on abortion and asks: is there a difference between being anti-abortion and being pro-life?

(The blue web-style underlines indicate hyperlinks on CyberDoc's website.)

While some Christians do accept abortion in some circumstances, many do not. This issue will review sites on the Internet which oppose abortion. To save on your typing, this quarter's links can all be found at http://xtn.org/cyberdoc/abortion/

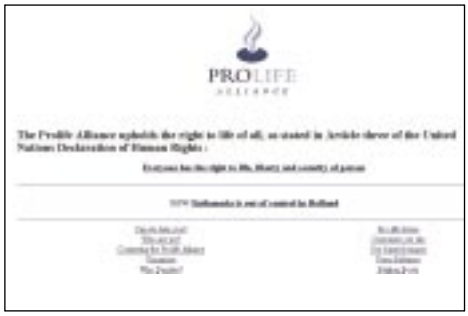
We cannot mention the Internet and abortion without discussing 'The Nuremburg Files'. This website published 'hit lists' of the names of US doctors performing abortions. The story of the offending website can be explored online on a page on a 'crime' site and in CNN's archives. After a court judgment the site was disconnected by its service provider although it resurfaced briefly courtesy of a Dutch free speech advocate. The site is no longer accessible and several other sites discussed here make the point that we are not so much anti-abortion as pro-life. It would seem sensible to make this distinction in the light of the murders of some of the doctors who appeared on those lists.

Prolife.com and prolife.org should not be confused. The former lives up to its 'com' status (short for 'commercial' to Internet users) with quotes from celebrity interviews on abortion, and a strident promotion of the 'save sex' campaign.

They also link abortion with the Pill, arguing strongly for the great unspoken likelihood that contraceptive pills may produce pre-implantation abortions. I would have liked to see more references to medical literature on this page to make their argument more compelling.

The other site with its 'org' status (loosely indicating 'charity' on the web) mainly lists online web pregnancy crisis services. The uk version of this was not so helpful with the explanation 'under construction' and only a couple of links. The Care for life site was also unfortunately brief with no way of tracking down any of their crisis centres. Life does have a list of their centres online although you could easily miss it and it is not very well designed.

Given a medical establishment in favour of abortion, perhaps it is necessary for there to be outlets for some form of research on abortion on the Internet. One of these is called 'after-abortion.org'. Here there is an online survey of post-abortion complications and a review of the literature on this subject. CARE has also made available the full text of their 'Commission of Inquiry into Fetal Sentience' which makes a strong case for babies feeling pain in the womb.



The prolife alliance website is informative, and up to date with latest news. If you would like to see the pictures of an abortion censored from their party political broadcast during the 1997 UK General Election they can be downloaded here.

I am pleased to report that if you want clear writing from a biblical perspective the Christian Medical Fellowship's collection of articles on abortion is by far the best starting point. These articles are simply brilliant, and provide a great source of biblical information together with UK facts and statistics. The important issue of conscientious objection being over-ridden is also handled well.

In my opinion some of the other pages about abortion on the world wide web seemed a little short on fact and high on hype.

CyberDoc is Adrian Warnock, an SHO in psychiatry on the Royal London Hospital rotation

readers' letters:

What is 'a Christian practice'?

*Brixham GP **Richard Montgomery** asks: What is an appropriate understanding of a sense of mission in primary health care?*

For the last three years I have been a partner in a Christian practice in a small town on the South Devon coast. During this time I have been struggling with the whole idea of what 'a Christian practice' means. I used to be a partner in a conventional practice in urban Nottingham, and certainly this partnership is different from my previous one, but I would be interested in hearing from readers as to what they feel a Christian practice should or should not be doing.

In the past there have been a number of models of Christian group practice. When I lived in the East End of London, where I was a medical student, I knew more than one doctor who worked in the Bethnal Green Medical Mission. That is clearly a very public upfront statement of what was trying to be achieved through that institution.

My current practice has had a long tradition also of being upfront about its Christian stance. At the time, this facilitated clear involvement in *Mission England*, with good results. In the past the practice has also held publicly to a particular moral and ethical position over contraception and abortion, although for various reasons this has relaxed in more recent years.

So in the previous generation, this practice's understanding of its sense of mission has been typified by activity in the areas of evangelism and morality. The question is, is this appropriate these days? What does it mean in this generation to be involved in a Christian practice?

I would be very interested to hear from readers. What 'Christian' things are being done in other similar practices around the country? I would be interested in provoking debate over this either in *Triple Helix* or by direct correspondence. If there was a lot of interest, I wouldn't mind co-ordinating some kind of seminar or workshop to consider the issue.

Clinical competence

*A recent case made retired consultant radiologist **John Bergin** from Cirencester ask some challenging questions about the Christian response to issues of competence:*

Most people will have read of the gynaecologist struck off the Register for what amounted to professional incompetence. Sadly there have been other similar cases. Do such examples raise issues which Christians in the health professions and the law ought to address? This particular case raises at least three issues:
1. How did an incompetent surgeon get appointed to a consultant post in the first place? I have sat on many advisory appointment committees over the years. Most of those appointed have proved capable and conscientious, but there have been mistakes. There are times when referees are more enthusiastic than accurate. As one cynic put it: 'some folk are glad to throw their dead cats over the wall'! How careful we should be both in giving and assessing references.
2. Not a few patients had suffered over the years from this surgeon's ministrations. Had none of the GPs who referred cases to him noticed that all was not well? Did they go on sending him cases?
3. This case like many others took years to come to light. Whatever the justifications for such delay (and I have heard many), 'justice delayed is justice denied' and this applies not only to the patient but also to the doctor involved. The medical profession is expected to reach what may be life and death decisions immediately. How can such legal delays be regarded as acceptable?

Are these not ethical problems which we as Christians should actively address?

Abortion Act 'Conscience Clause'

***Philippa Taylor** writes from CARE, Christian Action Research & Education:*

On behalf of the all-party Parliamentary pro-life group, CARE is carrying out some research into the operation of the Abortion Act 'Conscience Clause'. We are trying to obtain information on any cases of doctors or other healthcare personnel including nursing staff, ancillary workers or administrative staff who have had problems with the workings of this clause. For example, it may have failed to provide adequate protection or it may have been ignored.

If you have any information that may be useful, please write to:
Philippa Taylor, CARE, 53 Romney Street, London SW1P 3RF
e-mail: publicpolicy@care.org.uk

Conference for Nurses

***Jane Grier**, a staff nurse in London and former UCCF relay worker with nursing students, announces a day conference:*

On Saturday June 19th from 10.30-4.30 there will be a day conference in central London for qualified nurses. Titled 'The Gospel Challenge', there will be Bible teaching focusing on the urgency of the gospel and how the New Age is affecting nursing.

For a booking form please contact:
Jane Grier: 0411 506697
Jane Davies: 0117 983 8228

The Editor welcomes original letters for consideration for publication. They should have both Christian and healthcare content, should not normally exceed 400 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

fluid infusion and ethics

Gastroenterologist John Lennard-Jones discusses some problems of tube feeding and hydration

A good friend of mine, aged 82, whose life had been characterised by humour, independence and good health, suffered a severe stroke. He had few relatives and lived alone. When admitted to hospital he was stuporose and paralysed on one side. During the next six weeks, until he died, there was no sign of recovery and he lay with little or no recognition of visitors, unable to move in bed or to swallow. A tube was passed through his nose for fluid administration but he twitched his head, to express discomfort or disapproval, and repeatedly tried to remove it with his unaffected hand. An intravenous glucose-saline infusion was therefore substituted and until his death he became visibly and progressively undernourished. The IV infusion appeared to prolong the period of dying, but without clinical benefit.

Should it have been started and should it have been continued? Was it continued so carers could avoid a difficult ethical decision? Should they have over-ruled my friend's resistance to the nasogastric tube feed and restrained his hand? What else could have been done?

These are everyday questions of clinical practice but illustrate problems of patient autonomy and consent, withholding or withdrawing treatment, and the compassionate care of the dying. Many Christians are troubled about ethical problems like these and the following comments are made as much to provoke discussion as to offer guidance.

Attention to drinking and eating as an aspect of basic care

Those who care for babies, the handicapped, the sick, or the old have a duty of care to provide appropriate fluids and nourishment, and to assist with drinking and eating as needed, as long as the person in their care is willing and able to drink (or suck) and swallow safely. This ethical imperative is the fall-back position whenever ethical decisions arise concerning fluid infusion.

Fluid infusion

A distinction has to be drawn between simple solutions of salts and glucose, and nutritious fluids containing all the nutrients essential for life. Glucose-saline solutions can be given parenterally as a temporary measure to prevent fluid depletion. As the sole treatment over weeks their use is associated with progressive undernutrition and eventually death.

Nutritious fluids containing balanced proportions of fat, carbohydrate, protein, vitamins and trace elements can be introduced into the stomach or intestine provided that intestinal absorption is possible. Infusion of nutrients may be via the gullet or through the abdominal wall. A tube can be introduced through the abdominal wall at surgery or without open operation (percutaneous gastrostomy) using an endoscopic or radiological technique. Use of such a technique is now commonplace and generally successful, though it is sometimes complicated. A gastrostomy tube is out of sight and rapid infusion of a relatively large volume at a time is possible so that an optimal nutritional intake is easier to maintain than with a nasogastric tube.

Intravenous feeding requires considerable clinical skill and organisation. Since it is liable to major complications, particularly blood-borne infection, and is expensive, it is reserved for patients with intestinal failure.

Is there a legal and ethical distinction between basic nutritional care and tube feeding?

Legal judgments in the Tony Bland case and similar cases in this and other countries have regarded tube feeding for adults as a medical treatment. This is a crucial judgment because, if accepted, it means that like any other medical intervention a tube feed should form part of a treatment plan with a defined goal. It can be argued conversely that a nasogastric tube is simply a special utensil used for feeding and that tube feeding is therefore part of basic care. However, in view of its invasive nature, most health carers accept the legal judgment, except perhaps for infants who cannot suck when use of a tube may be regarded as part of basic care.

Possible goals of fluid infusion

The goal of giving a glucose-saline infusion may be to prevent or relieve thirst, or prevent fluid depletion with loss of circulatory fluid volume and failure of urinary excretion. The aim of giving fluid and nutrients is most commonly to maintain or restore nutrition when a person cannot drink or eat enough to do so unaided. A goal in neurological disorders may be to prevent malnutrition as an additional factor contributing to the muscle weakness caused by the disease. For patients with cerebral disorders who cannot swallow, the object may be to maintain

nutrition for sufficient time to allow some or complete neurological recovery.

Consultation, communication, consent and competence

Healthcare in this country is now usually given by a team, each member contributing a different skill. Christian practice should be marked by communication and consultation within the team so that, as far as possible, all agree on a treatment plan, especially if difficult ethical decisions are needed.

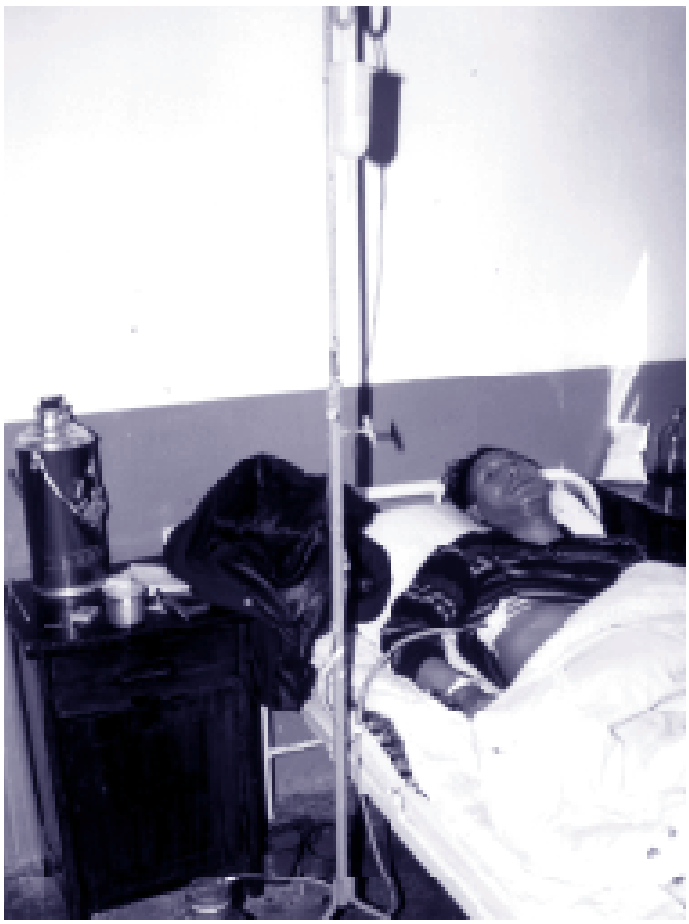


Photo: MSI

English law is explicit on the right of an adult to refuse any type of treatment, even though to others the decision is not apparently in his or her best interest. The ability to make such decisions is described as 'competence' which needs to be judged against the actual decision to be made, in this case the infusion of fluid into the body through a needle or tube. It may be difficult to assess whether a patient after a severe stroke understands what is said. Furthermore, patients with cerebral damage may have difficulty communicating their wishes. Despite these difficulties, a joint publication by the British Medical Association and the Law Society regards underestimation of competence as unethical and warns against it, provided that mental illness is not the reason for an apparently irrational decision.

Where a patient is unconscious, or in a vegetative state, or mentally confused, and is unable to make a decision the doctor should enquire as to whether, when competent earlier in life, s/he may have expressed wishes in writing or orally about the treatment s/he would wish to receive or refuse in these circumstances. At present such an instruction, especially if written, has ethical and some legal force. The Government has issued a consultation document on the whole matter of making decisions on behalf of incompetent patients and is likely to introduce proposals for legislation concerning advance refusals of treatment. It is suggested that a person should never be able to refuse basic care, including direct oral nutrition and hydration. There is controversy as to whether advance refusals should be allowed to forbid the use of hydration or feeding by tube. The major argument against such refusal is that it is impossible for anyone to envisage under what circumstances their advance directive may be applicable. In the situation that actually occurs it may be clinically appropriate to give liquid, with or without nutrients, by tube.

At present, the decision as to whether an infusion of fluid should be given, withheld, or withdrawn from an incompetent patient rests with the doctor in charge who needs to find out if s/he has previously expressed an opinion and who decides in his or her 'best interest'. If involved, a Court does not direct what should, or should not, be done; it forms a declaratory judgment about the legality of any action the doctor proposes to take. Clearly, good practice demands early, repeated and sensitive consultation with the family or others closest to the patient. As the law now stands a relative cannot make a decision on behalf of a patient but can give an opinion as to what the patient would have wished. Future proposed legislation may enable a competent patient to appoint a proxy, as is done in America, to make decisions on their behalf regarding health care if s/he becomes incompetent later.

When is a fluid infusion beneficial?

Hydration or nutrition by tube should be considered when adequate hydration or nutrition cannot be achieved by normal drinking and eating, and the procedure is clinically appropriate. Regrettably, the use of a fluid infusion is sometimes not considered because the need for it is not recognised.

When may a tube feed be withheld or withdrawn?

a. Success

First, and obviously, if the goal of treatment is achieved and the patient can now drink and eat enough to maintain health an infusion is stopped.

b. Care of the dying

Compassionate care of the dying is an essential part of care for the sick in which Christians have taken a lead. If a disorder is progressive, and no treatment is available to halt its progress, there comes a stage at which death in the near future appears inevitable. At this stage the goal of treatment is to provide comfort, relief of symptoms and loving support. People who are dying often lose the desire to drink or eat quantities normal in health. The situation is not that the person does not drink and therefore will die, rather that the person is dying and does not wish to drink. Many publications suggest that the dying do not often suffer from thirst and that a dry mouth can be relieved by local measures. Infusion of fluid by tube is intrusive unless thirst is truly a symptom and cannot be relieved by sips of fluid and mouth care.

The hospice movement has led the world in the care of terminal illness, particularly cancer and some progressive neurological conditions. It now seems appropriate to extend these principles of care to other common modes of death, for example severe stroke or dementia. There is public concern at present regarding the use or non-use of hydration by tube when patients are apparently unaware of symptoms, including thirst, when they need heavy sedation or analgesia to relieve pain or other unpleasant symptoms at the extreme end of life.

The guiding principles are to avoid distress to the patient and prevent concern among relatives if they feel that hydration is needed. If needed for either reason, the simplest and least distressing method of fluid administration should be used. For example, rectal infusion may have a role.

During the terminal phase of dementia sufferers may resist all attempts to assist them with drinking and eating. This causes great distress to carers and relatives. Provided that the failure to eat or drink is not due to a complication such as infection, carers and the family may decide, after much discussion and with great regret, that the sufferer should take as much or as little as he or she wishes because this behaviour usually indicates a terminal phase of the illness.

c. Failure of the therapeutic goal

If at the end of a trial period of infusion it is evident that the goal originally set has not been achieved, a decision is needed to continue, to stop or to change the treatment. In the widely publicised condition of persistent vegetative state the goal of a tube feed may be to allow time for possible cerebral recovery, or to prolong physical life for as long as possible. Minimal self-awareness or communication is very difficult to detect, especially if sight is lost, and requires skilled observation, preferably in a special unit, to avoid misdiagnosis of a 'locked-in' state in which mental function cannot express itself due to paralysis. Observation has shown that if there is not return of any self-awareness or communication within 6 months of an anoxic episode and 12 months of traumatic head injury, recovery is unlikely.

There may come a time when the healthcare team and the relatives all agree in believing that the tube feed has failed in the objective of giving time for cerebral recovery. A clinical decision to withdraw the feed because it is 'futile' may be recommended, though the consent of a Court is necessary. Such withdrawal does not mean abandonment of care. For example, the nurses looking after Tony Bland redoubled their solicitude until death occurred peacefully after about 10 days, not as popularly believed from starvation, but from the metabolic and circulatory consequences of fluid depletion. Death was due to the original cerebral anoxia; though it had been postponed by medical and nursing care.

Withholding a particular type of tube feed may be appropriate because it would be an excessive burden. For example, after a totally disabling stroke from which there is no evidence of recovery a percutaneous gastrostomy might prolong life, but the published evidence is that survival is often short, at a cost to the patient of a further period of prolonged immobility, dysphagia and impaired mental faculties. The social circumstances, especially the burden on an elderly spouse, have also to be taken into account, though the patient's welfare is paramount.

When can a tube feed be imposed on an unwilling person?

Patients admitted to hospital involuntarily under the provisions of the Mental Health Act 1983 can be given treatment for the mental illness without their consent but in their 'best interest'. Anorexia nervosa is a defined mental illness and a legal judgment has ruled that a tube feed can be regarded as part of the treatment for this condition. This situation would only arise if the patient's under-nourishment was so severe that it became a danger to life, thus justifying enforced treatment. Every effort would clearly be made to persuade the sufferer to accept a treatment regime voluntarily, and this might include a tube feed.

Conclusion

Christians believe that the soul is eternal but the body is temporal and mortal. The soul is inextricably linked with memory, purpose, moral qualities, personal relationships and spirituality, even if these attributes are present in the slightest degree. Christians thus seek to protect human life defined in these terms. Christians also have a distinctive view of death and dying. Death is a portal to eternity, not extinction.

Our duty as health carers is lovingly to help our patients through birth, life and death, but not to prolong their dying. It is not incumbent upon us to postpone death indefinitely when mental faculties have irrecoverably ceased due to cerebral damage or disease, and remaining life consists only of autonomically controlled systems.

There is no universal answer to these ethical problems; each has to be faced as it arises in the care of one person. Am I neglecting my patient's need for fluid or nutritional treatment? Am I prolonging death rather than promoting life? What are my motives in giving an apparently burdensome or futile treatment? It may take moral conviction and courage for a compassionate carer to give or continue an infusion, or conversely to withhold or withdraw it.

John Lennard-Jones edited a report published by the King's Fund Centre in 1992 entitled 'A Positive Approach to Nutrition as Treatment'. Now retired, he lives in Suffolk

Further reading

This article is based on a longer publication with an extensive bibliography entitled 'Ethical and Legal Aspects of Clinical Hydration and Nutritional Support' published by the British Association for Parenteral and Enteral Nutrition (obtainable from BAPEN PO Box 922, Maidenhead, Berks SL6 4SH, price £10)

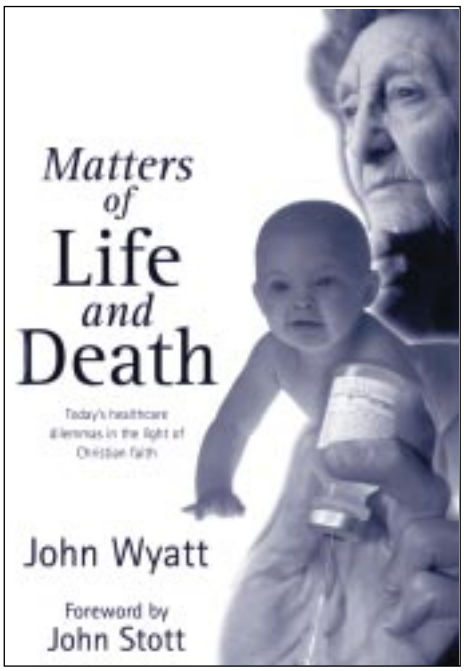
reviews:

Matters of Life and Death

John Wyatt. CMF/IVP, Leicester. 1998. 256pp. £9.99 Pb. ISBN 0 85111 588 8

How do you respond to the woman whose baby is born with severe abnormalities? What should be done with spare embryos following IVF? Is cloning wrong if the embryo is manipulated to generate cells for medical research? These real questions might affect us professionally or personally, but how do we respond as Christians? What does the Bible say? Do we become hardened and desensitised to these issues or paralysed by the enormity and complexity of it all?

The author delves thoroughly and systematically through the current dilemmas in healthcare, guiding us through the developments in science, technology and society which have brought us to this point. He illustrates with poignant test case examples as well as everyday ones, highlighting the complexities and legalities involved, and the human pain behind every ethical dilemma.



From the Christian perspective, he then makes sense of the changed (?warped) humanistic thinking when we remove God from the picture. For example, from the chapter on reproductive technology, one of our biggest problems is our understanding of how to manipulate the construction of our bodies: 'We can improve on the Mark 1 old-fashioned design' is the belief of those who have a 'Lego Kit view of the human body'.

Our bodies are instead wonderful, original artistic masterpieces which reflect the meticulous design and order imposed by a Creator's will and purpose. The individual has value not because of character or ability to perform everyday activities, but through being made in the image of God. This will affect the way we treat individuals and view suffering and people's supposed 'quality of life'. The author writes with integrity, compassion and biblical insight. He doesn't pretend to have all the answers yet speaks honestly with great experience and understanding. He is an expert in his field of neonatal paediatrics and has grappled with many of the issues described.

This book is not light reading, but I highly recommend it both to healthcare professionals and lay people interested in gaining an up to date, thorough, and faithful analysis of the major life and death issues in healthcare, and who wonder how to respond as Christians. It could also be recommended to colleagues not yet Christians, to help them make sense of the value of life that God has given us.

Jane Grier
(Staff Nurse, King's College Hospital, London)

GP Tomorrow

Eds Jamie Harrison and Tim van Zwanenberg. Radcliffe Medical Press, Abingdon. 1998. 204pp. £17.50 Pb. ISBN 1 85775 203 1

'Family doctors and community nurses in the lead' is a key theme of 'The new NHS - Modern and Dependable'. But what kind of family doctors will they be? Jamie Harrison and Tim van Zwanenberg have brought together a number of authors to seek to answer that question for the benefit of patients, managers and doctors. This is a tall order for readers having such different concerns so they propose different routes through the book: no one is expected to start at chapter 1!

The core of the book is a series of experiments on developing career patterns for future family doctors. How are you going to get people to work in practices under strain? What about pressures in mid-career? Can we support people who are isolated in rural districts? Above all, how

are we going to get people started on a worthwhile career in primary care once they've finished training? These may not sound like new problems, but the authors set the scene by suggesting that changes in training, the organisation of primary care, information technology, the nature of the consultation and, above all, the worldview of people in this post-modern society, give them a new perspective.

Doctors' wants and patients' expectations are discussed at length. Do they conflict? The authors do find ways to reconcile them although it is not always clear how a 'continuing relationship' with a GP can be developed alongside part-time working and portfolio careers. Perhaps it is the needs of the doctors, regaining control of their destinies, rather than the service, which seem the focus of the book? Nurses do not figure as much as they might - especially the idea of nurse-led primary care. It also seemed sad that a professional vocation should be seen as a key and altruism as no more than a defence which may give way under stress. This may be true for post-modern people, but what about the Good Samaritan?

Despite these comments, this is a useful book. It does more than raise questions, it sets an agenda for thinking through answers. All interested in primary health care would benefit from reading it.

Carl Whitehouse
(Professor of Teaching Medicine in the Community, University of Manchester)

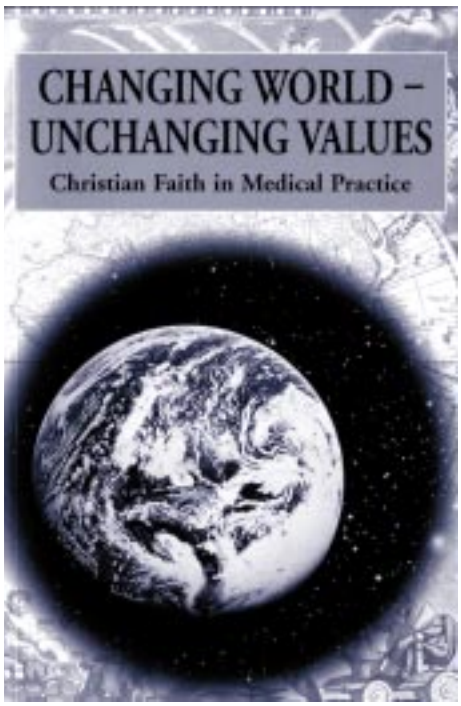
Changing World - Unchanging Values

Eds Janet Goodall and Keith Sanders. International Christian Medical and Dental Association, Cambridge. 1998. 395pp. £7.50 Pb. ISBN 0 9532690 0 0

This important book gives insight into the work of the International Christian Medical and Dental Association (ICMDA) and its predecessor, the International Congress of Christian Physicians, over the past 35 years. It is a partial record of the ten world congresses and 50 regional conferences held during this time, containing 63 of the Bible addresses and papers given, and some short summaries of papers including such gems as Robert Twycross on euthanasia and Denis Burkitt on 'front line' research. The book's purposes are to affirm the Christian principles that underlie ICMDA's work and to inspire doctors, dentists and students as they consider healthcare into the next millennium.

The book starts by restating the aims, basis and beliefs of ICMDA and then papers are arranged in five sections. It ends with a short subject index and author list. The three papers by Arnold Aldis forming the first section entitled 'The Firm Foundation' set the tone for the book as a whole. As in the Bible, healing is seen as implying spiritual and bodily renewal and the relationship between physical and spiritual health is discussed in several papers. 'Relationships', 'Ethical Principles', 'Christian Practice', and 'Responsibilities' are the further sections. It is perhaps unfortunate that some Bible studies given as series at particular conferences are separated in the text. Inevitably too, themes of separate conferences are lost in the arrangement into five sections.

Nevertheless this is a very useful book which is well worth reading. Some papers are outstanding. I found those by Malcolm Jeeves, Paul Tournier and Hans Gruber particularly thought provoking. A few have less impact in print than they probably had at the conference and all are weakened by the absence of any discussion. However, many provide useful analyses, advice and pointers to further



study and the transcultural and broad healthcare approach inherent in ICMDA is appreciated.

Topics covered include medical, surgical, hospital, community and dental practice; lifestyle issues including family, marriage, sexuality and drug abuse; suffering, disability and dying; education, poverty, affluence, and duty to the state; and reference to the healing ministry in the church. In view of the dates of the conferences, some more recent problems in genetics and infertility receive little attention. No doubt future accounts will correct this deficiency. Again, the wide spread of topics addressed prevents in-depth analysis of any particular area. The star is the internationality of ICMDA, so clearly portrayed. One looks forward to similar publications, hopefully before another 35 years go by!

Finally, the joint editors have been outstandingly successful in drawing the material together retrospectively. The book illustrates how well the aims of ICMDA have been met and should appear in several translations to enhance access to it.

Harold Jones
(Former Professor of Oral Medicine, University of Manchester)

The Bible and Healing

John Wilkinson. Handsel Press Ltd, Edinburgh - Eerdmans, Grand Rapids, Michigan. 1998. 350pp. £14.95 Hb. ISBN 1 871828 39 2

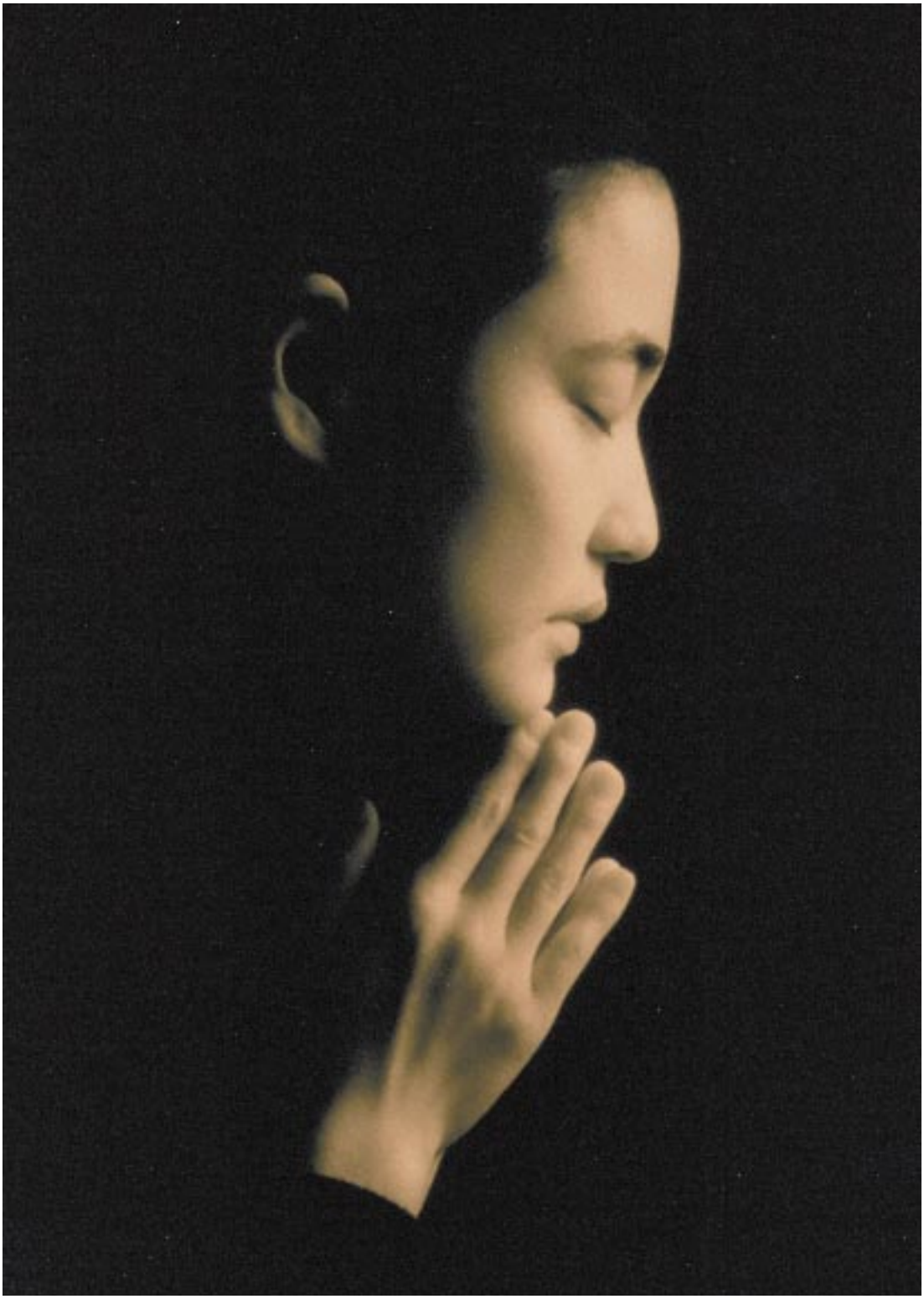
This book is described as 'a medical and theological commentary' on the subject of health and healing. As its author is a graduate in medicine and divinity of the University of Edinburgh he is well placed to tackle such a complex subject. He sets out the dilemmas in his introduction where he seeks to compare and contrast popular and professional understandings of the words 'health' and 'healing'. He underlines the fact that the term 'healing' has a chequered history and today is still virtually disowned both by medicine and theology, identified with charlatanism and quackery. Consequently he sets out to demonstrate that 'healing' is an acceptable description for modern professional health care as well as a biblical perspective of what God wills for mankind in general.

Wilkinson states that 'healing' in its ordinary sense means the restoration to normality of deranged physical functions and in the biblical perspective, the enabling of man to function as a whole in accordance with God's will for him. Following on from this he examines the scriptures to gain a wider understanding of what the Bible teaches about the words 'health' and 'healing' and seeks to understand the diseases and healings in the Bible in the light of modern medicine. What he achieves is to build a bridge of respect between medicine and healing whilst at the same time drawing boundaries between the disciplines of professional care and the Christian healing ministry, both of which are to serve the common aim of restoring the individual to wholeness and healthiness of life.

Where he is weakest is in the final chapter on the practice of the healing ministry today. This could well be expanded to include material on the need for a balanced style of ministry and some teaching on the subject of people who are not healed.

Russ Parker
(Director, Acorn Christian Healing Trust)

If any of you lacks wisdom . . .



. . . ask God