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For today's Christian doctor

BEATING BURNOUT

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EDITORIALS

While Europe Slept

History's clock turns full circle

The holocaust and the horrific 1939-45 World War had small beginnings. The Nazis talked such absurdities that few thoughtful people took them seriously. Common wisdom reasoned that the Nazis could serve a useful purpose: let them take out the Communists and *then* we'll take care of them. But while Europe slept the Nazis transformed themselves from a crazy gang into an all-but-unstoppable juggernaut.

This is why we cannot view the growing demand in Western culture for genetic selection and euthanasia as straws in the wind. Parallel to events like the legalisation of euthanasia in Belgium and the Netherlands, is a highly significant philosophic paradigm shift that threatens to break us from our ethical moorings. Peter Singer, past editor of the *Bioethics Journal*, and one of the most influential thinkers in bioethics is on record as saying: 'We can no longer base our ethics on the idea that human beings are a special form of creation made in the image of God…'.[1]

Failure to value the human person as bearer of the Creator's mark could easily propel us onto a slippery slope towards a replay of events in Germany in the 1930s. Dr Leo Alexander, a psychiatrist in the Office of the Chief Counsel for War Crimes at Nuremberg, traced the process: 'The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with an attitude, basic in the euthanasia movement that there is such a thing as a life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely but chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted …'. [2]

There are similarities between Germany in the 1930s and the direction of medicine today. Most worrying is removal of the Christian ethic of the strong laying down their lives for the weak (Romans 5:6) and support for a form of Darwinism that sees no problem about the weak being sacrificed for the strong.

John Martin
Associate Editor of Triple Helix

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Screening for Down's Syndrome and Cystic Fibrosis

Is there a sinister subtext?

Screening for Cystic Fibrosis and Down's syndrome is to be made available to all mothers and pregnant women under new government proposals unveiled in April by Public Health Minister Yvette Cooper (*BBC News Online 2001; 30 April*). Mark Barron, communications manager of the Cystic Fibrosis Trust, is not alone in hailing the proposal as 'fantastic news'. And it does sound like it.

At present only 20% of babies in the UK are screened for cystic fibrosis and earlier diagnosis must mean earlier treatment and better outcomes. A combination of therapeutic measures including mucolytics, airway clearance techniques, anti-inflammatories, antibiotics, pancreatic enzyme supplements and the advent of specialised treatment centres have meant vast improvements for CF patients' quality and indeed quantity of life. In the last 30 years alone the median lifespan of CF patients has more than tripled from eight years to 30 years (*www.cf-web.org/what-is-cf.html*). And then there is the future potential of gene therapy.

But just a minute! Were we talking about screening of babies or screening of pregnant mothers? There have been many advances in care for Down's syndrome children too, more in the educational, supportive and surgical (for associated anomalies) fields than in CF; and yet of the 1,000 Down's syndrome children picked up on antenatal screens each year 95% are aborted. Furthermore there is now a clear policy to search for those who have previously escaped the net through being born to younger unscreened mothers. If the government has its way, despite all the furore about not discriminating against Down's syndrome children for heart surgery, we can expect an even bigger drop in numbers born. Am I far-fetched in my concern that the same agenda might operate for cystic fibrosis; is the push for CF screening just a way of ensuring that these little people, who cost a lot emotionally and financially to care for, are going to be weeded out in a similar way to those with trisomy 21? I wonder.

If that is indeed the real agenda then as Christian doctors we must be ready to oppose it. Jesus laid down his life for the weak and the art of medicine, which he has had so much influence in shaping, is about strengthening the weak - not about eliminating them.

Peter Saunders
Managing Editor of Triple Helix

Aiding Africa

Antiretroviral drugs are important, but not enough

AIDS is a huge problem in Africa and at one time some expressed fears that it would not only wipe out a huge proportion of the population, but all healthcare provision as well. Viewed in that light it's hard for Westerners to understand the government of South Africa. At times it has sounded dangerously close to denial that there is an AIDS problem at all.

Of the 36 million AIDS sufferers world-wide, 25 million live in Africa. Of these, only a few thousand have access to antiretroviral drugs. In the West these drugs have effectively turned AIDS into a treatable chronic disease. But drug companies are unwilling to put them on the market at a price that the average African AIDS sufferer can afford. They insist they are entitled to recoup their huge investment in research and development.

Under the cover of its public rhetoric, however, the government of South Africa enacted legislation, the Medicines and Related Substances Control Amendment, allowing it to by-pass the patent laws and allow manufacture of cheaper antiretroviral drugs. In April, after a three-year legal battle, the South African High Court upheld the government's stance.

The South African ruling is a serious shot across the bows of powerful commercial interests. It will invite other governments to take a serious look at the unjust effects of patenting laws. It might include re-thinking issues arising from the patenting of genetic material and attempts to patent the genetic blueprint of staples such as basmati rice which has been produced by peasant farmers since the dawn of time.

But access to affordable drugs to treat AIDS is only part of a treatment regime. There needs to be counselling, testing, home and community-based care and much more. There have to be treatments for the various opportunist infections that are part and parcel of the curse of AIDS. Most importantly prevention, not just through condoms, but through marital faithfulness, must accompany any treatment strategy. But still, antiretroviral drugs could save millions of lives. And Christians whose God is demonstrably biased in favour of the poor will surely see the point of making these drugs affordable, and widely available.

John Martin
Associate Editor of Triple Helix

A Tragic Assisted Suicide

Prayerful commitment, not cynicism, is needed

A father suffocates his daughter after she fails to kill herself with an overdose and receives only a two year suspended sentence. The same girl had been turned out of a psychiatric hospital allegedly for giving cannabis to a fellow patient. The Media gives the impression that 'it's all the doctors' fault'.

How do we react to this? Ignore it as another anti-doctor story, and wonder if we can bring retirement dates forward? Why should we always be the fall guys for all of life's ills? Will this prompt another siren call from the euthanasia lobby?

Can we do any better than this? The poor girl's illness was long and difficult with eating disorder, severe alcohol dependency, manic depression and self harm (*BMJ 2001; 322:1311*). The NHS is not a perfect institution and by chance, sooner or later, she would have received an indifferent episode of care. GP trainers are encouraged to teach our registrars (and ourselves) to be honest with their feelings, so as to avoid them unconsciously tripping us up. Having faced our negative and therefore potentially destructive first thoughts we can then move on. Prolonged mental illness in a family does put indescribable stress on the other members. Who knows what we would do in a similar situation? Perhaps the mother is projecting her anguish, not to mention guilt, on to the NHS. Maybe we can hear the pain behind the voice. She's lost her daughter and may potentially too have lost her husband to gaol. The story might encourage us to consider what our local community psychiatric services are like and to press for more resources. Depression can be a very satisfying treatment to treat, but this tragic case is a reminder that it can be a fatal disease, especially for young people. Yet we are not omnipotent. Not every depressed person wants treatment nor can be treated successfully even in optimal conditions. But not caring is not an option.

But I'm out of my depth here. Rationalising may help to a degree, but something else is required. Prayer is needed, for the girl's soul, her parents, the medical staff involved, for challenging patients with intractable problems that it is our responsibility to see, and for ourselves.

Paul Vincent
GP trainer in Birtley, County Durham

New Global Health Fund

Too little, too late?

Poverty and health are closely linked; but it is not as widely known that communicable diseases now account for 77% of the 25-year difference in life expectancy between rich and poor nations. Tropical climates, poor nutrition, ignorance about prevention and treatment of disease and poorly developed health systems all contribute. And according to Professor Jeffrey Sachs, a Harvard economist and chair of the World Health Organisation's commission on macroeconomics and health, the malaria and HIV-AIDS pandemics between them are now proving two of the most important factors shaping both economic development and health in the poor world.

In an effort to bridge some of the gap the World Health Assembly has recently announced a new global health fund to fight infectious disease in developing countries (*BMJ* 2001; 322:1321-2, 2 June). The aim is to raise £5-7bn to be donated for HIV-AIDS, malaria and tuberculosis, but so far the US and Britain have pledged only £216m between them, much of that with strings attached.

Recent history gives little cause for hope. The gap between the rich and poor world is widening with over 40% of the 614 million people in less developed countries now living in absolute poverty. Since OECD countries agreed 10 years ago to scale up their development assistance aid flow has actually decreased to its lowest level for 20 years. Rich country aid to sub-Saharan African countries in 1999 was £600m or about 91p per person per year.

It's not well appreciated that God's judgment of Sodom was as much as for her greed and indifference as her sexual immorality. According to Ezekiel, 'She and her daughters were arrogant, overfed and unconcerned; they did not help the poor and needy'. (Ezekiel 16:48-49) Not a bad description of the Western world in which we live! By contrast 'defending the cause of the poor and needy' (Jeremiah 22:16) and spending oneself on behalf of the hungry (Isaiah 58:10) is part of what knowing God is all about. I wonder how we measure up as Christian doctors in Britain today?

Peter Saunders
Managing Editor of Triple Helix

Trevor Stammers sees similarities between the gay sex and tobacco smoking debates.

Sex, Lies & Cigarettes

Tasteful. Sensitive. Beautiful. That's what the creators of the recent gay advertising campaign say about their posters. On one level I'm inclined to agree with them. The image accompanying the slogan 'Thank God for men', could easily be of two brothers embracing each other. I certainly don't find it offensive on the grounds of indecency. But as a Christian doctor, I object to it because it is utterly dishonest. It reminds me of the tasteful, sensitive and beautiful images used in cigarette advertisements and like them it ought to carry a government health warning.

If the gay lifestyle only consisted of thanking God for other men, that would be fine. However, despite protests to the contrary from gay activists, it is anal intercourse that is central to gay sexual expression. Of course ano-receptive intercourse is an equally dangerous practice for gay men and straight women alike, but it is not integral to heterosexual union.

This is why anal cancer is now more common in homosexual men than cervical cancer is in women. Indeed, homosexual sex is altering the entire demographics of this disease and several others.

'I had a patient diagnosed with syphilis recently', a colleague from the North of England told me at a conference recently. 'Was he gay?' I ventured. 'How did you know that?' he gasped. Actually, it wasn't difficult. Even in Holland with its celebrated gay culture and safer-sex education, rates of syphilis have quadrupled and those of gonorrhoea doubled, in gay men in 1999. The latest statistics on sexually transmitted infections (STIs) in the UK show the same upward pattern here. To try and divert attention from such worrying trends, gay groups are propagating the spin that AIDS is a more common problem in the straight community. One of the directors of the current advertising campaign tried to push this line with me in a recent BBC debate. If he is right, why does the National Blood Service prohibit men who have had sex with men - even just once, from donating blood? Only when this presumably irrational policy of discrimination against gay men is abandoned in the UK, will I be inclined to give credence to the claims of gay advertising executives.

Alongside the much higher risks of anal cancer and STIs, anal intercourse also involves another excess risk to health in the form of drug abuse. Male homosexuals commonly use amyl nitrate (poppers) to relax the anal sphincter to facilitate intercourse. Viagra is often used with it as a recreational drug - a combination that can kill. Rates of other drug misuse are widely acknowledged to be higher in the gay community. In his book 'State of the Queer Nation', gay journalist, Chris Woods, states 'the fleeting nature and instability of many gay and lesbian relationships and the poorly defined rules of cruising mean that that drug consumption, … plays an important role in our social habits. Studies have reported that gay men and lesbians are often unable to have sex unless using drugs of some nature…'.

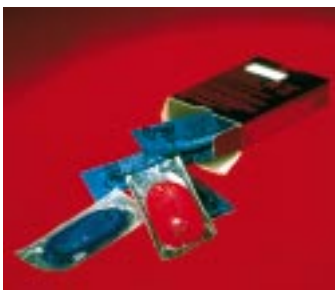
It is no surprise that studies from Denmark, Sweden, Norway, Australia, USA and Canada all unanimously indicate that male homosexual activity leads to a shortened average lifespan - probably of the order of 10%. As far back as 1997 the *International Journal of Epidemiology* reported 'although we have revealed that the life expectancy of gay and bisexual men has sustained a tremendous deficit relative to all men, the true effect is likely to be larger because of problems of under reporting and underdiagnosis of AIDS'.

A few years ago when columnist Anne Atkins courageously drew attention to this fact, the Press Complaints Commission upheld a complaint against her saying there was no scientific evidence to support it. Philip Morris still refuses to acknowledge that there is any scientific evidence to support the relationship between passive smoking and lung cancer. Their 1996 advertising campaign for example claimed that passive smoking posed a lower risk to health than eating one biscuit a day. *The British Medical Journal* commented, 'The tobacco industry capitalises on the situation to protect its commercial interests through the promotion and magnification of confusion. The industry is guarded about its real knowledge on the heath damaging effects of smoke and tries to influence opinion through… intimidation of its opponents.' The commercial interests promoting gay sex use similar techniques.

In the 1950s, most doctors were reluctant to accept the evidence linking lung cancer with smoking. This is now generally attributed to wish bias; doctors who smoked wanted to conceal from themselves the fact that their enjoyable habit was damaging their health. Those who didn't smoke did not want to make the smokers feel bad. It usually takes several decades for the truth to emerge from the suffocating blankets of personal compromise and political correctness.

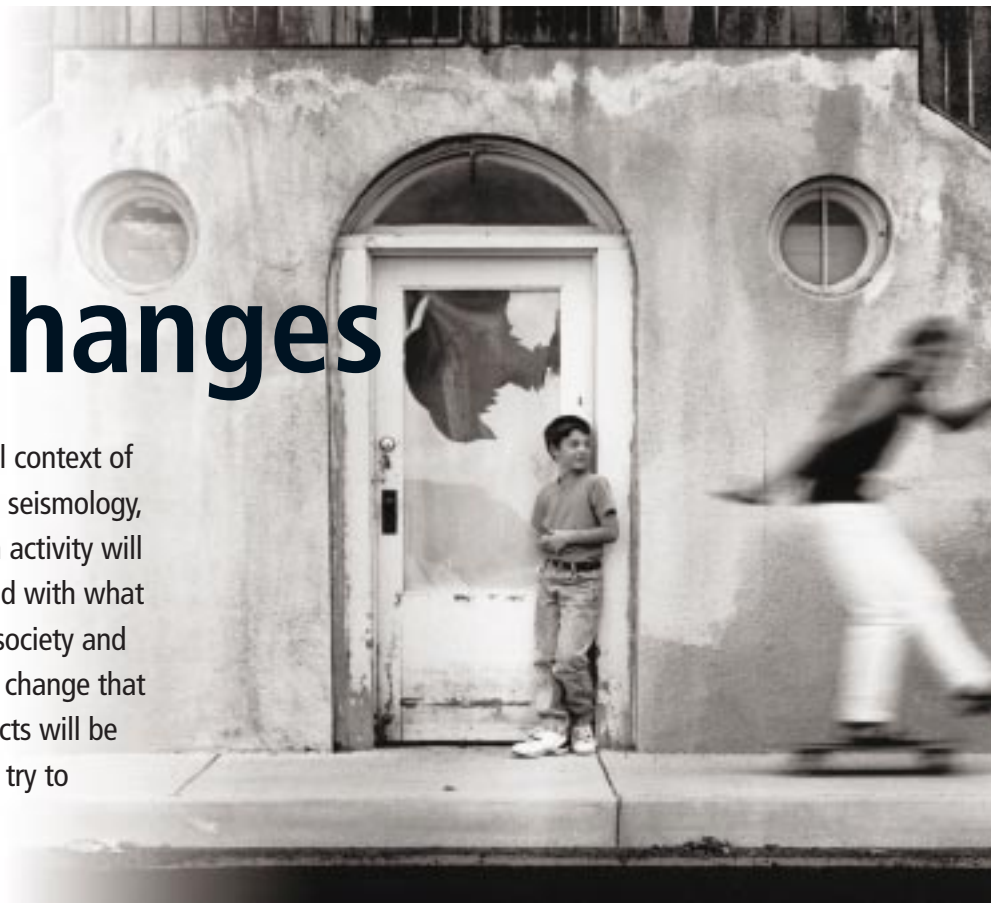
It cannot be hidden forever though. 'Wisdom is proved right by its results', Jesus said. (Matthew 11:19 NEB) The results of anal intercourse surely prove it far from wise.

Trevor Stammers is a General Practitioner in West London who writes and broadcasts on sexuality.



IT USUALLY TAKES SEVERAL DECADES FOR THE TRUTH TO EMERGE FROM THE SUFFOCATING BLANKETS OF PERSONAL COMPROMISE AND POLITICAL CORRECTNESS.

Bishop Michael Hill surveys the massive forces that are re-shaping our culture.



Seismic Changes

The tectonic plates underlying the cultural context of Western society are on the move. As with seismology, where it is possible to predict where such activity will take place but impossible to say when and with what velocity the activity will happen, so with society and cultural change. There are aspects to that change that we can observe and describe but the effects will be hard to predict with any accuracy. Let me try to describe some of these changes.

Materialism

By this I do not mean materialism in its popular sense, ie. the pursuit of human happiness by the acquisition of money and things, but materialism in its philosophical sense, ie. an explanation of the world without reference to a Supreme Being.

Patterns of churchgoing and belief are changing. Atheism is on the increase. Francesca Klugg, in her recent book *Values for a Godless Society* argues that the Human Rights Act, which came into force in October 2000, is a necessary moral charter for a society which no longer believes in God strongly enough to take its moral guidance from such a Supreme Being.

Similarly, Professor Peter Singer, in his book *Rethinking Life After Death* declares, 'after ruling our thoughts and our decisions about life and death for 2000 years, the traditional Western ethic about the sanctity of human life and the traditional religious view that all human life is sacrosanct is simply not able to cope with the array of modern medical dilemmas.' Singer goes on to replace what he considers to be an obsolete Judaeo-Christian ethic with his own five new commandments of bioethics:

1 Recognise that the worth of human life varies
2 Take responsibility for your own decisions (eg. acceptance of mercy killing)
3 Respect a person's desire to live or die
4 Bring children into the world if wanted
5 Do not discriminate on the basis of species

As has been demonstrated recently in the case of Jodie and Mary, the Siamese twins, where the will of God-fearing parents was overruled by the press, the medical profession and finally the judiciary, we apparently end up with some kind of distorted utilitarian ethic having removed God from the scene.

For me, a belief in God would have at least the following consequences:

- It would affect the way I approached the moral maze of medical ethics; it would ask some fundamental questions about the Bible and its authority; it would give me some criteria to assess interventions such as Professor Singer's.
- It would mean that as a person treating the sick, I would not see myself as an autonomous person, but somebody who felt a sense of calling to care for and bring wholeness in body, mind and spirit to the sick and dying.
- It would affect my approach to people. I would not see them as apparently Richard Dawkins does, as merely genetic survival machines.
- I would see people with personality and hopes and fears and anxieties and with a God-given potential for a possibility of a life lived for ever in heaven.

Post-Rationalism

Much of the way our world thinks was fashioned by a rationalist, post-Enlightenment way of thinking. Sometimes it is referred to today as modernity. There is much that is good about this, although it has tended to elevate human reason above all else. In consequence, one of the authors of the 'movement' was the philosopher Descartes with the famous phrase 'I think therefore I am'. This worldview has inclined to give people faith in science, rather than in the God of Science; somehow it seems logical that the more questions science can answer the smaller God becomes.

John Wyatt, in his book *Matters of Life and Death* describes 'scientific reductionism' which has some very unhealthy outcomes, leading, for example to a machine view of humanity and suggesting a way of self-mastery or self-transcendence. The outcome is belief in pure chance, the lottery of life inevitably leading to a pessimistic fatalism.

However, it seems that there is today a

PLURALISM CONSIGNS BELIEF, WORLDVIEWS AND VALUES TO A PRIVATE SPHERE FROM WHERE THEY ARE NOT PERMITTED TO INFLUENCE PUBLIC POLICY.

kind of post-rationalism around, eg. the liberal quest for making Christian faith more relevant to a modernist mindset. Many Christian doctors and surgeons I have known have had a real sense of being guided, either in making a diagnosis or whilst performing an operation, in a way that has left them little doubt that there is a Supreme Being. Will this disillusionment with modernity impact some of the complex moral debates that are on the future agenda for medical ethicists?

Consumerism

Choice versus The God of Choice. Consumerism does not just affect the economic choices we decide on, it affects many different areas of human life. It is driven by marketing and creates a worldview in which, in Western society at least, the world is full of goods and services which are there to meet my deepest needs. In medicine, I suppose consumerism is at its most blatant in the area of cosmetic surgery and the future possibility of being able to manipulate the genetic coding of tomorrow's children to meet parental desires and aspirations. Biology, genetic cloning, and robotics are increasingly pooled resources that raise the spectre of spare part surgery to replace obsolete and worn out units. But does there come a point when this becomes out of proportion and, if so, where would that point be and how would we know when we have reached it?

Individualism

The triumph of the individual has been one of the coherent themes of the last half-century. Of course there are many good things about individualism, but it can lead to the undermining of human community. Health is affected by non-medical factors. Many a patient does not need medicine but someone to talk to. Individualism also leads to privatisation, that process by which I see myself as the centre of the universe. Privatised morality is a very worrying example of that process. Such privatisation leads very quickly to complication in relation to ethical debate. Without any accepted norms of morality, the feel is 'we can make it up as we go along'. The consequential dangers of arguing from the particular to the general are obvious.

Pluralism

The presence of people who bring very diverse cultural and spiritual values into a community poses some wonderful opportunities, and some potential problems. The way we go about treating people in the West is to some extent an expression of our culture. Hospitals are traumatising places enough to those whose background could be described as Western. What they must be like to people who do not share that cultural background, is hard to imagine. But, as pointed out by Bishop Michael Nazir-Ali in his excellent book *Citizens and Exiles*, pluralism brings with it a frightening by-product:

'It is also often the case that 'pluralistic' attitudes, while paying lip service to the equal validity of different systems of belief, actually marginalise all of them. Bishop Leslie Newbigin has pointed out over many years and in several books how pluralism consigns belief, worldviews and values to a private sphere from where they are not permitted to influence public policy.'

Fragmentation

By this I refer to the breakdown of the traditional units of human society. You can track this fairly clearly in the last century; 1900-1945, the era of the extended family; 1945-1980, the emergence of the nuclear family; 1980 to the present, the redefining of 'family'. What does all this mean to the practice of medicine? Let me mention but a few. We know that people's health is impacted by the social ecology in which they develop. It means that families find it harder to take responsibility for one another and therefore have expectations that the State, in its manifest forms, will take the responsibility for them.

De-personalism

All this, it seems to me, poses big questions about how as Christians we function in today's world. How do we match the grace of God [unconditional compassion] with the truth of God [the Bible]? It seems to me that we shall have nothing to contribute to ethical debate if we emphasise compassion alone. Compassion must always be refracted through the truth of God's Word. In the same way, were we to take only a truth-centered approach to these things, we should end up saying nothing that anyone would be able to hear.

The Right Revd Michael Hill is the Bishop of Buckingham, Diocese of Oxford. Based on a talk at the CMF Oxford Day Conference, November 2000.

KEY POINTS

Western Culture and Society is undergoing seismic change characterised by a worldview which denies God, a mindset which is disillusioned with science and human reason, and a belief that personal fulfilment can be bought. These factors, along with a selfish individualism which undermines human community and a pluralistic attitude, which by paying lip-service to all belief systems marginalises all, are having profound effects on health and medical ethics. To make the most of the opportunities Christians need to understand the times, and hold the grace of God (unconditional compassion) and the truth of God (the Bible) in balance.

Peter Sidebotham offers a biblical model of child development.

Growing up

- in wisdom and stature, and in favour with God and men

UNLIKE OTHER ASPECTS OF CHILDHOOD CHANGES, SPIRITUAL DEVELOPMENT CAN OCCUR IN ONE OF TWO DIRECTIONS: TOWARDS GOD AND HIS PURPOSES OR AWAY FROM HIM

'When I was a child,
I talked like a child,
I thought like a child,
I reasoned like a child.'[1]

As I grew, I put off some childish traits but built on others. Now as a paediatrician, I spend much of my time observing children going through the same process. Article six of the UN Convention on the Rights of the Child asks member states to 'ensure to the maximum extent possible the survival and development of the child'.[2]

I have tried to understand the process from a biblical perspective, drawing on my understanding of the Christian faith, observations of children, and reading of medical and Christian literature.

Jesus Christ started life as a fertilised human embryo. He went through embryogenesis and fetal development before being born into this world. There is no reason to assume that he did not follow the same predictable process as all children. Following normal patterns of motor, language, social and cognitive development, he moved from complete parental dependence to increasing maturity and independence.

Luke tells us that Jesus spent three days in the temple, questioning and learning. Like all adolescents, Jesus had to work out his own identity. Luke concludes: 'Jesus grew in wisdom and stature, and in favour with God and men'.[3]

I believe child development could be defined as a series of overlapping categories within four domains: mental (wisdom), physical (stature), social (favour with men) and spiritual (favour with God). This view encompasses a biblical understanding of the nature of mankind and our purpose in this world without negating our current understanding of the process of and factors influencing child development.

Wisdom - *Mental development*

Cogito, ergo sum. I think, therefore I am. Descartes' words reflect how man is distinguished from all other creatures. Our cognitive development involves various components, including memory, logical thought and questioning. Mental development seems to underlie most other aspects of development. An infant's inquisitiveness leads him to explore: fixing and following, reaching out and grasping, putting objects in his mouth, crawling and walking. Inquisitiveness extends to questions: 'what' as he learns to identify things, then the persistent 'whys' of the pre-school child trying to understand his world.

Stature - *Physical development*

Physical growth is an awe-inspiring process.[4]

Beginning at conception, almost all tissue differentiation occurs in utero with growth continuing throughout childhood, especially during the first year and puberty. Motor skills develop along with growth. The development of an upright stance frees the hands for manipulation. The baby therefore goes through parallel processes: changing from a supine posture, through sitting, to independent walking; concurrently learning to grasp and manipulate objects. Thus we have three aspects of motor development: posture, mobility and manipulation.

Favour with men - *Social and Emotional development*

The newborn baby focuses on physical needs. Nevertheless, he soon displays different emotions, crying when upset, calming when comforted. Around eleven months, he clings to his parents, becoming wary of strangers. His emotions start to reflect feelings (both positive and negative) as well as physical needs. With time, he gives names to emotions and expresses them in a variety of ways. A healthy child will be allowed to do this although most societies place some restrictions on when and how.

Humans have complex social patterns involving communication and relationships. Both verbal and non-verbal communications develop, with increasing capacity to express ourselves and

understand others. Alongside this, social development involves increasing independence and responsibility. Development of self-care skills (such as feeding, toileting and personal hygiene) brings increasing responsibilities towards others. Parents are familiar with the 'terrible twos' when toddlers start to test out their independence. The underlying change from dependent infant to independent adult must progress.

Much of our emotional and behavioural development as children hinges on the balance between desire for independence and ongoing need for dependence, love and security. This mirrors our relationship with God: a desire to be our own master coupled with a longing to know and be loved by him.

Favour with God - *Spiritual development*

Spiritual development has three aspects: awareness of self, God and others. Unlike other aspects of childhood changes, it can occur in one of two directions: towards God and his purposes or away from him. It is a complex process that will not be complete until we are transformed into the likeness of God.[5]

I will briefly highlight those areas that are pertinent to children.

Awareness of self

A young baby plays with his fingers and toes; a toddler is fascinated by the different bits he sees in the bath. Emotional awareness develops along with likes and dislikes, a sense of wonder and appreciation of beauty. He still needs help in interpreting conflicting emotions such as joy and sadness. He begins to understand how others view him, in relation to who he is and to how he acts. Hopefully, he will grow up knowing that he is loved and valued for who he is, not just for what he does or doesn't do. Emotional well-being is highly dependent on having positive self-esteem; this is crucial to our appreciation of how God views us.

Awareness of God

All children go through a stage of questioning. 'Where did I come from?' reflects a deeper longing to know what lies behind it all. A child can also learn that God is the Creator. His understanding of God is influenced by what he sees of him in his parents, along with their beliefs and culture. Most children learn that their parents love and care for them, even when they aren't visible. Sadly, some children grow up in an environment that portrays a very distorted image of God: their parents don't display the qualities of consistency, love and nurture that reflect God's nature. Generally though, parental shortcomings are more than balanced by attitudes and actions that portray some of God's positive attributes.

A child's relationship with God changes as he grows, reflected to some extent in the way he relates to his parents. He starts off knowing God, moves to loving and trusting him, finally submitting to his will out of love and respect. *Children finding faith* describes how spiritual development is influenced by parental and other factors to determine very different outcomes.[6]

Awareness of others

Social development has been briefly described. However, spiritual development adds a further component to this in terms of respect and love for others. Most religions and cultures value life and acknowledge human rights. The biblical view starts by looking at responsibilities rather than rights. 'Love your neighbour as yourself' should be the goal of our spiritual development.[7]

We learn to recognise that all people are made in God's image and loved by him. Love for others does not come naturally, as it goes against the child's developing independence. It needs to be nurtured and will include awareness and respect for others regardless of their background, character or beliefs, and a particular concern for the vulnerable expressed through justice and compassion.

Summary

Doctors have traditionally focused their attention on five aspects of child development: cognitive skills, gross and fine motor abilities, language, and personal-social development.[8,9,10]

These reflect the uniqueness of humans: upright stance and bipedal locomotion, fine motor skills for manipulation, unique depth of communication and expression, and complex social structures. However, the Christian viewpoint suggests that such an understanding is incomplete. What sets us apart from all other creatures is being made in the image of God, being spiritual beings with a purpose. 'It is in the nature of the developing body to be continually active, of the developing mind to be intensely curious and of the developing personality to seek good relationships with other people.'[11]

We could add that it is in the nature of the developing spirit to seek God. Understanding some of the spiritual development that underlies our social, emotional and cognitive development can help in appreciating some of the struggles children experience. It can also help us direct children's development, the goal being healthy adults with positive self-esteem, sense of purpose, knowledge of God and respect for others.

Peter Sidebotham is a Consultant Paediatrician in Bristol

KEY POINTS

Child development has traditionally been understood in terms of cognitive skills, gross and fine motor abilities, language and personal-social maturity. But this approach ignores the fact that we are spiritual beings with a purpose, made in the image of God. Using the biblical description of Jesus' childhood given in Luke 2:41-52, we can better understand growing up in terms of four overlapping categories: mental (wisdom), physical (stature), social (favour with men) and spiritual (favour with God). Unlike other childhood changes, spiritual development is a complex process which may be towards God or away from him.

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David Short outlines
an avoidance strategy

IT MUST BE ACCEPTED THAT MANY DOCTORS CHOOSE (OFTEN SUBCONSCIOUSLY) TO BE OVER-BUSY.

Beating Burnout

Recently, a consultant surgeon in mid-career wrote to me, 'Many of us are very tired and many just want to get out of work as soon as possible. There is certainly a perception that things have never been worse in the memories of anyone working today. I think perhaps the worst thing is that a lot of us can see no hope that things will get significantly better. In fact, we think that things will probably get worse.' My GP speaks in similar vein.

The tiredness, disappointment, disillusionment, hopelessness and job dissatisfaction that I sense in many senior NHS staff strongly suggests that they are at the end of their tether and heading for burnout. Why should this be so? In many cases, over-work is a factor: Britain is said to have the longest working hours in Europe. However, the problem is not simply the volume of work: it is more the pressure of work with impossible targets and deadlines. This is often compounded by disappointment, frustration and non-forthcoming promotion as well as reorganisation leading to loss of privilege and prestige. For those serving overseas, things are often much worse. The volume of work can be phenomenal, ill health is common and there are frequently legal hassles, to say nothing of severe satanic opposition.

Is there an answer? I believe there is, even before more reasonable terms and conditions of service are introduced. Firstly, it must be accepted that many doctors choose (often subconsciously) to be over-busy. We find our work enjoyable and fulfilling: the constant stimulus of diagnosis with remarkable recoveries and gratitude from patients and relatives. We also like to be busy and to appear to be busy: such an aura is a useful defense against the call to give time to people whose needs are not strictly our concern.

A desire for greater professional prestige or power is another element involving choice. So, in some cases, is a commitment to research. It is also tempting to take on additional well-paid work such as writing. However such activities are very time-consuming and need to be balanced against any value in terms of status or income.

Christians also face additional demands on their time. Many of us are urged or drawn to commit ourselves to specifically Christian service, sometimes to the detriment of the work we are paid to do. This can lead to a false distinction between sacred and secular. We are called to serve God primarily by doing our work conscientiously and well and by discharging our responsibility to our spouse, family and society. To put overtly 'spiritual' work on a pedestal is a fundamental misunderstanding of vocation. Duty is sacred and it is essential to get one's priorities right. Trumbull's rule[1] is a good guide: 'Do first the things you are paid to do, then the things you have promised to do, then the things you would like to do.'

If we don't have such a safety margin, crucial matters can blow up suddenly and overwhelm us. As in the planning of a military operation, it is important to maintain a strategic reserve. Time can then be set aside for people. Important things rarely have to be dealt with the same day or even week. Urgent tasks call for instant action and so devour our energy and crowd out the important matters. So, learning to distinguish between urgent and important issues is very important.

Before committing ourselves to non-essential but prestigious work, we should think carefully of the time and strain involved. It is important to be prepared to say 'No' to things outside the main thrust of our lifework. Our Lord did this - he had a clear goal and made everything

How to beat burnout

- Adopt a right attitude to success
- Get your priorities right
- Regard duty as sacred
- Distinguish between the urgent and the important
- Maintain a strategic reserve
- Know yourself and your limitations
- Be prepared to delegate
- Build in regular recreation
- Honour God on his day
- Undertake periodic review
- Embrace the 9th beatitude - 'Blessed are those who expect nothing, for they shall not be disappointed'.
- Follow Trumbull's rule: 'Do first the things you are paid to do, then the things you have promised to do, then the things you would like to do.'
- Find and be faithful to a complementary life partner who shares your Christian commitment

subservient to it.[2] Periodically, it is important to review our workload and priorities, particularly when ill or before embarking on any major additional commitment. Whilst ensuring that junior staff do not become overloaded, we should readily discard duties that others could do just as well.

Dr Robin Taylor of Dunedin, New Zealand gives a valuable talk for medical students on stress management. He makes three points: know yourself and your capabilities, be prepared to take advice (especially with regard to delegation)[3] and honour God on his day. It is important to make a realistic evaluation of our talents. There is great inequality of gifting between one individual and another. Some have a brilliant intellect or a phenomenal memory. Still others have a strong constitution and need very little sleep. In one of Jesus' parables, he spoke of one man being given five talents, another two and another one. Most of us have only one or two talents and we are wise to recognise our limitations. One talent used wisely can be of lasting value.

I find that Christians are often confused about Sunday. Of course, we often have to work on a Sunday and we should do our duty without hesitation. Nevertheless, it cannot be denied that the fourth commandment is embedded in the Decalogue and that none of the other nine commands has been abrogated. We should accept that this command is still relevant today but that it has to be kept in the spirit rather than the letter. Legalism was Christ's criticism of the religious leaders of his day. In my view, there is no need for rigid dos and don'ts. We 'keep the Sabbath day holy' when we are kind and merciful and do activities that enhance our service to God. Sunday should be different and special. In past generations, Sunday was prized as a day of physical and mental relaxation. Today, we still need a day when we can turn our thoughts to eternal things. As Wordsworth wrote: 'The world is too much with us; late and soon, getting and spending, we lay waste our powers'.[4] We need to pause and contemplate God and eternity. Meeting with other Christians and hearing God's Word is immensely valuable.

Part of each day (ideally the beginning) should be fenced off for a brief, attentive, reading of the Word of God with meditation and prayer. We need a right attitude to success, viewing it as the fulfilling of God's will for our life. We need to recognise that success is in God's hands. What he said so long ago is still true: 'Those who honour me, I will honour'.[5]

David Short is Emeritus Professor of Medicine in Aberdeen

Medicine should be a fulfilling and enjoyable profession; but the pressure of work, impossible targets and deadlines and the loss of privilege and prestige are resulting in more NHS doctors becoming disillusioned, dissatisfied and disappointed - leading to burnout. An effective avoidance strategy involves recognising first that busyness is partly a matter of personal choice. We need to know our gifts and abilities, prioritise and delegate carefully and maintain a strategic reserve. Learning to say 'no', honouring a weekly day of rest and fencing off time for personal devotions are essential coping mechanisms.

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Do they have a future?
asks **Gordon McFarlane**

Africa's Church Hospitals

Most missionary ventures have contained elements of medical work. The latter half of the nineteenth century saw the introduction of missions that were specifically medically orientated. Over the last century and more, in the West, the role of the church in providing medical care has been taken over by governments and by private companies, with the responsibility for health gradually moving from the individual through churches and charitable organisations to the state. This pattern has been repeated in many developing countries, with the state seeking to provide health care. In the process some have taken over hospitals previously run by churches or missions.

This article seeks to examine the plight of hospitals in Africa that are still under church or mission control. While it draws on nine years experience in Africa, I believe lessons can be applied to developing countries throughout the world.

That a tremendous amount of good is being done through church-based health care programmes cannot be denied, but there are questions that demand answers. To whom is the care given? Can the poor afford the fees payable at many Church Hospitals? What is the cost to the church?

Government-run Healthcare

In many countries in Africa, government-provided healthcare is far from ideal. Admission may be almost free but relatives often have to buy drugs or surgical supplies before treatment can commence or an operation be carried out. Nursing staff may be poorly motivated. Doctors are often hard to find, spending much of their time in private practice to the detriment of their non-paying patients. For the poorer nations of Africa, taking over church hospitals has not been a great success. Some have even been handed back.

There are, however, a number of positive aspects to provision of healthcare by governments. Care may not be ideal but there is little restriction on access. More than one missionary doctor with a call to serve the poor has moved from a church hospital to government-provided healthcare.

Who is served by church hospitals?

Over the last decade, financing of church hospitals has become increasingly difficult. The plight of Eastern Bloc countries has diverted the attention of donor agencies and mission supporters away from African nations. Structural

Above. Church ministers and elders spend much valuable time attending hospital committee meetings

Top. National resident house officer being trained in basic surgery

A Theological Education by Extension leaders' training day - vital for the future of the church

MEDICAL MISSION IS A PROPER CHRISTIAN RESPONSE TO OVERWHELMING NEED BUT THERE IS NO BIBLICAL JUSTIFICATION TO REGARD THESE INSTITUTIONS AS ESSENTIAL ELEMENTS OF MISSION

readjustment has left many Africans less well off and many cannot afford to pay for health care, while the cost of healthcare is escalating. Unions are pushing for better wages for unskilled staff; professionals are demanding better recognition for their skills; and the cost of medicines and equipment is increasing, but government subsidies to church-run hospitals have dwindled.

The result is that the rapidly escalating cost of healthcare has to be recovered from user fees and these fees have risen to a point where church hospitals are serving only the middle-income groups. The poor, towards whom the church is supposed to feel a greater responsibility, are excluded. In order to stay financially viable, some church hospitals have had to turn patients away or postpone elective operations until the full fee is paid in advance - hardly a witness to the surrounding community.

The cost to the church

African church leaders, however, are very keen to maintain their church hospitals. They believe they provide a good opportunity for witness to many who otherwise may not come near the church. There may be other reasons for their enthusiasm, too. They are a status symbol in the often fierce interdenominational competition. Relatives can find jobs. Some see their church hospitals as potential income generation projects for the church. Financial corruption is a serious temptation, too.

More serious yet is the effect that ownership of a large institution such as a hospital may have on the life of the local and national church. Ministers with ten or more churches can be called upon to sit on management committees, health boards, attend courses and seminars relevant to the work of the institution, or get involved in sorting out staffing and disciplinary matters. Church leaders with little or no training are often called on to make decisions affecting 500 staff, a health care system for 500,000 people and an annual budget of over 1.4 million pounds sterling.

The overall effect is that much valuable time is spent in looking after huge status symbols that threaten to engulf the local church. Ministers and elders are called to attend to the spiritual growth of the church, not manage health institutions for which they have little or no training. Involvement of ministers and elders in healthcare is a time-consuming distraction for many and a fatal temptation for others.

The way forward

For those who have not worked overseas, many of these facts may come as a surprise. What is the way forward? As disciples of Jesus we have been commissioned to preach, baptise and teach (Matthew 28:19, Mark 16:15-18, Luke 24:46-9, John 20:21, Acts 1:8). Medical mission is a proper Christian response to overwhelming need but there is no biblical justification to regard these institutions as essential elements of mission nor to perpetuate them when they may be having a negative impact on the life and witness of the church.

Unless a new generation of well-qualified and highly-motivated national doctors and managers come forward to work in and run these hospitals, the future looks bleak. In countries where there is little or no government subsidy, they must either close or lose their image as charitable Christian institutions. Recent moves towards income-generating activities within church hospitals and community-based health insurance have failed to provide a solution for those in the lowest income bracket. (McFarlane GA, Sammon A. A prepaid healthcare scheme in rural Africa. *Tropical Doctor* (in press)).

It is vital that the African churches come to realistic solutions that will divest the church of the huge burden of responsibility that Western medical missionaries have left them with. The greatest impact that the Western-based mission organisations can currently have is in discipleship courses, TEE courses (Theological Education by Extension), and formal theological education to help churches and individual Christians to deepen their spiritual lives.

Graham McFarlane was a Medical Missionary in Africa

KEY POINTS

Whilst medical mission is an appropriate response to overwhelming need, the worsening poverty in Africa, diversion of Western Christian giving to other regions and the rising cost of healthcare mean that church hospitals are becoming less effective as agents of mission. Maintaining financial viability now requires user fees which disenfranchise poor patients, encourage internal corruption and undermine Christian witness. Unless a new generation of well-qualified and highly motivated national doctors emerges to run these institutions, local church leaders would be better off investing their scarce resources elsewhere.

Triple Helix asked four other Christian doctors with extensive African experience, **Eldyrd Parry, Janet Lefroy, Kevin Vaughan** and **Peter Bewes**, for their comments.

Responses to McFarlane

Triple Helix: Is Gordon McFarlane right?

Peter Bewes: One can sympathise with many of his findings - they ring true. Yet many, to their financial disadvantage, waive their fees to the really needy.

Kevin Vaughan: The author's generalisation that 'church hospitals are serving only the middle income groups' needs to be strongly challenged. Recent experience (from Uganda and Malawi, for example) shows this to be far from true.

Triple Helix: Can Church hospitals give Christianity a bad name?

Janet Lefroy: The Church hospitals with which I worked were staffed by Christian Tanzanians who were trusted by their local community to offer qualitatively different care from the often inhumane and corrupt handling of the government health services - worth paying a small fee for.

Eldyrd Parry: It can be very difficult for a foreigner to understand how much a local community prizes its local hospital. Credibility and trust can be won if workers set as their overriding goal to be 'among them as those who serve'.

Triple Helix: Is charging fees as big a problem as Gordon McFarlane suggests?

Eldryd Parry: I have seen people who have walked for days to a remote rural polyclinic. They were prepared to pay, though it cost them dear, because at least this clinic had drugs and staff who did not demand a bribe. Simple people were being well served and they knew it.

Triple Helix: What is the case for the Church hospital versus the government one in Africa?

Kevin Vaughan: In Uganda, careful research by government departments has shown that church-based healthcare programmes provide 'more service per shilling' than government programmes and therefore the Government has recently increased its subsidy to church hospitals.

THE PAST ACHIEVEMENTS AND ONGOING CONTRIBUTIONS OF CHURCH-BASED HEALTHCARE IN AFRICA ARE ENORMOUS AND WHILE RECOGNISING THAT SOME ISSUES OF GENUINE CONCERN ARE RAISED, A POSITIVE ATTITUDE OF RISING TO MEET THE CHALLENGES OF THE TWENTY-FIRST CENTURY WILL ACHIEVE MUCH.

Triple Helix: Can Christian service balance out issues such as lack of state-of-the-art equipment and up-to-date facilities?

Eldryd Parry: Out-dated methods may take years to change, but the opportunity for outgiving service is all around.

Peter Bewes: I can witness to the great benefits that have been brought to that continent by Christian medical workers using their skills to improve not only the work in the Church-related hospitals, but by visits, lectures, practical teaching and sharing experiences, to the Government hospitals too.

Triple Helix: What's your view of Gordon McFarlane's suggestion that TEE and the like should be a greater priority?

Kevin Vaughan: While agreeing that TEE and other courses are greatly needed for building up national churches in Africa, let us also recognise that overseas healthcare personnel are likely to have an important role in assisting valuable church-based healthcare services in Africa for some considerable time to come and let us continue to look for innovative ways of providing such services.

Triple Helix: Do church facilities face temptations to corruption, nepotism and divert Christians from other key priorities?

Peter Bewes: Yes, it is true that a single church-related hospital may have a deleterious effect on the finances of the local church. The Christian has to realise that we live in a fallen world.

Kevin Vaughan: Many African countries are in considerable economic difficulty. Under these pressures, problems of nepotism and financial corruption for personal gain are common in secular and church life in Africa, but are no worse in healthcare than anywhere else.

Triple Helix: What of the future?

Peter Bewes: Christ sent us 'into the world' to serve Him and 'the world' does not limit its meaning to perfect institutions. Some of us have to make do with situations that involve financial stringency, sacrifice, facing corruption and even personal danger.

Janet Lefroy: The fatter parts of the Body of Christ in this world can well afford to continue to assist the thinner ones who are genuinely trying to do this. Why else did our Lord call us one body?

Kevin Vaughan: The past achievements and ongoing contributions of church-based healthcare in Africa are enormous and while recognising that some issues of genuine concern are raised, a positive attitude of rising to meet the challenges of the twenty-first century will achieve much.

OPPORTUNITIES ABROAD

Specific Vacancies by Country

Overseas posts often require you to be **UK-based** with your own **financial** and **prayer support**. These brief entries could be gateways to fulfilling professional service. Please investigate further if at all interested. Many are advertised at the request of CMF members. The CMF Overseas Support Secretary often can give more information (usually in CMF office Monday afternoon, Wednesday, Friday). Enquire locally for visa, work permit and registration requirements. Overseas emails should be considered to have no more privacy than a postcard.

A much larger multidisciplinary list of vacancies and opportunities for service exists in **Healthserve**.

Contact MMA Healthserve, First Floor, 106-110 Watney Street, London E1W 2BR. Tel: 020 7790 1336.
Email: info@mmahealthserve.org.uk.
Website: www.mmahealthserve.org.uk

AFRICA

Gambia

Sibanor Clinic. **Doctors** sought especially by Summer 2002 (rainy season). Mainly GP skills required.

Contact Dr Jamie Erskine, WEC International, P O Box 86 Banjul, Gambia. Email: theerskines@hotmail.com or Gambia field desk of WEC International with details of faith and career. Administrator Mrs Judy Wesson. Email: jwesson@qanet.gm

Kenya

St Anna Centre for the elderly and orphans. Retired Anglican Bishop John Mahiaini needs a **doctor** to develop a nurse run clinic. Nearest hospital 20 km away. The doctor could be stationed in Nairobi. Could this be the start of visiting many similar clinics for those too sick and poor to travel?

Contact at Gathukiini, PO Box 532, Muranga, Kenya.

Uganda

Rushere Hospital, an independent hospital with a new Christian Foundation and the President as Patron, is situated in a remote but beautiful area. Nearest major hospital 70 miles away. A dedicated Ugandan lady doctor needs help establishing a surgical service (minimum 3 months). Other volunteer staff could cover imaging, dentistry, psychiatry, health education and ophthalmology.

Contact this office or the administrator, Rushere Hospital, P O Box 2, Rushere, Mbara, Uganda.

ASIA

Bangladesh

Lamb Hospital requires **lady obstetrician** or **doctor** able to do Caesarean Sections, from August 2001 for a few months.

Contact Dr Mark Pietroni. Email: mark@pietroni.demon.co.uk or locally Dr Felicity Mussel. Email: lamb@citechco.net

India

Friends of Karigiri, a small charity with Roman Catholic connections supports a Disabled Children's Centre in South India and is building a surgical facility. Would welcome a visit from an **orthopaedic surgeon**.

Enquire from Dr Janet Goodall, a retired paediatrician, through this office or contact Alison Davis.
Email: alison.davis2@btinternet.com

Pakistan

Bach Christian Hospital. Female obstetrician still needed to cover extended leave Jan 2002 - see Spring Issue.

Contact Dr Elspeth Paterson, Bach Christian Hospital, PO Qualandrabad, Distt Abbottabad, NWFP 22000, Pakistan. Email: ecpaterson@bigfoot.com

Kunhar Christian Hospital. The founder and medical superintendent of this hospital asks for a **surgically experienced doctor** to work with him, a **woman doctor interested in obstetrics**, a **midwife** and an **ultrasound technician.** The costs would be travel and living expenses. Promises not to overwork missionaries! Can be lonely but a recent letter describes excellent Bible teaching and fellowship. Photographs show a beautiful setting.

Contact Dr Haroon and Miriam Lal Din at KCH, P O Box Garhi Habibulla, Dist: Mansehra, 21240 Pakistan. Email: kcc@kcc.isb.sdnpk.org

North West Frontier. Hospitals require, **administrators** and **business managers** (short term 1-2 yrs: long term 3-5 years: flexible and able to learn local language). Also **doctors**, **nurses** and **two surgeons**.

Contact Humphrey Peters, Diocesan Secretary, St John's Cathedral, 1, Sir Syed Road, Peshawar, Pakistan. Email: humphrey@brain.net.pk Also Ron Pont FRCS through this office or Email: 113113.3613@compuserve.com

Tibet

The KunDe Foundation is looking for a **doctor with community/public health skills** for teaching village doctors, village volunteers and for other projects.

Contact Dr Ray Pinnigar, Health and Sanitation Bureau Shannan Prefecture, Tibet, Peoples' Republic of China. Email: drrayp@bigfoot.com

Indonesia

Dili, East Timor National Hospital still looking for **Physician**, **Paediatrician**, and **Anaesthetist**. Paid posts.

Contact Email: timorhealth@hotmail.com

MIDDLE EAST

Female obstetrician and **midwives** still sought - see Spring issue

Contact 'Thanksgiving', P O Box 1134, Clacton-on-Sea, Essex, CO16 8EF

RESOURCES AND REQUESTS

'***The obstetrician and gynaecologist***' is available free to all paid up members of the RCOG. The Emmanuel Hospital Association provides healthcare resources to some 35 million people in India. One copy given to one unit over the past two years greatly appreciated. Ten copies could be used.

Contact EHA (UK), 50 Grove Road, Sutton, Surrey SM1 1BT Tel:020-8770 9717 Email: enquiries@eha.org.uk Website: www.eha.org.uk

Operation Mobilisation is offering Medical Exposure trips to Central Asia as well as looking for doctors, nurses and paramedical staff in several parts of the world including ships.

Contact Email willows@ukonline.co.uk or Tel: 01691 776710/650658

Liz Croton gets practical about witness in the wards.

Sharing Christ with Patients

SHARING OUR FAITH IS AN INTEGRAL PART OF OUR WALK WITH GOD. WE KNOW THAT HOSPITALS ARE A UNIQUE MISSION FIELD BUT WHERE DO WE START?

Unsociable hours joined at the hip to a little black box that regularly bleeps at me! My first few months as a Christian junior doctor have been akin to juggling with slippery balls.

Hospitals are funny places. A nurse friend thinks she would be challenged to think of a place that has more diversity under its roof than one of our NHS Trusts: so many people, all with differing backgrounds and distinct needs. A parallel may be drawn with characters Jesus encountered during his earthly ministry: the paralytic who reinvented the grand entrance, the lady troubled with menorrhagia and the invalid of Bethesda.[1] Jesus turned their lives upside down: they were healed and didn't even have to come back for follow-up! Healing chronic, incurable conditions was no problem for the Creator.

John the Baptist was the man who told of Jesus' coming. Did he wear a sandwich board advertising Jesus' miraculous powers? No, his words were far more sobering: 'Repent for the Kingdom of Heaven is near'.[2] Jesus came to establish the New Covenant, the forgiveness of sins made perfect by his death at Calvary. This is the Good News of the Gospel.

Picture the scene

You're sitting in A&E, your NHS coffee getting cold. Lying before you is a middle-aged bronchitic who smokes and is a poor historian. Just as you reach the end of your tether, she bursts into tears, saying she has no hope for the future. Mentally you add 20 minutes onto the consultation and wonder what to say. It would be easy to mumble 'Don't worry', prescribe antibiotics and shuffle out. However, Christians are called to be 'imitators of God' and so we should ask what Jesus would have done.[3] He was used to dealing with social problems and his encounter with the woman at the well comes to mind. He always dealt with his 'patients' with compassion and sincerity, healing when necessary but always whetting their appetites for more knowledge of the Father.[4] Jesus would have seen and loved that bronchitic lady. He would have listened to her worries and told her the Good News.

I find it difficult to tell patients about Christ. It is hard to 'clinicalise' God, to see him in the maze of our daily duties. I am also frightened: what if I offend or if that nice old lady decides to re-proclaim the Good News to my consultant? Is it appropriate? Our Master felt it was supremely important and this is a superb encouragement. Paul also gave his seal of approval, witnessing on countless occasions throughout the New Testament. He frequently urged individuals to be active in sharing their faith.[5] This sounds scary but is also incredibly thrilling. We have no reason to be afraid: God has promised that he will uphold us through all our endeavours in his name.[6]

KEY POINTS

Healing was a strategic part of Jesus' ministry but his clear priority was preaching the Gospel. Whilst it is neither practical nor appropriate for us to share the good news with every patient, prayer does open doors and we need to be sensitive to the leading of the Holy Spirit and prepared to step out in faith. This takes courage, but God has promised that he is with us. The question 'Do you have a faith that helps you as such a time as this?' is a great opener, but we also have to be careful not to over-plan our day and squeeze out the opportunities that arise through small acts of service.

Prayer changes things

Sharing our faith is an integral part of our walk with God. We know that hospitals are a unique mission field but where do we start? Start each day with prayer - let him lead you to patients earmarked for you. I remember feeling prompted by God to speak to an alcoholic man. Using a great conversation opener I'd learned, I asked him if he had a faith that helped him at a time like this or if he wasn't sure about such things. He opened his heart about longing to get back to a relationship with God. I offered to pray for him and he prayed to accept Jesus into his life.

Seasoned with salt

We must always be prepared to explain the Gospel to non-believers. Paul was blunt about this: 'How can they believe in the one of whom they have not heard?'[7] Clearly, it is not appropriate to launch into a Gospel presentation with every patient. We need to discern God's will by prayer and then evangelise those to whom we feel called. The question of faith becomes profoundly important to many when faced with illness and death; asking about it in the social history is an effective, non-threatening way of starting a conversation about Jesus. Sensitive questioning can draw these issues to the surface and expound them.

Recently I finally mustered up the courage to bring issues of faith into the social history. It took an awful lot of prayer before it got easier but it does work brilliantly. The first time I tried it, I asked a poor lady every conceivable question about her social life before God told me to get a move on. I turned crimson: 'Er, do you have a faith that helps you at a time like this?' We had a great chat after that and I thank the Lord for giving me the strength to initiate it and carry it through.

Once we've shared Christ with patients, they may wish us to pray with them. The last time I did this, I was surprised to find the three ladies in the opposite beds joining in. They were all Christians and carried on my work for the rest of my patient's stay!

The Servant King

Whenever I think about Christian service, Jesus' words come to mind: '…just as the Son of Man did not come to be served, but to serve...'[8] How can we serve our patients as Jesus would have done?

Lack of time is a problem for every junior doctor. Even so, make some time for your patients: stop, even for a minute, and ask patients how they are. Emulate Timothy and take a genuine interest in their welfare.[9] It is all too easy to look at a patient and see a walking disease rather than a person created in the image of God. Soon after I started my house job, I found myself becoming very cynical about the number of daily distractions. If, like me, you're an obsessive planner, drug charts waved in your face and relatives wanting to talk when you're busy can seriously shorten your fuse.

Jesus' agenda was clear: 'I have not come to call the righteous, but sinners to repentance'.[10] There was intrigue surrounding him and he was frequently distracted during his travels.[11]

In fact, much of Jesus' ministry was carried out through distractions. Let's take a leaf out of our Master's book: medicine certainly requires daily planning but not at the expense of dealing badly with interruptions.

I continue to be awed by the wonderful way that God uses Christian healthcare workers to reach out to patients. I really want to encourage readers who have been thinking about faith-sharing to go ahead and take the plunge.

I will close by quoting a wonderful Irish lady I met recently. She was close to death and looked awful physically. However, her thin and wasted frame paled into insignificance as I saw the light and vivacity in her eyes. Almost automatically, I asked her if she knew Jesus. 'Oh yes Doctor, I know him', she answered. 'He's sitting on my bed now.' That lady died knowing she would soon be in the presence of our Lord. That experience, seeing Jesus change lives and welcome home those we cannot save, makes hospital witness so worthwhile.

Liz Croton is a PRHO in Birmingham

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4. John 4:13-15, 21-24
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7. Romans 10:14
8. Matthew 20:28
9. Philemon 2:20
10. Luke 5:31-32
11. Matthew 15:21-28

Should doctors evangelise their patients?

Liz Croton makes an excellent case for sharing faith with patients (see also Palmer B. Should Doctors evangelise their patients? *Nucleus* 1996; October:2-12). But is hospital witness seen as ethical by the profession at large? The following statement makes the General Medical Council's view clear. Whilst warning against 'abuse of privilege', we believe it still leaves an open door for *appropriate and sensitive sharing of faith* if and when God creates a door of opportunity. All the emphasis is ours.

'The Committee's attention was drawn to the activities of a very small number of doctors who use their professional position to proselytise patients, or who offer diagnoses based on spiritual, rather than medical, grounds. The Council has hitherto taken the view that *the profession of personal opinions or faith is not of itself improper* and that the Council could intervene only where there was evidence that a doctor had failed to provide an adequate standard of care. The Committee supported that policy and concluded that *it would not be right to try to prevent doctors from expressing their personal religious, political or other views to patients.* It was agreed, however, that doctors who caused patients distress by the *inappropriate or insensitive expression* of their religious, political or other personal views would not be providing the considerate care which patients are entitled to expect. This view was supported by the Council and a report of the debate was published in the *GMC News Review;* further guidance on the issue will be included in future editions of the Council's booklet of guidance.'[1]

Reference

1. Doctors' use of professional standing to promote personal interests or beliefs. *General Medical Council Annual Report*, 1993:4

EUTYCHUS

Ends and Means

A trial using transplanted brain cells from aborted fetuses to improve the symptoms of Parkinson's disease, has seriously backfired. Researchers at Colorado University found that whilst some clinical improvement had occurred in younger patients, those over 60 had not benefited and in 15% the procedure had exacerbated pre-existing severe dyskinesia. (*The Times* 2001; 15 March)

'Sex outside marriage OK', say Christian young people

A third of young British evangelicals believe that living together with a partner before marriage is morally acceptable, according to a survey commissioned by the Evangelical Alliance. 33% of Christian 18-35 year olds surveyed, compared with 82% of non-Christians, supported the practice. In another survey of 13-15 year olds, 82% of Anglicans thought divorce was acceptable and 85% of Roman Catholics disagreed with their church's teaching on sex outside marriage. (*Daily Telegraph* 2001; 14 March, *The Times* 2001; 7 May)

Women Doctors under stress

Medicine is a high-pressure profession, and a new study has shown that suicide rates among women doctors are on the increase. The report in the *Journal of Epidemiology and Community Health* found that the suicide rate was 13.6 per 100,000 women doctors per year between 1991 and 1995, double the national rate of 6.3 in the general female population. The male doctor suicide rate was higher (14.3 per 100,000), but only two thirds that of the male average of 21. (*Electronic Telegraph* 2001; 15 March)

Ban on genetic testing

Insurance Companies have brought in a two-year moratorium on the use of genetic tests for life insurance policies under £300,000. The Association of British Insurers (ABI) said that the limit was necessary to stop individuals testing positive for genetic illnesses from taking out unusually large policies. The move falls short of the three-year moratorium for all policies under £500,000 recommended by the Human Genetics Commission. (*The Times* 2001; 2 May 2001)

Pill cover-up

An investigative team from the Dutch radio station VPRO has unearthed the fact that the pill manufacturer Wyeth had shelved a 1997 study said to indicate clear increases in the risks of developing deep venous thrombosis in several third generation pills. Although the 1995 pill scare subsided, in part due to a political and legal offensive by the three main parties concerned (Wyeth, Schering and Organon), observers have noticed continued discrepancy between industry-sponsored surveys of the third generation pills and the research findings of independent scientists. (*BMJ* 2001; 10 March)

The real cost of mistakes

Patients are claiming £3.9bn in compensation from the NHS according to a National Audit Office official report. The figure has increased seven-fold in the last five years and more than 20,000 are suing for negligence. The rising backlog of claims now amounts to 10% of the £40bn annual NHS budget in England – and could pay for 31 new hospitals. In response, Lord Phillips, the country's most senior civil judge, has advocated a state-funded no-fault compensation system, to speed up claims and reduce costs. (*Metro* 2001; 3 May, *The Times* 2001; 21 May)

Morning-after-pill legal challenge

A pro-life group has been granted permission to bring a high court action before the end of July aimed at stopping over-the-counter sales of the abortifacient morning-after-pill levonelle-2. The Society for the Protection of the Unborn Child (SPUC) is arguing that the new move flouts the Offences against the Person Act 1861which prohibits the administration of drugs with the intention to procure miscarriage. Levonelle-2, which was previously only available on a doctor's prescription, has been on sale from pharmacists since January. (*The Times* 2001; 3 May)

Is gay orientation really fixed?

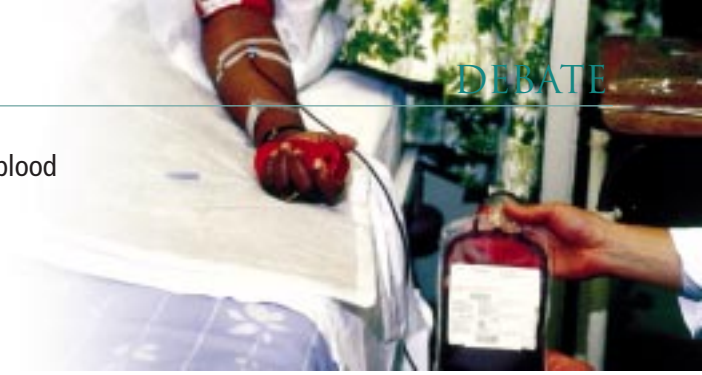
New Research has challenged the claim that sexual orientation is fixed in childhood and cannot change. Columbia University Professor Robert Spitzer presented his findings on 200 homosexuals who claimed to have changed their orientation, at the annual meeting of the American Psychiatric Association in New Orleans, concluding that 66% of the men and 44% of the women had achieved 'good heterosexual functioning'. The American Psychiatric Association removed homosexuality from its list of mental disorders in 1973. (*Daily Telegraph* 2001; 10 May)

Unhappy doctors

UK doctors are unhappy because they are overworked, underpaid, inadequately supported, and because politicians are stoking patients' expectations. These are the findings of a poll run by the *British Medical Journal* and answered by 1,400 doctors in 90 countries. Furthermore 85% of 38,000 GPs polled by the General Practitioners' Committee (GPC) of the British Medical Association are ready to resign from the NHS in twelve months if nothing is done to address the problems. (*BMJ* 2001; 19 May and 9 June). A similar demand to make bricks without straw prompted an earlier exodus, but only after some significant struggles. (Exodus 5:1-21)

Abortion funding ban upheld

President Bush's ban on taxpayers' funds going to overseas groups that perform or promote abortion has been upheld by 218 votes to 210 by the US House of Representatives. (*BMJ* 2001; 2 June)



Anne Sanderson reviews subtle changes in the Jehovah's Witnesses' blood transfusion policy.

Blood Feud

Last June the media heard of an apparent change in Jehovah's Witnesses' blood policy.[1] The subsequent headlines prompted a statement from the Watch Tower Society. 'There is no "U-turn"', they insisted. 'Nothing major has changed, there's only a slight difference in how we deal with members who deviate from our official view on blood treatments. The policy itself has not changed.'[2,3] However, people with knowledge of how the Society moves its goal-posts were not convinced. The Society said that congregation and hospital liaison elders had been briefed but it seemed that Jehovah's Witnesses (JWs) did not know anything about the matter.[4,5,6] The official *Watchtower* magazine didn't mention the issue. Why not?

The answer seems to be linked to a legal requirement the Society had entered into with the Bulgarian government in order to be re-registered as a religion. In return for the Bulgarians arranging alternative service (instead of prison) to JWs who refused conscription, the Society had promised not to sanction members who wanted blood. This news spread via the internet and soon became public knowledge,[7] apparently prompting the Society to guarantee this concession to all members world-wide. However, as members have been discouraged from looking at Internet sites that criticise it, the Society must have felt confident enough to proceed without informing rank and file members.[8,9]

The Society's wording of their policy change was very cautious: they would no longer disfellowship members who *repented* of taking blood. However, they have *never* claimed to reject a member who repents of an alleged sin. No, the real change lies in a new approach to members who show (eg by accepting blood) that they disagree with a core teaching. Such members are now viewed as having dissociated themselves, so official action is not required. What the public doesn't realise is that shunning tactics can be employed against both the dissociated and the disfellowshipped.[10] So, despite toning down official sanctions, the end result is virtually the same: a JW known to have taken blood will be shunned.

Another subtle change came with the Society adding more blood products such as interferons and interleukins to its 'acceptable' list.[11] The *BMJ* carried an article on this, mentioning that products derived from 'prohibited' cellular components were also listed. The possible implications of haemoglobin-based blood substitutes being introduced into general use were also discussed.[12] The Society claims that individual members are free to exercise their consciences on such matters, so those who *do* want blood-based treatments should be helped to ensure confidentiality in order to avoid congregational judgment. Unfortunately, members have been encouraged to break confidentiality and ensure that elders get to know of serious sin such as abortion, fornication or taking these 'disapproved' blood treatments.[13]

The *BMJ* article has generated considerable correspondence on the *BMJ* web-pages. Of note are the comments of JWs who have to work anonymously from within the religion for reform on this issue. The founder of this movement said, 'As recently as this week (28 January 2001)...members were once again indoctrinated on 'apostasy' and the need to shun completely anyone who disagrees with the channel that God is using to communicate with his people - the Watchtower Society.'[14]

Helped by public debate, the tide is slowly turning. More and more JWs are realising the indefensible nature of its Society's ever-changing pronouncements on life and death matters. Thinking JWs see the need to test the Society's claim that they are free to choose. Clinicians need to know what's really going on so they can ensure that JW patients make independent choices, free from fear or pressure.

Anne Sanderson is a Christian Author and Medical Secretary

The Bible and Blood

Jehovah's Witnesses argue that transfusion involves the use of blood as a nutrient and base their objection to it on three biblical passages forbidding blood ingestion: Genesis 9:4, Leviticus 17:11-14 and Acts 15:20, 29.

But both Genesis 9:4 and Leviticus 17:11-14 clearly relate to the blood of animals and birds killed for food or sacrifice and make no mention of human blood. Similarly in Acts 15:20,29, the Jerusalem Council's edict to 'abstain from...blood' makes no suggestion that human blood is being implicated. Furthermore this was a command primarily aimed at maintaining peace between early Christians from Jewish and Gentile backgrounds.

Christians are not under Mosaic Law today (see Galatians 3:23-25; Colossians 2:13-15) but even in the Old Testament the punishment for blood ingestion was not excommunication, but simply to bathe and wait until evening when one would be considered 'clean' (Leviticus 17:15,16). The Jehovah's Witnesses position is not biblically defensible.

Under the Old Covenant blood shed in animal sacrifices was sacred, epitomising the life of the sacrificial victim, and therefore had to be treated with respect. But its real significance was to point forward to the blood of the Lamb of God (Jesus Christ), who obtained 'eternal redemption' for his people (Hebrews 9:12) through shedding his own blood on the cross.

It is tragic that the Watchtower Society's policy denies Jehovah's Witnesses life-saving transfusions. But there is a greater tragedy. Failing to understand the deeper meaning of Old Testament blood laws may mean they also fail to find personal salvation in Christ. (www.cmf.org.uk/pubs/nucleus/nucoct93/jehovah.htm)

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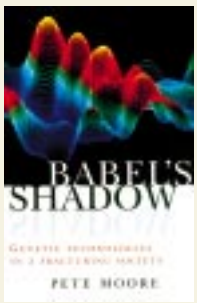
BOOKS

Babel's Shadow - Genetic Technologies in a Fracturing Society



Pete Moore
Oxford 2000
£18.00 pp 256 HB
ISBN 0 7459 4423 X

If you want to update yourself with molecular biology and the implications of the human genome project, then this is the book for you. Pete Moore's name may be familiar as series editor of the *CMF Files*. He has a gift for making complicated technology easy to understand. The early chapters, which describe molecular technology, are a model of his lucidity. The following chapters contain discussions on the medical applications of this technology, personhood, personality and the role of personal responsibility as the genetic bases for personality traits are discovered. Cloning, insurance, employment and forensic issues are all tackled, and a balanced view on the implications for each are given.

The author's Christian viewpoint is frequently expressed. He uses a metaphor of a new tower of Babel, with 'technology man' saying: 'Come let us build ourselves an industry... so that we may make a name for ourselves, build future generations to our own specifications and not be afflicted by any disease or illness'.

He stresses our need to be aware of pressure from different sources: parents for flawless babies, professionals to deliver these and health economists to reduce the number of individuals suffering from expensive, chronic disability. He argues that the possibility of altering genes must not distract us from our responsibility to alter society, and that market forces must not be allowed to control these new developments. He states that genetic technology has potential for good but only if we are prepared to use it in a spirit of humility and concern for our neighbour. Pete Moore believes that we are unable to assess the inflated claims often made unless we have some basic understanding of the new technology. Reading this book is the first stage to making a contribution in this vital area.

Caroline Berry, Emeritus Consultant Geneticist, London

Running for Revival

Ruth McGavin
Christian Focus Publications1999
£6.99 Pb 350pp
ISBN 1 85 792 522 X

This biography of Harry (Henry Brash) Bonsall is written by his daughter who once lived with her ophthalmoIogist husband Murray in Afghanistan. It is recommended by George Verwer, International Director of *Operation MobiIisation* and has a foreword by Brother Andrew.

Harry, born in Preston UK in 1905 into a godly family tree, emigrated to Canada with his parents in 1913. He started preaching as a child. He stood up against modernism and was present at the start of the Student Christian Fundamentalist Society in 1925 which became the Canadian Inter-Varsity Fellowship of Toronto in 1928. This had links with the British IVF (now UCCF) and Douglas Johnson, CMF's first General Secretary, was responsible for sending Howard Guinness to work with them.

After years of training, ministry often in remote prairies, rather strange illnesses and being confined to bed for three years (where he learned to pray) Harry was led back to the UK in 1935 with a vision to start Bible Colleges to prepare for a revival which would happen after at least 50 years. He taught in several Bible Colleges, was held back by war and experienced opposition both from Spiritualists and from staff and students. Eventually the Birmingham Bible Institute materialised. He remained there over 35 years until he had handed on the responsibility to others and was called home at the age of 85 still longing to see the revival come. The marathon race is still being run.

Harry is unconventional, shy but a leader and a visionary who needed others to make the system work. He was greatly supported by his mother Gettie and later his wife Dosie. His proposal of marriage to her in 1949 was abrupt and providential in its timing. The accumulation of the property that became the Bible Institute resulted from steps of faith that caused his friend and accountant at one stage to threaten resignation. But at the end of his life his advice to others was to take the Red Sea Route, depending on God for an impossible sea crossing, rather than to take a clear-cut land route. He and Dosie made students and others a part of their extended family. He prayed for them and with them. It was not always clear when he was talking to them and when to God. He wrote theological books that were both academic and inspirational. There are many hilarious stories about him but behind them was a disciplined spiritual life, a commitment to a single vision and a teaching ministry based on the twin pillars of the Spirit and the Word.

David Clegg is CMF Overseas Support Secretary

Health Care Beyond 2000 - Reconciliation and Integrity Through Christ. Proceedings of the ICMDA 11th World Congress

ICMDA 2000
£7.00 Pb 296pp
ISBN 0 620 26176 5

World Congresses have been held by the International Christian Medical and Dental Fellowship (ICMDA) every 3-4 years since 1963. The last Congress was held in Durban, South Africa in 1998 and attended by over 1,000 doctors from 60 countries. 100 students from 20 countries met at the Student Conference in Pietermaritzburg before joining the main conference. The proceedings of this Congress have been published in this book and are stimulating and highly relevant to medicine in the 21st century. Biblical principles are examined, relevant

applications made, and moving testimonies of Christian experience are given from different cultural backgrounds.

The book contains the full text of plenary talks. Ten talks from the main conference include, 'Integrity in Medical Decision Making', 'Uniting Faith and Medicine', and 'The Role of the Christian doctor and dentist in preventing the Demoralisation of Healthcare'. Similar themes are continued in the student sessions, with talks on 'The Myth of Moral Neutrality', 'Christian World View' and 'African World View'. The abstracts of 43 thought-provoking parallel sessions are also given. These are more focussed on specific issues such as AIDS, abortion, medical mission and the family.

With at least 59 contributors from all over the world, a wide range of issues are covered in a helpful and challenging way from an international perspective. I wholeheartedly recommend this book.

Stephen Browne is a General Practitioner in Birmingham

Comfort and Care in Final Illness

June Kolf
Sheldon Press 2000
£6.99 Pb 128pp
ISBN 0 85969 833 5

June Kolf has had a great deal of experience of caring for terminally ill people. She was a hospice volunteer and bereavement counsellor in California, and has been involved in caring for dying relatives. Out of this experience she has compiled a helpful guide to comfort and caring for people who have reached an incurable stage of illness.

The book is divided into a section for the patient and another for the carer. Mrs Kolf covers physical, emotional and spiritual aspects of the patient's experience; the carer's role, communication issues, making final arrangements and death itself. There is a good section on spiritual care. The writer speaks naturally of the benefits many find from prayer, the importance of forgiveness and forgiving, and of peace with God. Her writing is practical and readable. She concludes with lists of helpful addresses and of appropriate further reading.

Originally written for an American readership, the book has been well adapted for British readers although there are still some Americanisms (What is the 'proverbial dropping of the second shoe'? - p9) Some of the references to home-hospice and hospice volunteers are truer of the American scene than of the British. She seems not to know that UK hospices do not charge fees (unlike America - p19).

Mrs Kolf provides excellent ideas and up-to-date suggestions (see her comments on the cordless phone and e-mail - p40) and much comes from her own memories of caring. I found the directive nature of her advice rather irritating after a while. 'Do not fight your pain, but do not suffer in silence either. Let your carer ... know you hurt.... Strive to get the greatest relief... Experiment under your doctor's direction to find the best treatment...' (p10) is an example of much of her style. Nevertheless, I think this book will prove helpful for many carers and for people who are facing their final illness.

Anthony Smith is a Hospice Doctor in Canterbury

Unleashing the Lion - The Power of God in Health and Healing

Eric Petrie
SPCK 2000
£14.99 Pb 217pp
ISBN 0 281 05324 3

This is a perplexing book. It provides analysis of some of Christ's healings and challenging anecdotes. It gives a humbling review of the history of medicine and a useful history of Christian healing. It contains a passionate discussion on the problem of suffering. It also warns against abuses by the church, such as raising expectations falsely, applying rituals without consent, and accusing those unable to be healed of having insufficient faith. Sentence by sentence, the writing is a pleasure to read.

Overall, though, the book has no sense of direction and could leave a novice confused. My biggest concern is the approach to Scripture. The book states, for example: 'We do not have any direct, unbiased, first-hand accounts of anything that Jesus said or did', and, 'The Gospel writers were concerned with the meaning of Jesus' life, not the facts'. Furthermore, it says, 'They were ... propagandists, publishing underground radical pamphlets', and even, 'Luke may possibly have put a speech into the mouth of Paul in Athens'.

The most disturbing theological error occurs when the author claims that we, in the face of our own suffering, see God as guilty and need to forgive him for what he has done. I can accept that we may feel this way and may have a subjective, emotional need to forgive God. But the author does not make it clear that it is our limited understanding which is at fault, and that there cannot possibly be any objective need to forgive God. In not making this clear, I think the author is very seriously wrong.

This is not a book for those wondering about receiving Christian healing as it will probably put them off. It is not a book for beginners in the field. It is a book for the experienced who want a challenge. It will not 'comfort the afflicted' but I guarantee it will rather 'afflict the comfortable'!

Andrew Fergusson is Chairman of Acorn Christian Foundation

RevieWWWs with Cyberdoc

Cyberdoc reviews Jehovah's Witnesses and blood, Sharing faith with patients, Being a house officer and Burnout – the words in bold correspond to links on Cyberdoc's website at xtn.org/cyberdoc/jw

Jehovah Witnesses and Blood

The Associated Jehovah's Witnesses for Reform on Blood **(AJWRB)** website is fascinating. It is written by some current Jehovah's Witnesses (including some serving elders) and others who have left. It has the feel of a secret society warning its members to be cautious as one brother had been disfellowshipped when his wife reported to local elders that he had received an email from the AJWRB. In spite of at times severe criticism of the JW hierarchy the site seems committed to work for change from within. The articles are therefore that much more interesting. There is good coverage of recent changes in the official position.

JW blood review lacks the emotion of the previous site but contains a well-reasoned review of the JW's own Bible translation and attempts to show that a change in the view on blood would not be inconsistent with previous statements in Watchtower. The **Free Minds** page is not as extensive on the blood issue and was a little confusing to navigate. I have used the link direct to the page on blood to simplify readers' browsing. The **Blood Issue File** was by far the longest article on the subject I could find on the web, weighing in at a massive 5,500 words! The **Jehovah's Witnesses Official Web Site** provides a surprisingly superficial 'official' view of the organisation which is remarkable in its brevity and lack of mention of dissenting views.

Sharing Faith with Patients

Evangelising patients is the provocative title of a page on the CMF website, where the author explains his reasons for believing that sensitive sharing of faith with patients is neither unethical nor unwise. My first attempts at finding other pages on this subject on the web failed quite dismally. The closest match was a page that claimed **having Religious Faith Can Speed Recovery From Depression In Older Patients.** In the end I did find one page which shared an example of a **Medical Student** who had shared his faith with a convicted murderer.

Being a House Officer

The Northern Deanery have an introductory page on the house officer year which would make good reading. Apart from another page on the **CMF** site there seems to be very little out there on the web of use to house officers. Maybe they are all too busy getting burnout to write!

Burnout

The **Burnouts Homepage** is a collection of images, not of burned out doctors, but rather cars collected by a Glaswegian teenager. Although entirely pointless I couldn't resist sharing this particularly bizarre find. In fact it is almost depressing the number of pages on burnout on the web today. It isn't just doctors that suffer, and **Christianity Today** have a page that, although aimed at church leaders, makes useful reading. **Stress Managing Life** uses a weather metaphor and a few Bible verses to explore the subject somewhat superficially. For a biblical study of burnout take a look at **studies in the Life of Elijah.** The CMF site once again comes up trumps with a **Triple Helix** article from two years ago which contains a fantastic quote from the Message translation of the Bible that deserves to be heard again. Jesus says:

'Are you tired? Worn out? Burned out on religion? Come to me. Get away with me and you'll recover your life. I'll show you how to take a real rest. Walk with me and work with me - watch how I do it. Learn the unforced rhythms of grace. I won't lay anything heavy or ill-fitting on you. Keep company with me and you'll learn to live freely and lightly.'

Cyberdoc is Adrian Warnock, SpR in Child Psychiatry in London.

This article and links to previous Cyberdoc reviews' can be found at http://xtn.org/cyberdoc/

Go to the ant

It was early May, the traditional time for drilling wheat in our part of Australia. As the days passed everyone was getting noticeably more worried. Every time he'd go out Dad would cast an anxious eye heavenwards, but the skies remained monotonously clear as they'd done for the last four months. We would sometimes spy him squinting at the barometer, almost willing the atmospheric pressure to drop....

Then one morning dawned overcast. 'Do you think it's going to rain?' Pat Williamson our share-farmer asked. How would I know? I was only eleven. For some reason, though, instead of surveying the skies my eyes caught sight of an ant's nest. That morning it was a hive of activity. Ants seemed to be scurrying in every direction. 'Sure it's going to rain', I answered. 'Can't you see the ants on the move?' Pat laughed out loud but, sure enough, as evening drew in, the temperature suddenly dropped, the west wind blew up and down came the rain, a great sound on a hot tin roof. If I remember rightly we had a bumper harvest that year.

Ants. We know that no individual ant possesses any great intelligence, but collectively their achievements are amazing. These animals work without any apparent pre-planning and entirely without supervision. Certain species of ants are noted for being able to find the shortest path to food, merely by laying and following chemical trails.

It works something like this. Two ants leave the nest at the same time and taking different routes find the same food source. On the way their bodies emit a trail of pheromone. The ant taking the shortest route to the food will return first and since his trail is marked with twice the amount of pheromone compared to the route traced by his colleague, other ants will follow his route. Very soon, and very efficiently, a food convoy will form up and the ants will work away until the food source is exhausted or sufficient has been gathered in.

I was surprised to learn recently that ants have become an object of interest for industry and commerce, in particular by organisations looking for creative new approaches to solving complex logistical problems. This is especially so among companies making telecommunications systems, airfreight operators, and providers of complex delivery systems for products like domestic heating oil. All are benefitting from the study of what's been labelled 'swarm intelligence'.

But why should I be surprised? Some 3,000 years ago the writer of the Proverbs noticed that humans stood to gain from observing the behaviour of ants. 'Go to the ant... consider its ways and be wise!' counsels the greatest sage of the ancient Hebrew people. (Proverbs 6:6).

In medicine there needs to be a functional hierarchy, so I somehow doubt that doctors can expect to discover how to do complex procedures without either pre-planning or systems of supervision. But doctors do work in multidisciplinary teams and can always benefit from insights about teamwork. And above everything else, considering the ant might remind us to try to shape our approach to teamwork to ensure, for example, that the best ideas and contributions of even the most junior or lowly team member are recognised, encouraged and when possible used.

John Martin
Associate Editor of Triple Helix

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