TRIPLE HELIX

Summer 2002

For today's Christian doctor

SEXUAL HEALTH

TEENAGE SEXUALITY

LOVE FOR LIFE

CONDOM CONTROVERSY

FUNDING HEALTHCARE

RELIGIOUS TOLERANCE

CHINA AND BIRTH CONTROL

DIANE PRETTY

KENYA

OVERSEAS OPPORTUNITIES

ISSN 1460-2253

Triple Helix is the quarterly journal of the
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A Registered charity no 1039823

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Contributions
The editor welcomes original contributions which have both a Christian and medical content. Advice for preparation is available on request.

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EDITORIALS

Sexual Health

Christian doctors have a huge role to play

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The nation's sexual health is in decline, as evidenced by rising rates of teenage conception, abortion, sexually transmitted diseases, cervical cancer and mental health problems linked to early risky sex. The government is committed to lowering the under 18 conception rate by 50% by 2010, but its policies of 'over the counter' emergency 'contraception' and condom promotion look more like panic damage limitation than an attempt to address the root causes of the problem.

This issue of *Triple Helix* focuses on sexual health. Trevor Stammers (p3) reviews a major study indicating that family planning services may be increasing rather reducing schoolgirl pregnancy and abortion rates. Chris Richards (p4) challenges the decision to make Levonelle-2 available at Tesco's, which he says will undermine the doctor-patient relationship and parental accountability and expose teenagers to more pressure to have sex before they are ready. Hazel Curtis catalogues the legacy of the sexual revolution for teenagers (pp6-8), and argues that little progress will be made without attacking the widespread belief that teenage relationships are somehow incomplete without sex. Trevor Stammers (pp10-11) later demonstrates that widespread condom use has been accompanied by increasing teenage conceptions and sexually transmitted diseases due to a combination of method and user failure and their inability to protect against herpes, HPV and chlamydia. Looking further afield, Claire Stark Toller (p5) and Jason Roach (p15) take issue with UN policy that has promoted abortion as part of 'reproductive health services' and condoned coercive sterilisation and abortion in China.

Jason reminds us that objections without solutions often meet opposition, scorn and resentment and Christians have often come across as judgmental and moralistic when speaking about sex. And yet it is obvious that societies that embrace the biblical model of enjoying sex within marriage will avoid many of the consequences of sexually transmitted disease, abortion and illegitimacy.

Christian doctors have a huge role to play in promoting effective sex education, crisis pregnancy counselling and the message that 'virginity is good and that saying "No" is OK'. Dickie Barr's *Love for Life* programme (p9), which is now used by an amazing 60% of schools in Northern Ireland, is a wonderful example of 'best practice'. Let's be doing more of the same.

Peter Saunders
Managing Editor of Triple Helix

Family planning services are ineffective

But when will those responsible admit it?

'*Teen sex advice"ineffective"*'. The BBC News website[1] could not report it without using inverted commas. Anne Weyman, the Chief Executive of the Family Planning Association, blustered about it on the *Today* programme with noticeably less self-confidence than usual. However, *The Observer*, which normally avoids covering such news altogether, was uncharacteristically the most frank in its coverage. 'Abortions rise in under-age sex crisis – Morning-after pill, lessons in family planning and early puberty are all blamed for soaring pregnancies.'[2]

The cause of all this press furore was the publication by a prestigious journal of a paper by Dr David Paton indicating that family planning services have no positive impact on reducing the rate of pregnancy or abortion among schoolgirls and may in fact be having the reverse effect.[3]

Using a mathematical model of rational choice, Paton suggests that improving access to family planning has an ambiguous impact on underage conceptions. Teenagers who will engage in sexual activity in any case have a reduced risk of pregnancy but increased access raises the likelihood of engaging in sexual activity for those who otherwise would not have done so. Thus the overall effect may be to increase or decrease underage conceptions. Paton tests these competing hypotheses using UK regional data from 1984-1997 in two ways.

First, he examines the effect of the 1984 Gillick ruling,[4] which severely reduced the attendance of under-16s at family planning clinics for some time, until it was overturned in 1985. Using data for over-16s (who were unaffected by the ruling) as a control, Paton concludes, 'There is no a priori evidence in the raw data that the Gillick ruling had the effect of increasing underage conceptions'.[3]

The second approach estimates conception and abortion rates for under -16s as a function of attendance at family planning clinics. Again Paton finds 'no evidence that greater access to family planning clinics has reduced underage conceptions or abortions. Indeed there is some evidence that greater access is associated with an increase in underage conceptions in our sample.'[3]

I have argued elsewhere in this journal (pp10-11) the reasons why increasing provision of condoms in particular may be counter-productive. The sad thing is that Paton's research was immediately rejected out of hand by the FPA whose spokesperson Juliet Hiller 'rejected the suggestion that giving young people advice was ineffective'.[1]

The vested commercial interests of contraceptive manufacturers and providers are as powerful as that of the tobacco industry in blinding their eyes to the evidence of the harm they are doing. Jesus had strong words to say both to those who led young people astray[5] and those who rejected clear evidence because of ulterior motives.[6] It has taken decades for a tobacco executive to declare publicly for the first time ever recently that smoking harms health. It will probably take decades more before those who promote the false security of the 'safer sex' message as the primary answer to declining teenage sexual health actually admit they are wrong, but Paton's important paper does bring that day a little nearer.

Trevor Stammers
General Practitioner in West London

1. *Teen sex advice 'ineffective'*. *www.news.bbc.co.uk* . 4 March 2002
2. Ahmed K. Abortions rise in under-age sex crisis. *The Observer* 2002; 17 March
3. Paton D. The economics of family planning and underage conceptions. *Journal of Health Economics* 2002; 21:207-225
4. In Dec 1994 the UK Appeal Court ruled in favour of Mrs Victoria Gillick in *Gillick vs West Norfolk and Wisbech Health Authority*, that contraceptive advice should not be given to those below the age of 16 without parental consent. The ruling was eventually overturned by the House of Lords in the autumn of 1995.
5. Matthew 18:6
6. John 5:44-47

Going down to Tesco's

More foolish 'damage limitation'

Two Somerset branches of the supermarket chain Tesco's are to take part in a pilot scheme in which a company pharmacist may dispense the morning-after pill (MAP) free without prescription to those under 20, but without lower age limit, after an interview. Named records are not to be kept and no one else will know of the request.

This initiative, allowed in a named area under a Ministerial Order of August 2001 called 'Patient Group Directions', is the latest manifestation of a government programme that aims to reduce the under 18 conception rate by 50% by 2010. While the aim is laudable, the means is not. We should be concerned about this liberalisation of the MAP availability for at least four reasons.

First, the MAP can work as an abortifacient. The Levonelle-2 preparation used in this initiative is a progesterone-only MAP whose makers acknowledge sometimes works by preventing implantation of a fertilised ovum.

Second, the supermarket pharmacy, even having a quiet room away from the queue, is the wrong context for a young distressed girl to make such a request and to receive counselling and care. Even exchange of essential medical and social information will need time and sensitivity. Issues include side effects (nausea and/or vomiting in 25%), what to do if the girl vomits within three hours of taking the tablet, and the 'failure' rate of perhaps 15% of all potential pregnancies. A discussion of the social context is equally essential (eg. coercion by an older man, concomitant alcohol and drug use).

Third, these arrangements remove all accountability of the child to the parents and other health professionals in the discredited belief that this has a negative effect on teenage conception rates. The evidence suggests otherwise. For example, in the ten months after the Gillick case of 1984 it was unlawful in England for doctors to provide contraception to girls under 16 without parental knowledge and consent. Under 16 family planning clinic attendance fell by over 30% but conception rates remained unchanged.[1] Accountability to parents, it seems, was not only a disincentive to family planning clinic attendance but also to sexual activity.

Accountability to parents and others also has the important benefit of affording the young girl protection from exploitation by older men. This is one important reason for there being an age of consent in this country.

Finally, this government strategy is underpinned by the disastrous assumption that there is no right or wrong in teenage sexual activity - just choice. As teenage conception rates continue to rise, they conclude that the choices are not being made accessible enough.

The amoral assumptions of a health service with an increasingly dominant atheistic worldview are damaging our nation's children. When a society chooses to ignore God's wise rules for living, the practical outworkings in damage limitation often look desperate and disturbing. Like what has just appeared in our supermarkets.

Chris Richards

Consultant Paediatrician in Newcastle-upon-Tyne

1. Paton D. The economics of family planning and underage conceptions. *Journal of Health Economics* 2002; 21(2): 27-45

For further information on the MAP refer to *The Morning-After Pill - Promoting Promiscuity* published by The Christian Institute 2001 and *Young People and the Morning-After Pill* published by the Family Education Trust.

'Religious Tolerance' on Campus

A wolf in sheep's clothing?

A disturbing trend was highlighted by the recent publication of a document entitled *Religious Tolerance and Respect on Campus*.[1] Written by a Muslim chaplain at Oxford University, it claims the support of several organisations, including the National Union of Students.

Its aim is the establishment of interfaith discussion groups on campus, a seemingly innocent goal, and yet on closer reading there is a distinct undercurrent against evangelical Christianity. Proposals for a code of practice include: 'no university student organisation should discriminate on grounds of religious belief in their rules for membership or leadership, and no doctrinal test should be imposed on members or leaders'.

Specific mention is made of the 'discriminatory doctrinal test' of CMF and UCCF groups. This strange proposal would leave groups open to infiltration by anti-Christian elements and even leadership by Muslims or anyone else.

The document mentions groups such as Al-Muhajiroun (a Muslim group with links to terrorist organisations such as Hamas and Hizbollah), alongside 'fundamentalist missionary groups' such as the 'Ishmael mission' (a reference to CMF's 'Ishmael my Brother' conferences) and All Souls' church in London.

It then describes fundamentalism as 'throw[ing] out entirely the heritage of centuries of both modern and ancient sacred scholarship and debate'. Furthermore, 'the Fundamentalist's Bible or Qur'an is a "loose-leaf" text, where you selectively tear out the pages that don't suit you.'

Further proposals include that 'no proselytising activity should be directed against another faith community'. This would outlaw any dialogue between Christians and other faith groups aimed at reaching objective truth and allow only that aimed at gaining understanding of another person's beliefs.

Biblical dialogue, on the other hand, is concerned not only with seeking understanding, but also with opposing challenging false belief, albeit 'with gentleness and respect'.[2] It is seen in the many instances of the use of *dialegomai* in the New Testament, such as Acts 17:2,3, where Paul 'went into the synagogue, and… reasoned (*dialexato*) with them from the Scriptures, explaining and proving that the Christ had to suffer and rise from the dead' (Acts 17:2,3).

Andrew Carey responded to *Religious Tolerance* in the *Church of England Newspaper*: 'under the guise of tolerance, we have a clear attack on religious freedom'.[3] Don Horrocks of the Evangelical Alliance stated that 'it is unrealistic to expect religious groups to leave their religious beliefs at the door of public debate in pursuance of some politically correct, ridiculous, lowest common denominator'.[4]

This initiative is disturbing in its subtle attack on religious freedom of speech. It reflects the rising tide of aggressive pluralism, where any and every opinion is welcome, just so long as it doesn't claim to be objectively true. We must pray for our students on campus, who are in the 'front line' of evangelism, that they will take their lead from those like Paul and not be afraid to stand up for the truth of the gospel.

Mark Pickering

Trainee General Practitioner and CMF Student Secretary

1. Available at *www.university-church.ox.ac.uk/rtc.htm*
2. 1 Peter 3:15
3. Carey A. New threat that could close Christian Unions. *Church of England Newspaper* 2002, 12 April
4. Bonthrone PJ. Muslim's call on Christian groups is 'ridiculous'. *Telegraph* 2002, 1 May. See also letters of same edition.

EDITORIALS

Ian Stillman

A gross miscarriage of justice

Ian Stillman

Ian Stillman is profoundly deaf, diabetic, has only one leg and is a Christian. He has lived in India for 30 years and established the Nambikkai Foundation for the deaf. It has helped over a thousand deaf people to find jobs, and endeavours to improve the image of the deaf - many in India still believe disability reflects sins from a previous life.

In August 2000 Ian was in North India, researching work amongst the deaf there. Police allegedly found a bag containing 20kg of cannabis in his taxi. Incredibly the others in the taxi were released, but Ian was arrested and charged with drug smuggling. At first he and his family adopted a low profile. Knowing he was innocent and physically incapable of carrying a 20kg bag of anything, Ian trusted Indian justice, and was confident that he would soon be free. He did not want too much fuss lest the authorities be antagonised, and his release delayed.

The case is scarcely credible. He was tried in Hindi – which he doesn't understand, was denied a sign language translator and had to rely on lip reading his lawyer's English. He was convicted and sentenced to ten years imprisonment. His appeal failed, the court deciding he was 'hard of hearing' rather than deaf. All hopes were pinned on his appeal to the Indian Supreme Court, but in May this year the court refused to allow his appeal, one of the judges stating that the disabled were 'well known to be involved with drugs'. Characteristically, Ian was more upset at this slur on the disabled than on his own continued incarceration.

With the legal process ended, there is a growing campaign to persuade the authorities to think again. There are real concerns for his health, and prejudice against the disabled - especially the deaf - has been unmasked.

Ian, like his Saviour before him, has been a victim of gross injustice but has been sustained throughout by a sense of God's presence and of prayer support from around the world. But why not write to him in prison, sign the petition (contact *Friends of Ian Stillman, 13 Hilton Place, Leeds, LS8 4HF - www.ianstillman.fsnet.co.uk)* or write to your MP? Get your church concerned and praying!

Richard Henderson
Consultant Radiologist in North Yorkshire

A World Fit for Children

The UN takes a welcome step

On 11 May, after tense and protracted negotiations, the UN General Assembly Special Session on children unanimously adopted a draft resolution entitled, 'A World fit for Children' to protect children from poverty, exploitation and disease. This marked a victory for the US, allied with the Holy See and Muslim countries including Sudan and Pakistan, who had campaigned hard to remove from the document language that promoted abortion and recognised homosexual marriage as a type of family.

Controversy centered round the phrase 'reproductive health services'. The EU and Canada had endeavored to ensure that children had access to these services. [1] However, in discussions in June during the lead up to the Summit, the Canadian delegate to the UN admitted, 'Of course [reproductive health services] includes, and I hate to say the word, but it includes abortion'.

This admission prompted the US and her partners to insist that the phrase be removed from the final UN document. This campaign was successful and all references to reproductive health services have been removed and replaced by less concrete terms: 'we resolve to achieve the following goals… access…to reproductive health for all individuals of appropriate age'. [2] At the end of the special session, the US gave a separate statement in explanation underlining that it in no way understood any of the other terms, such as 'basic social services' or 'family planning services', contained within the final document to include abortion, abortion-related services or abortifacients. [3]

The US also reaffirmed its commitment to the promotion of sexual abstinence and delayed sexual initiation as the central message of sexual education. [3,4] This approach received a predictably dismissive response from European and Canadian delegates in particular. With reference to HIV/AIDS pandemic, the Director-General of the WHO, Gro Harlem Brundtland, said, 'we need to focus on the realities of teenage lives, rather than on our views about how young people should live'. No mention of sexual abstinence was included within the final document.

The second controversial phrase 'various forms of the family' was added to the UN lexicon in 1994 at the International Conference on Population and Development with the support of the Clinton administration, the EU and Canada. Pro-family nongovernmental organisations have long held that this term is an attempt to include homosexual marriage within UN instruments. [5] In its statement in explanation, the current US administration confirmed that it understood the phrase 'to include single parent and extended families'; no reference to homosexual partnerships was made. The term, without explanation, remains within the current UN document.

'A World Fit for Children' is a very positive document that promises to achieve much for children over the next ten years. As Christians, we should endeavor to ensure that children throughout the world are protected from abortion and changes to the traditional family.

Claire Stark Toller
Senior House Officer in Buckinghamshire

1. Venis S. UN conference on children bows to US pressure. *The Lancet* 2002;359:1753
2. *A World Fit for Children*. Outcome document of the Special Session on Children, unofficial advance unedited version. Section 1:36 (g) – *www.unicef.org/specialsession*
3. Statement in Explanation of Position by United States Ambassador Sichan Sav at the Special Session of the United Nations General Assembly on Children following Adoption of the Outcome document - *www.un.int/usa/02_070.htm*
4. The Whitehouse News and Policies - *www.whitehouse.gov/news/releases/2002/02/welfare-book-06.html*
5. Catholic Family and Human Rights Institute. *Friday Fax* 2002;5:15 - *www.c-fam.org*

Photo: Wellcome Photo Library

Hazel Curtis explores how Christian doctors can help teenagers grow to understand their sexuality positively

Teenagers and sex

Britain now has one of the highest rates of teenage pregnancy in Western Europe. This has significant health and social consequences for our society and so the government has started to implement a two-fold national strategy for England over the next ten years:[1]

- To halve the rate of conceptions among under 18s and set a firmly established downward trend in the conception rates for under 16s by 2010.
- To increase the participation of teenage parents in education and work.

This article explores the underlying factors contributing to these statistics and offers a Christian perspective on the deep significance of healthy sexual relationships within society. It highlights how we as Christian doctors can play our part in helping teenagers think positively about their sexuality and understand Christian values.

If we give children and teenagers the impression there is something inherently wrong with sex we will risk leaving them convinced that there is something wrong with them

Health statistics

- In England there are about 90,000 conceptions per year to teenagers, of which 7,700 conceptions per year are to girls under 16 and 2,200 to girls aged 14 or under.[1]
- Roughly 60% of conceptions result in live births.[1] Of about 180,000 abortions each year, about 35,000 occur in teenagers.
- Despite knowledge about contraception, teenagers are not good contraceptive users.
- Sexually transmitted diseases (STDs) are increasing. Chlamydia has increased by 61% since 1996 and is the leading cause of pelvic inflammatory disease and infertility. The highest rates of gonorrhoea are in men 20 – 24 years and women 16 – 19 years.[2]
- Cervical cancer caused by human papillomavirus type 16 is increasing.
- Young people with mental health problems carry a disproportionate burden of risk of disease associated with sexual behaviour. The most prevalent, clinical depression, is associated with increased rates of risky sex, sexually transmitted disease and early sexual experience.[3,12]

Social statistics:

- The norm for girls and boys under 16 years in the UK is to be a virgin.
- Less than one third of teenagers are sexually active by the time they are 16 and half of those who are use no contraception the first time. With hindsight many young women wish they had waited. For a significant group, sex is unwanted.
- This problem affects every part of the country but conception rates are about five times higher in the poorest areas than in affluent areas. They are higher among the most vulnerable young people, including those in care and those who have been excluded from school.
- Teenage parents are more likely than their peers to live in poverty and unemployment and be trapped in it through lack of education, childcare and encouragement.[1]

Images of sexuality in our society

Sexual imagery plays a strong part in our culture today and attractive sexual images are used in nearly all areas of advertising and the media, in

fashion and dress, in order to generate interest and make money. Increasingly popular advertising works by association of images, linking sexual attractiveness with 'lifestyle'. In the media, particularly on TV and in films, human relationships are often portrayed as incomplete without sex, yet these same relationships are seldom lasting ones.

With the rise of postmodernist thinking, individualism is emphasised in our culture and teenagers may well pick up in secular society that there are no universal values or norms, that rules and boundaries for sexual expression are meaningless and that they can do what they feel like.

To teenagers, sex is seen as adult and exciting, a barometer of attractiveness, as a solution to problems and never the cause of them. Yet this belies the evidence, since many teenagers have experienced break-up of the family themselves and they are familiar with statistics, which show that marriage is in decline and divorce is commonplace.

A Christian view of sexuality and marriage

As Christians, we would assert that this commoditisation of sex outside of permanent relationship is a much-distorted view of sex, and that many sexual images in popular culture are negative or manipulative, usually self-centred and focused upon 'what I can get out of it'.

Instead, we need to communicate a Christian view of what God has revealed in Scripture, affirming the positives of sex as his precious gift. It is God who made mankind and God made us male and female (Genesis 1:27). Everything God made is good (Genesis 1:31), including our sexuality. The two sexes complement one another perfectly. The biblical context of sexual intercourse is within the exclusive and life-long committed relationship of marriage (Genesis 2:23-25; 1 Corinthians 7:3-5, 39). God's design was for pleasure and enjoyment. As CS Lewis put it, 'Pleasure is God's idea, not the Devil's.' The Song of Songs celebrates sexual intimacy as a profound form of communication and being between the bride and her husband. Instead of 'what I can get', the Bible sees sex as giving of ourselves in love to another.

God gave us the clear boundary for sexual intercourse within marriage for the health and well being of both individuals and society. The Bible teaches clearly that sexual immorality is sin – both sexual intercourse outside of marriage and lustful thoughts (Matthew 5:27, 28). In 1 Corinthians 6, the Apostle Paul argues strongly that, for Christians, our bodies are a temple of the Holy Spirit and that sexual sin is an offence against our own bodies (1 Corinthians 6:18-20).

The focus in our churches upon the married family unit can leave singles feeling left out, isolated and unfulfilled. We need to affirm that celibacy within singleness is a valid expression of our sexuality.

Teenagers' needs

Teenagers are crossing the long bridge between childhood and adulthood: physical/sexual, mental and emotional maturities do not occur simultaneously. It is adults who have shaped our society and are broadly responsible for their nurture and education. Yet all too often teenagers are the ones who are blamed as being solely responsible for embarking on sexual relationships and for becoming pregnant. This happens regardless of the fact that it is adults who have exposed children of all ages to a society which is obsessed by sex, thus putting them under enormous pressure to conform.

Teenagers need and appreciate

- Being accepted
- Being listened to
- Being helped to explore issues
- Having their knowledge and skills recognised
- Being taken seriously
- Being valued

If we give children and teenagers the impression there is something inherently wrong with sex we will risk leaving them convinced that there is something wrong with them when they start being attracted sexually and when their emotions are swinging. Sexuality is about who we are as human beings so it is vital for their self esteem that teenagers have a positive attitude to sexuality.

What are teenagers saying?

Teenagers, even more than the rest of us, desperately need to feel loved and accepted, not least by their friends and peers. Their self-confidence can be extremely brittle and their desire for approval can lead them to do things that they do not feel comfortable with, just because they do not have the know-how to walk away with their self-confidence intact.[4]

A number of research studies have shown that teenagers often regret the age when they started having intercourse.[5,6,7] A comparative study of reasons cited by teenagers behind first intercourse showed marked differences between The Netherlands and the UK (See figure[1]). Over 40% of teenagers in the UK give peer pressure as the reason for first intercourse. It is clear that the reasons behind first intercourse are different between The Netherlands and the UK, with over 50% of teenagers in The Netherlands stating love and commitment, compared with 15% of boys and less than 50% of girls in the UK. Teenagers involved in sex education stated that 'some people only want a relationship for sex, especially males'. The teenagers expressed the idea of unwritten codes finding a balance between trying to get what you want without risking rejection.[4]

Once teenagers have experienced sex, they are very likely to have sex in subsequent relationships and often this occurs at an earlier stage in the

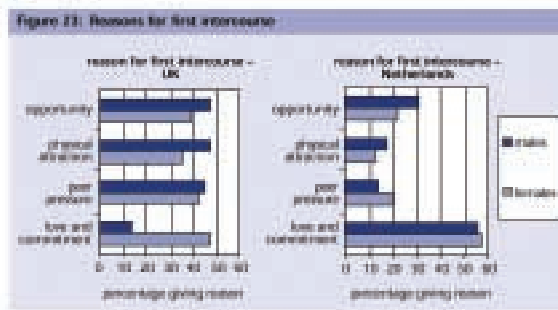
Photo: Wellcome Photo Library

KEY POINTS

The government is now committed to lowering Britain's escalating teenage pregnancy rate, but we cannot deal effectively with teenage sex and its legacy of sexually transmitted disease, illegitimacy and abortion, without attacking the widely promoted idea that teenage relationships are incomplete without sex. Teenagers need help and support in crossing the border between childhood and adulthood; affirmation from peers, family and friends, accurate information about sex and its consequences and assurance that virginity is good and that saying 'No' is OK. Overall they need to hear that sex is God's invention to be celebrated in the context of a lifelong heterosexual marriage relationship.

relationship. There is an addictive element to sex, which makes it hard to break this pattern.

We need to establish that virginity is the norm in both sexes in adolescent years and that saying 'No' is OK



Sex education – at home, school, church and work

We need to be involved in developing communities and families where children are loved, cared for and affirmed; where relationships are seen more holistically than just sexual relationships. We need to establish that virginity is the norm in both sexes in adolescent years and that saying 'No' is OK. However, we also need to be supportive, caring and understanding to those who become pregnant.

At Home

Two-way communication is essential within the home. We want teenagers to develop a healthy personality, which will enable them to cope with the challenges that life presents. We want them to have all the information they need to make choices, particularly in relation to sexual matters, which they are happy with. Compared with The Netherlands, families in this country seem reluctant to talk to their children about sex and relationships.

Boundaries are important (eg. curfew time, asking where their child is going etc) and although perhaps not perceived as such by a son/daughter, are an important indicator of parental love and responsibility.

At Work and School

The DfEE issued new guidance on sex and relationships (SRE) in 2000,[8] as part of the Personal, Social and Health Education (PSHE) Framework. Within this guidance, SRE is stated as being 'lifelong learning about physical, moral and emotional development ... about the understanding of the importance of marriage for family life, stable and loving relationships, respect, love and care. It is also about the teaching of sex, sexuality, and sexual health. It is not about the promotion of sexual orientation or sexual activity - this would be inappropriate teaching.' The three main elements of SRE are to be: attitudes and values, personal and social skills, and knowledge and understanding. All schools are now required to have an effective SRE policy, which is regularly inspected and reviewed. Schools are encouraged to work with parents and with the wider community (eg. health professionals, social workers, youth workers) when planning and delivering sex and relationship education.

All health professionals need to be aware of those at risk of risky sexual activity. We need to be proactive in asking pertinent questions, perhaps using the HEADSS mnemonic – Home, Education, peer Activity, Drugs, Sexuality, Suicide.[9] Time needs to be given to those who have become pregnant to listen to them, whatever the outcome. Time is essential in order to listen to those who have come to attention, eg. through overdoses, where relationship issues have been the trigger. Those who have a concern for children and teenagers perhaps need to consider becoming involved with schools as governors or as professionals offering input/resources/examples of good practice, eg. A PAUSE (Added Power And Understanding in Sex Education).[10] All primary care trusts have had to put together a teenage pregnancy strategy and their strategy groups may well welcome such examples of good practice.

At Church

How often in church youth clubs do we hear why God's plan was for sex in the context of a life-long relationship of marriage – that it was for our health and well being? Many teenagers feel that sexual sins are put on a much higher pedestal than others – they feel that sexual sin is the unforgivable sin. Sexual issues too often are taboo and teenagers feel they cannot talk about relationships, sex, their anxieties and mistakes for fear of being criticised or condemned, or perhaps because they do not feel adults know what they are going through. Teenagers may well feel too guilty to talk about their mistakes or to ask for help if they feel trapped in an addictive cycle.

We need churches that are supportive and caring of teenagers and parents – evenings for debating issues and sharing the breadth of Christian resources and books that are available.[11,12,13]

God's ideal

Teenagers are not yet mature in all areas of their life – they are crossing the long bridge between childhood and adulthood. They need affirmation from peers, family and friends – they like belonging to a crowd. We want them to have accurate information and to develop the skills they need to make choices and to be confident enough to stand up for what they believe in. Children and teenagers in the Christian community need to know that our sexuality was created by God and is good and to be celebrated. God gave us clear guidance for living so that we can live life to the full, whether married or single. All of us fall short of God's standards and sin, and yet we can know forgiveness through the Lord Jesus Christ. Let us not be afraid to stand up and get involved and share God's ideal for relationships.

Hazel Curtis is a Consultant Paediatrician in Berkshire

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Dickie and Janice Barr and family.

How can teens be convinced to say 'no' to premature sex? **Dickie Barr** tells about the work of *Love for Life* a Northern Ireland agency helping teenagers to do just that.

Love is for Life

'Never before have adolescents been exposed to such relentless media pressure to have sex as early as possible' (Dr Trevor Stammers, 1999).

How do we support teenagers today who face incredible pressure from media, peers, and in relationships to become sexually active prematurely? Today's teenagers are bombarded by media messages of recreational rather than relational sex. Increasing numbers have to cope with an environment of increasingly dysfunctional family backgrounds. Then there is the spectre of easy access to alcohol and drugs. Put all these together and it should be no surprise that many will lack the inner convictions and resistance skills to say 'no' in situations of sexual opportunity or pressure.

I have the privilege of being Director of *Love for Life*, a relationships and sex education project that supports young people and those caring for them in their decision-making about sexual choices. The project has enjoyed incredible growth and has the support of those working in the health and education arenas. The *Love for Life* post-primary programme is now used by an amazing 60% of the schools in Northern Ireland.

Interestingly enough, we did not originally set out to establish a Relationships and Sexuality Education project. Our original plan was to launch a 'crisis pregnancy' centre. *Love for Life* developed as an extension of this work and the realisation that it was important to address some of the root causes that bring teenagers to unwanted pregnancy.

Soon after the crisis pregnancy centre opened in 1994 we received invitations from local schools to talk about the work of the centre. This, coupled with seeing teenage girls in school uniform attending the centre for pregnancy tests, challenged us to look at what part we could play in relationships and sex education in our local and wider community.

TEACHER COMMENT

'A KEY FEATURE FOR US AND ONE WHICH THE PUPILS APPRECIATED WAS THE PROFESSIONAL MANNER IN WHICH SENSITIVE MATERIAL WAS PRESENTED AT A LEVEL APPROPRIATE TO THE PUPILS' NEEDS AND STAGE OF DEVELOPMENT'

A programme was developed for full year groups using a multimedia, interactive format. Team members and volunteers were trained to provide three different age-presentations to engage young people in discussion about various aspects of relationships and sexual choices. We now have five full time staff with a further three part-time. They are backed up by numerous volunteers who make up the two presentation teams as well as support staff.

This academic year we carried out pilot work with P7 pupils and in youth club settings. Presentations to parents and youth workers have prompted development of a parent/carer programme, which has been presented to well over a thousand adults this current academic year.

PUPIL COMMENTS

'THE PRESENTERS WEREN'T UNCOMFORTABLE TALKING ABOUT THINGS THAT WE WOULD NEVER TALK TO ANYONE ELSE ABOUT'

'WE WILL USE WHAT WE LEARNT FOR FUTURE DECISIONS WE HAVE TO MAKE'

Although we have secured statutory funding, so far on a year-to-year basis, we are heavily dependent on individual and church contributions, one-off voluntary trust contributions and fundraising events. God has always provided for our needs.

All the programmes are presented from an abstinence-centred perspective and affirm marriage. They emphasise the uniqueness of the individual, the positive choice of delaying sexual intercourse and of treating oneself, others and sex with respect.

We are amazed at how God has blessed the work since we opened our *Care For Life* crisis pregnancy centre in 1994 and how from that the *Love for Life* relationships and sex education project has developed. God has blessed and multiplied our efforts. We would probably not have had the faith to step out if we had known all that lay ahead and yet we are aware that the journey is probably only just starting.

God has given us an Irish-wide and British-wide vision for the *Love for Life* relationships and sex education project. We have already begun to make presentations in schools in the Republic of Ireland in Drogheda, Dundalk and Clonmel. Pilot work has been carried out in Birmingham and Basingstoke with ACET and with *Care For Life* personnel delivering the programme in their own local schools. The feedback from pupils, teachers and presenters was very encouraging. Now *Care For Education* is exploring ways whereby the programme can be adapted and rolled out in a consistent format across the whole of the UK.

It is my belief that young people today can make healthy choices if they are supported and empowered to do so. We in *Love for Life* are committed to reaching as many young people as possible by making the resource God has given us available for others to use. It has been our privilege to play a small part in the training and personal development of those we have presented to and we look forward to making an ever-greater impact alongside others in Britain and Ireland as God gives us the opportunity.

Dickie Barr is Director of Love for Life and a General Practitioner in Lurgan, Co Armagh.

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Volker de L'Homme de Courbiere, Chairman of the Cologne-based 'Condomi AG' (Ltd.).

Trevor Stammers questions the prevailing wisdom

The condom controversy - safe sex or russian roulette?

KEY POINTS

Condoms are widely promoted as offering protection against pregnancy and infections; and are increasingly used as contraceptive of choice. But method and user failure, combined with a false sense of security leading to higher rates of intercourse with greater numbers of partners, mean that over half of girls relying on them will become pregnant over a five year period. And whilst, if used correctly, they protect against HIV and gonorrhoea, they do not offer substantial protection against the much more common Herpes, HPV or Chlamydia. The much more biblical 'saved sex' message (sex saved for a long term monogamous relationship) is much better than the 'safer sex' offered by condoms.

My London medical practice has seen a huge rise in sexually transmitted infections (STIs) over the past few years. Genitourinary medicine clinics are struggling with the increasing workload and the Medical Society for the Study of Venereal Diseases is promoting training courses to help GPs cope. Despite well-funded Government initiatives, sexual health is actually declining.

The Importance of Condoms

Condoms are considered to be 'the only products that offer protection against both pregnancy and infections'.[1] As such, they are the major priority in most sexual health improvement strategies. Half of girls under 16 attending family planning clinics in 2000-2001 chose male condoms as their main contraception method. The proportion of those of all ages using condoms rose from 6% in 1975 to 35% in 2001; use of the contraceptive pill declined from 70% to 42%.[2,3]

Of course, choosing condoms does not equate with using them. A large survey found that only 40% of unmarried 18-59 year olds used them at last intercourse. Even when this contact was casual, still only 62% used them.[4] Another study of 8,500 American undergraduates found that only 43% always used condoms and 24% never did. Men with the most partners reported lower condom use. Men who only had homosexual sex were less likely to use condoms than those who only had heterosexual sex.[5]

With UK STI rates soaring, condoms' effectiveness is increasingly questioned. Their use has been equated with playing Russian roulette.[6] Leading experts are asking 'why condom promotion is apparently not having much effect in most developing countries and whether we have the right balance between messages about condom promotion and partner reduction and selection?'[7] Others question, 'have we as health care professionals been co-conspirators in propagating the erroneous belief that using condoms makes sexual activity safe?'[8]

Effectiveness and Failure

Contraceptive failure rates (CFR) are calculated in relation to resulting pregnancies. As infection can be transmitted during both fertile and non-fertile phases of the menstrual cycle, STI rates are very much higher than failure rates.

Contraceptive failure rate =
method failure (eg latex weakness) **+** **user failure** (eg incorrect or inconsistent use)

Condom method failure rate is 3% but user failure rate is 14%.[9] So, at least one in seven condom users become pregnant each year. CFR does vary greatly and depends more upon experience in correct condom use rather than the user's age *per se*. A study of 4,600 cumulative use attempts in monogamous couples found that condom breakage was only 0.4% and the CFR was 1%.[10] However, a third of heterosexual students said that they delayed putting on condoms until after initial penetration.[11]

Approximately 80% of emergency pill requests arise from contraceptive failure, mostly of condoms.[12] Reliance upon condom use alone will not reduce teenage pregnancy rates if a false sense of security

in their effectiveness results in more acts of intercourse taking place.[13]

Using probability theory and assuming an average 14% per annum CFR, girls using only condoms for contraception have a 53% chance of becoming pregnant over five years.[14]

Risk displacement

The principle of risk displacement is well recognised in public health. Reliance on condoms leads to an increased frequency of sexual intercourse with either the same or a number of partners.[15] Given their 14% CFR and failure to address changes in consequent sexual behaviour, condom promotion may well result in increased STI transmission and unplanned pregnancies.

Protection provided for individual sex acts is not the only factor when considering a population's sexual health. If over-confidence in condoms' 'safety' leads to increased intercourse rates, the actual number of acts of unprotected sex within the population may actually increase.

Sexually Transmitted Infections

Even without considering incorrect use and risk displacement, condoms' protection against STI transmission varies considerably with each particular STI.

■ *HIV*

The risk of contracting HIV from one unprotected act of penile-vaginal sex with an infected partner is around one in 1,000; receptive penile-anal sex is thirty times riskier, ie. one in 33.[16] Condoms give substantial protection against the vaginal transmission of HIV, though none are specifically approved as safe for anal sex.[17]

Theoretical concerns about the 'holes' in latex being larger than HIV virus particles are not born out in practice. Most semen HIV is found within potentially infectious lymphocytes that can't pass through an intact condom.[18] In a multinational study of 378 seronegative partners of HIV-infected heterosexual men and women, no seroconversions occurred among the half of the sample who used condoms consistently. The 121 couples who used condoms inconsistently had a seroconversion rate of 4.8 per 100 person-years.[19]

Condoms offer substantial protection against HIV if used consistently and correctly but inconsistent use carries considerable risks of transmission. The recent USA Department of Health and Human Services report concludes that consistent condom use is 85% effective in reducing the risk of HIV transmission.[20]

■ *Human Papilloma Virus*

The UK's commonest STI, HPV is probably transmitted by both skin-to-skin contact and genital fluids. The high–risk types are associated with cervical and anal cancers. Other, lower-risk types cause genital warts and/or dysplasia. There is no evidence that condom use reduces the transmission of HPV.[21]

■ *Herpes Simplex Virus*

Genital herpes infection results in multiple, painful blisters that shed virus particles. It is often recurrent and remains incurable. There is no conclusive evidence that condoms offer substantial protection from HSV, though one recent paper has proposed some protection to women.[22,23]

■ *Chlamydia*

Chlamydia is the UK's commonest bacterial STI with a 10% prevelance in sexually active women. It frequently causes asymptomatic tubal damage and subsequent infertility. Though theoretically they should, there is no convincing evidence that condoms protect against chlamydia.[24]

This article is adapted from '*The Condom Controversy*', a leaflet published by Family Education Trust. Copies can be obtained from FET, Mezzanine Floor, Elizabeth House, 39 York Road, London. SE1 7NQ or downloaded from *www.famyouth.org.uk*

Safe sex or saved sex?

Condoms do provide good protection against HIV, but this has a very low prevalence in the UK and USA in comparison to other STIs. They also provide good protection against gonorrhea but the degree of protection against other, more common diseases is less clear.[25]

Condoms also reduce sexual sensitivity and interfere with spontaneous sex. Overall, consistent condom use rates are very low.

What then is an effective alternative to the inadequacies of 'safer sex'? Saved sex is being widely suggested by many sexual-healthcare workers.[26,27,28,29,30,31] This concept is that sex is saved for a time when the relationship between the partners is at such a level of intimacy and commitment that they are able to make a reasoned decision that, once having made love, they will go on making it together exclusively with each other for the rest of their lives.

This of course is the biblical model of monogamy.[32] Whilst we cannot expect our non-Christian patients to live this way just because 'the Bible tells me so', there is every reason why we can promote 'saved sex' as a reliable and practical sexual health strategy. God taught this because it works and even if our patients are not prepared to live fully by its principles, we can and should encourage them to live as close to it as possible.[33]

As the failure of the 'safer-sex' message becomes increasingly apparent, it is time for sex education policy-makers in the UK to take the saved-sex message as a serious alternative.

Trevor Stammers is a London-based GP tutor who writes and broadcasts on issues of family and sexuality

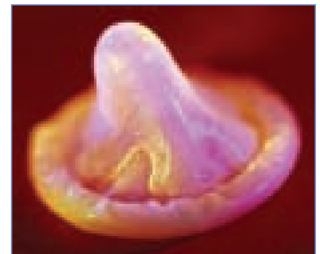

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Photo: PA

What principles should underlie healthcare financing and what are the options available? **Howard Lyons** offers insights on a debate that goes far wider than simply what's right for Britain.

Funding Healthcare

Former Group Chief Executive of Natwest Derek Wanless with a copy of his report on the future financing of Britain's National Health Service (NHS).

Christians have been in the vanguard of providing healthcare to those in need - regardless of their ability to pay - for nearly 2000 years. We have much still to offer

Ever since January 2000, when the Prime Minister Tony Blair was bounced into a commitment in a TV interview to raise spending on healthcare in Britain to the European average, healthcare funding has been a major issue for debate in this country.

The Chancellor Gordon Brown almost stifled the debate at the outset when he assured Parliament that the fundamental basis of funding the National Health Service from central taxation would not change, but the recent publication of the Wanless Report and the Chancellor's commitment to increase NHS spending by 7.2% per year over the next five years have brought the subject right to the forefront of people's minds.

The question being asked is: will this massive increase in spending, funded by increases in taxation, actually deliver health services in Britain which are at least equal to our European neighbours, notably France, Germany and Holland?

Almost ever since the introduction of the National Health Service in 1948, expenditure on healthcare as a percentage of Gross Domestic Product has fallen behind our European rivals (see chart 1) but the NHS was hailed as such a momentous social experiment removing, at a stroke, the financial burden which the threat and onset of illness imposed that few dared to criticise the concept.

The main options

In most Western (OECD) countries there are four main options for funding healthcare systems: **central taxation**, **social insurance**, **local taxation** and **private medical insurance**.

The NHS is the most obvious example of funding by **central taxation**. The Beveridge model of providing a comprehensive range of healthcare services free at the point of use with universal access and no co-payments or user fees was adopted, in different shapes and forms, by many Commonwealth countries from the 1950s onwards. Few countries, however, have adhered to the basic principles as rigidly and obsessively as the United Kingdom.

The most common alternative is social insurance. One of the first **social insurance** schemes, or Earmarked Payroll Tax as it is sometimes known, was introduced in Germany by Chancellor Bismarck in the 1880s requiring employers and workers to contribute a fixed percentage of their salary into a ***hypothecated fund*** which would then be used exclusively to provide healthcare services for employees and their families. It was also used to pay workers' compensation and pensions according to size of contributions made. Most continental European countries adopted social insurance. So have Latin American countries who came under the influence of European colonial powers.

Local taxation is a system much like our rates or council tax and gives much greater local accountability and responsiveness. Scandinavian countries like Denmark still retain a significant amount of local funding and accountability.

Private medical insurance involves individuals buying insurance cover from commercial or not-for-profit companies with the level of premiums

dependent on the health risk of the individual and the range of cover required. The United States is the best-known example of a system which relies heavily on individual private medical insurance cover with the inevitable adverse consequences for the indigent and those at greatest risk.

The Wanless Report has come down decisively in favour of a continuation of central taxation as the main method of funding. However Gordon Brown's latest budget transferred more of the taxation burden to employers and employees by increasing the National Insurance contribution.

Key principles

The inescapable truth is that, whichever system of healthcare funding is used, it will involve a trade-off of basic principles held dear. In some ways, health is a commodity just like any other and can be purchased as such (eg. a hip replacement or an obstetric delivery). But in other ways, healthcare is unique. If I go to the supermarket for a bag of sugar, I'm unlikely to be told by the check-out assistant that I need five bags. This illustrates the concept of ***information asymmetry*** prevalent in healthcare, whereby the doctor/supplier usually knows better than the patient/consumer what the consumer needs. Pricing and funding of healthcare therefore can't be left to basic market principles as they might to sugar, tinned beans, cars or houses.

Healthcare is unique in the way it is likely to be needed most by those least able to pay. That is why the concept of ***risk-pooling*** must be a fundamental element of any government-sponsored system. The woman who touched Jesus' cloak (Luke 8:43) had spent all she had on doctors. It's salutary to remember that for many people this was the situation which applied in Britain before 1948. It left millions in dread of contracting an untreatable illness and this remains true today in many developing countries.

Equity should encompass vertical equity whereby unequals are treated unequally and where contributions are related directly to the ability to pay. It should also encompass horizontal equity whereby equals are treated equally and those with equal means make an equal contribution. Someone who succumbs to a chronic illness should never have to pay more than someone who never has a day's illness in their life. And someone who uses health services twenty times a year should not have to pay any more than someone who only visits their GP once a year. But then the concept of ***moral hazard*** applies whereby free services are more likely to be abused than those for which people have to pay something. For this reason, systems have been supplemented by user fees but this unfortunately can discriminate against the poorest.

In addition to equity and comprehensiveness, any system for funding healthcare should be measured against six further criteria:

Comprehensiveness is a much-lauded feature of the NHS whereby all citizens have access to a full range of healthcare services. Many Commonwealth countries which tried to adopt the NHS model quickly found they could not afford to provide this and now offer a basic package of services including emergency care, obstetrics and primary healthcare. The NHS is gradually restricting the range of services and forcing patients (many of them elderly) to resort to private healthcare and use of their savings.

Chart 1

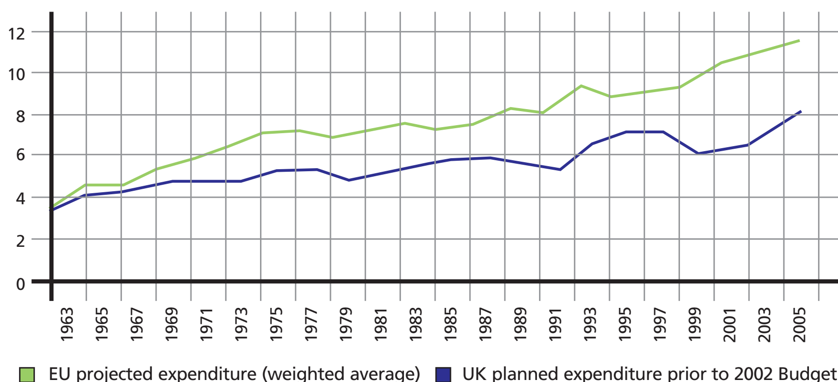


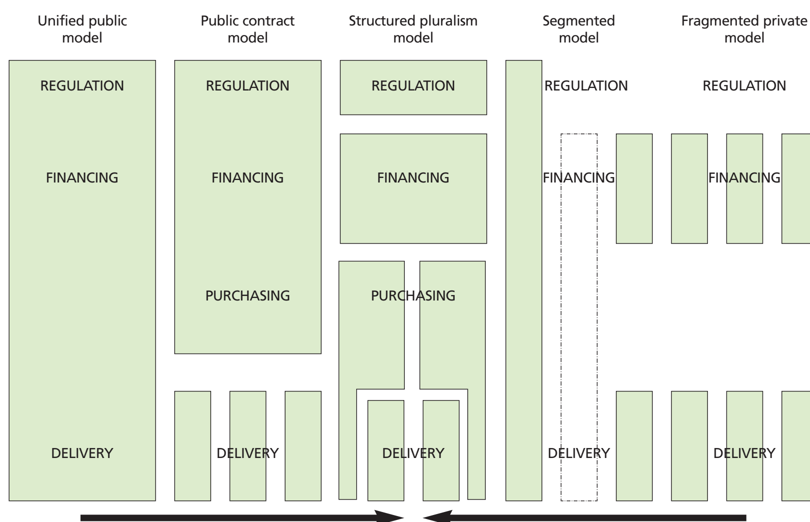
Chart 2

Main charcteristics of funding systems

	EQUITY	COMPREHENSIVE-NESS	EFFICIENCY		TRANS-PARENCY	CHOICE		AMACRO-EFFICIENCY	POLITICAL ACCEPTABILITY	STABILITY	
			Alloc.	Syst. Cost		Individ.	Comm			Econo-mical	Political
Central Taxation	Green	Green	Red	Green	Red	Red	Black	Green	Black	Black	Red
Local Taxation	Black	Green	Green	Black	Black	Red	Green	Black	Black	Black	Black
Private Insurance	Red	Red	Red	Red	Green	Green	Black	Red	Red	Red	Black
Social Insurance	Black	Green	Black	Black	Green	Red	Black	Green	Black	Red	Green

Green - Scores High Red - Scores Low Black - Scores Neutral

Chart 3



whichever system of healthcare funding is used, it will involve a trade-off of basic principles held dear

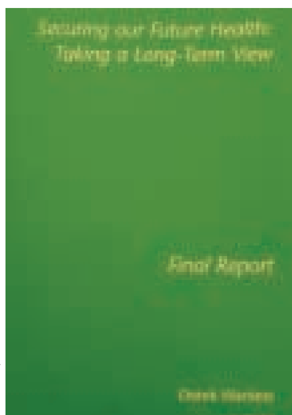


Photo: PA

KEY POINTS

In Western countries there are four main options for funding healthcare: central taxation, social insurance, local taxation and private medical insurance. The recently published Wanless Report reinforces the government's commitment to the first of these only, but the issue is still being fiercely debated. The ideal healthcare delivery system needs to be equitable, comprehensive, efficient, transparent, politically acceptable, stable and offering consumer choice. As Christian doctors we need to take an active part in the debate and seek a solution which protects the interests of the vulnerable whilst at the same time ensuring that individuals take personal responsibility for their health.

Efficiency. Despite constant criticisms of the cost of NHS management, the NHS has the lowest administrative cost of most comparable systems and is much more efficient than private medical insurance.

Transparency. The NHS scores poorly here because of the nature of risk-pooling and the way taxes are raised and disbursed. In contrast, with private medical insurance, it is transparently clear when I take out a policy what my annual premium is and what services I am entitled to.

Choice is a principle cherished by American society and reflects the extent to which consumers (or communities) can exercise choice over the amount paid for healthcare and the providers from which treatment can be obtained. Again, private medical insurance scores well here.

Macro-efficiency is a criterion for assessing the extent to which the funding system allows control to be exercised over total expenditure. Housing, sanitation and education are all determinants of health status so spending too much on healthcare delivery may not bring the same benefits which increasing expenditure on housing and education might bring.

Political Acceptability. Hilary Clinton met opposition when she tried to implement changes to the highly-fragmented and inequitable US system in the 1990s. Here in the UK, employers would be unlikely to welcome a move to social insurance if they ended up bearing most of the burden.

Stability of Funding takes account of the business cycle which often runs counter to the need for healthcare. The unemployed are generally less able to contribute to healthcare funds but more likely to need services. Also a funding system which is safe from the idiosyncrasies of short-term political priorities is likely to be more stable. For over forty years, healthcare was a low priority in government spending in the UK behind education, social security and defence but now it is a top political priority and so is attracting more funding. But for how long?

No single system can hope to satisfy all these criteria and naturally the question of affordability overrides almost all other considerations; but setting the criteria alongside the different funding options (Chart 2) illustrates which systems fare better than others on each of the main characteristics.

A Christian model

From a Christian perspective, our motivation will always be to care for those less fortunate than ourselves and to balance our obligations with an expectation that individuals will take personal responsibility for their health and well-being. The biblical principles of progressive taxation and vertical equity are well-accepted in Britain but much less so in the United States and many developing countries where individuals who require healthcare are left to fend for themselves. The story of the Good Samaritan has inspired many benefactors to 'go and do likewise' and provide for those in need and, on an individual basis, that must be our inspiration as well. But looking at this from a systemic or community perspective, wouldn't the local taxation model be more appropriate for many societies using the Israel of the Old Testament as an example? And the New Testament model from Acts 2:44-45 appears to endorse the idea of community risk-pooling amongst Christians but how does it apply in a 21st century post-modern secular democracy?

I believe we need to move away from the unified system we have clung to in the UK for the past fifty years whereby the four system components of regulation, financing, purchasing and delivery have all come under the monolithic NHS. There is no reason why each of the four components can't be undertaken by separate organisations as is increasingly the trend in Europe, as long as the basic principles of equity and comprehensiveness are met (Chart 3).

Without the vital ingredient of transparency, our system lacks a healthy balance of incentives and disincentives which would encourage patients to look after themselves and not to abuse the availability of 'free' healthcare, whilst healthcare professionals need more checks and balances to ensure they are fairly rewarded for their expertise and effort without being tempted to exploit the system for their own ends.

There are signs of change with Alan Milburn's paper, published days after the Wanless Report, entitled *Implementing the NHS Plan*. It suggested that New Labour's tax and spend U-turn is not simply going to involve pouring bucket loads of money into the NHS without requiring some fundamental reforms. It seems that the Government has belatedly realised that the imperfect vectors of the internal market introduced by the Tories in 1990 and abandoned by New Labour in 1997 nevertheless had some merits, although they would never admit it.

Meanwhile the Tories are currently scouring Europe for new ideas on healthcare for the next general election. There is no doubt that if Labour fails to deliver better health services with vastly increased funding from increased taxes, a variation on social insurance will be the preferred option.

As Christian healthcare professionals we need to take part in the debate in an informed and constructive way, discarding our prejudices about the merits and demerits of the NHS compared with, say, private medical insurance. We have much still to offer in shaping a compassionate and caring health service for Britain in the 21st century.

Howard Lyons MSc BSc(Econ) FIHM MIPD is Managing Director of London International Healthcare and Chairman of MMA HealthServe. He is involved in advising governments on healthcare financing and delivery especially in developing countries.

Family Affairs

Jason Roach argues that the end doesn't justify the means in family planning

'When the most powerful president in the world will not release money already allocated to prevent unwanted pregnancy, to stop the spread of HIV/AIDS, for the poorest citizens in the world, where is the morality in that?' [1]

Amy Coen - President of Population Action International

At the time of writing, the Bush administration are withholding $34 million appropriated by congress for the UN population fund (UNFPA), because of accusations that it condones forced abortions in China. [1] Similar moves are underway in the UK Parliament as well. [2, 3] On this issue, both the US administration and UK government seem to believe as Christians do, that not all means can justify the end. Amy Coen is president of Population Action International, a private organization in Washington that focuses on voluntary population planning. Her language, and that of many others in recent weeks, would seemingly like the world to think differently. However, American apologist Gregory Koukl puts it like this, 'There is a relationship between means and ends, and there are ethical considerations not just for the goals that we have in mind, but for the way that we get to those goals. We have to weigh both of those things in light of biblical commands and the biblical ethics of absolute truth.' [4]

The accusation

The decision to withhold US funding was made after congress representative Christopher Smith, Vice Chairman of the International Relations Committee, wrote to President Bush in October last year. He alleged that the fund condoned Chinese birth control policies that include forced abortions and involuntary sterilisation. The evidence for these actions came from the Policy Research Institute, an international organisation set up by the pro-life group Human Life International. Josephine Guy, director of governmental affairs for the institute was a key witness. She spent four days in a region of China where the UNFPA was known to operate. She interviewed many women about the methods of family planning enforced in the region, one in which the fund claims that women are free to determine the timing and spacing of pregnancy. All the interviews were videotaped.

The interviews paint a picture of 'ongoing, rampant and unrelenting' abuse. [5] One 19 year old girl was forced to have an abortion, as she was too young according to the strict family planning policy. Women reported having to hide their pregnancies and their children, to escape retribution from officials for not having an abortion. Some described punishments inflicted on those who wished to freely determine for themselves the timing and spacing of pregnancy. [5] Others described non-voluntary intra-uterine device insertion, and mandatory checks to ensure they remained in place. All interviews were conducted within a few miles of a UNFPA office, in areas under its governance.

The explanation

The UN, however, contends that its work in China is limited to areas where the one-child family policy is no longer enforced. It also says that it does not use US money for Chinese programmes. [1] Other sources report that the population fund was instrumental in helping China design pilot projects to test relaxed target approaches to family planning that stress quality of care. [6]

After frantic negotiations earlier this year, the Bush administration told the UNFPA that it would set up a delegation to go to China to uncover the real situation. The body was assembled on 1 May, amidst concern from some that the Chinese may have had too much notice to cover up evidence that the UN is working in countries practising forced abortions. [7]

Our reaction

Whatever the truth is about the situation in China, the furore surrounding it raises important issues for Christians.

Firstly, the Bible is clear about the sanctity of life. It lays out a fundamental worldview as to what it means to be human [8] and created in the image of God. [9] God is described as having total authority over his creation and our demise [10] and having a relationship with us even before conception. [11, 12]

Secondly, we cannot distinguish between personal and social ethics as if they were separate fields of enquiry. [13] It is sometimes suggested that in the name of love, we might decide that abortion is indicated where the baby is unwanted by the family, society, or an overcrowded world. But we cannot adapt our ethical principles for the greater good. [14] Love does not override divine principle, or justify utilitarian social policy.

Thirdly, the US/UN argument is a reminder of the ongoing struggle of Christians able to influence debate, in a society seemingly enslaved to relativism. The wisdom revealed to us is for the whole world. Just as whole kingdoms benefited from Solomon's wisdom, so the whole world can benefit from the knowledge of God and his purposes for mankind. Most importantly, this comes through the spiritual dimension of eternal life. But we also know living life God's way is the best way for humanity. So, it is good to strive for a society in which following God's path is at least possible, within the frameworks of imperfect societies.

Finally, we must remember that objections without solutions often meet opposition, scorn, and resentment. If possible, loving, practical alternatives are needed too. Our trust in the truth of Scripture should spur us on to find practical ways of following God's law in a fallen world, both personally and politically.

Jason O'Neale Roach is a Medical Student in London and Former Editor of the Student BMJ.

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Photo: PA

Charles Foster reviews the European Court judgement on Diane Pretty

Hemlock in Strasbourg

The European Convention on Human Rights (ECHR) is less malleable and less of a euthanasist's charter than many commentators feared. That is the effect of the judgment of the European Court of Human Rights in *Pretty v United Kingdom (www.echr.coe.int/Eng/judgments.htm)*

The facts

Diane Pretty suffered from Motor Neurone Disease (*Triple Helix 2002; Winter:7*). She wanted to die but was physically unable to kill herself, so asked the Dierctor of Public Prosecutions (DPP) for an undertaking that if her husband helped her to commit suicide he would not be prosecuted under s. 2(1) of the Suicide Act 1961, which makes assisting suicide a criminal offence. Unsurprisingly, the DPP refused. She challenged that refusal in the Divisional Court and the House of Lords, saying that the de facto prohibition on her suicide, which English law imposed, infringed various rights under the ECHR. The English courts dismissed her application. She went to Strasbourg. Her contentions, and the court's response to them, are considered under the headings of the individual Articles.

Article 2

Article 2(1) provides: '*Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of the court....*' Mrs Pretty said that Article 2 protected not only the right to life but also the right to choose whether or not to go on living. Nonsense, said the court. A right to life is not a right to be killed.

Article 3

This provides: '*No one shall be subjected to torture or to inhuman or degrading treatment or punishment....*' Mrs Pretty's difficulty here was in establishing that the UK Government had subjected her to ill-treatment. She suffered terribly, of course, but her disease caused her suffering, not the government. Certainly the DPP's failure to give the undertaking did not amount to treatment or subjection to treatment. The Convention's Articles had to be considered together in line with their overall purpose. Article 3 had to be read together with Article 2. Article 2 was first and foremost a prohibition on the use of lethal force or other conduct which might lead to the death of a human being. It did not give any individual a right to require a state to permit or facilitate his or her death.

Article 8

Insofar as relevant this says:

'*1. Everyone has the right to respect for his private and family life....*

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.'

Mrs Pretty said that this gave her a right to self-determination. She had a right to decide how to live, and a right to decide when and how to die.

The Court thought there was something in this. But that was not the end of the matter. It went on to say that Article 8(2) justified an interference with the Article 8(1) right. It was legitimate for the criminal law to protect a class of potentially vulnerable people by a law like s. 2(1) of the Suicide Act, even though that might sometimes affect the Article 8(1) rights of some members of that class.

Article 9

This provides:

'*1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.*

2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.'

Mrs Pretty argued that she had a belief in assisted suicide which the law prevented her from manifesting. The Court gave this short shrift. A belief in assisted suicide was different from religious or comparable beliefs of the type that the Article existed to protect. Diane Pretty was free to think what she wanted about assisted suicide, but a right to think what one wants does not mean that one has a right to do anything one wants in pursuit of that belief.

Article 14

This provides: '*The enjoyment of the rights and freedoms set forth in [the] Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.*'

Mrs Pretty said that she was discriminated against because of her disability. If she were not disabled she would be able to kill herself, but because she was disabled she could not. The prohibition against assisted suicide therefore discriminated against her. This was wrong, said the Court. It was reasonable for legislation not to distinguish between those who could kill themselves and those who, by reason of a disability, could not.

Conclusion

Mrs Pretty's case was an audacious attempt to use the ECHR to do precisely the opposite of what it primarily exists to do. She sought to say that her right not to be killed gave her a right to be killed. She sought to use legislation which was designed to protect vulnerable people in a way which would have increased vulnerability.

The Court was having none of it. In a judgment which reviewed a vast number of authorities on all the cornerstone articles, it has laid down a number of important markers which will prevent subsequent abuse of the Convention. In rejecting Mrs Pretty's submissions the Court went back to basics. Except in relation to Article 8, its construction of the Articles was conservative in the way it must be if the Convention is not to be a joke. Article 8 is elastic, and it is right that 8(1) should be allowed to stretch to fit all corners of human life. But the Court's conclusions on Article 8(2) indicate that it will not allow a few tragic but unusual individuals to re-write the laws by which contracting states protect against dangers facing whole classes of vulnerable people.

Charles Foster is a Barrister in London and a member of the CMF Study Group

EUTYCHUS

Lessons in spiritual history taking

What is a spiritual history? The Joint Commission on Accreditation of Healthcare Organisations (The US answer to CHI, NICE and GMC all rolled into one) sets down guidelines: 'Spiritual assessment should, at a minimum, determine the patient's denomination, beliefs, and what spiritual practices are important to the patient. This information would assist in determining the impact of spirituality, if any, on the care/services being provided and will identify if any further assessment is needed. The standards require organisations to define the content and scope of spiritual and other assessments and the qualifications of the individual(s) performing the assessment.'

The guidelines go on to say that 'examples of elements that could be but are not required in a spiritual assessment include the following questions directed to the patient or his/her family' : 'Who or what provides the patient with strength and hope? Does the patient use prayer in their life? How does the patient express their spirituality? How would the patient describe their philosophy of life? What type of spiritual/religious support does the patient desire? What is the name of the patient's clergy, ministers, chaplains, pastor, rabbi? What does suffering mean to the patient? What does dying mean to the patient? Has belief in God been important in the patient's life? etc'

There is much here that CHI, NICE and the GMC could learn from! *(www.jcaho.org/standard/pharmfaq_mpfrm.html)*

Help for Refugee Doctors

Thirty refugee doctors per year will be helped to train to work in the UK under a new programme being launched by the University of London's Queen Mary College. The Mercers' company of the City of London have funded the programme with a £300,000 grant (*British Medical Journal* 2002; 324:868, 13 April)

Heated debate on euthanasia

The November *BMJ* editorial by Doyal and Doyal arguing for the legalisation of euthanasia and physician assisted suicide (see *Triple Helix* 2002; Winter:16) attracted 110 electronic replies to the *BMJ* website within a week of the piece being available on bmj.com and 70 within a week of the publication of the printed journal. Of those expressing a firm viewpoint, 30 responses supported euthanasia and physician assisted suicide and 54 were against. Only 6 letters were published in the *BMJ* itself, including one by Malcolm Savage, CMF's North England staffworker (*British Medical Journal* 2002; 324:845-8, 6 April)

Birth defects from assisted reproduction

Babies born as a result of assisted reproduction techniques have nearly one in ten risk of major birth defects – twice the risk among babies born naturally. Researchers at the Institute of Child Health Research at the University of Western Australia in Perth found that at one year of age 8.6% of babies in the ICSI group (intracytoplasmic sperm injection) and 9% in the IVF (in vitro fertilisation) group had at last one major birth defect diagnosed. Birth defects covered the full range of defects found in newborns, and may be due to the underlying cause of infertility itself, drugs used to promote ovulation or some aspect of the techniques themselves (*New England Journal of Medicine* 2002; 346:725-30). Another study in the same journal found that assisted reproduction increased the number of low birth weight babies six fold (2002; 346:731-7)

Wrong Diagnosis

An Australian woman suicide victim, who was allegedly suffering from incurable bowel cancer, was apparently free of the disease at post-mortem, and had been told so before her death. Nancy Crick, who was 69, took her own life with an overdose of barbiturates, on an evening in May, whilst friends, relatives and euthanasia campaigners drank champagne in the next room. The country's most prominent right-to-die advocate Philip Nitschke said that since she was in agony and wanted to die, it was irrelevant whether she had cancer or not. Marget Tighe, president of the Australian Right to Life group, said Nancy Crick 'was a sick vulnerable person who was used'. (*The Times* (2) 2002; 18 June)

Scientific spin

The Prime Minister's enthusiasm for developing new treatments for degenerative diseases like Alzheimer's, Diabetes and Parkinson's (*The Daily Telegraph* 2002, 24 May) is most welcome, but his implication that opponents of embryo cloning are being unscientific and uncaring in their objections to the practice was grossly unfair. Using cloned embryos in stem cell research remains highly controversial and the considerable international opposition to the practice is based on strong ethical and scientific arguments, that it is: untested and technically problematic, unethical in using embryos as a means to an end, unnecessary because ethical alternatives exist and dangerous because cloned babies could well follow.

Mind the Gap

The gap in research funding between developed and developing world (see *Triple Helix* 2002; Spring:14-15) remains wide. Of the 1,200 drugs that reached the global market between 1975 and 1997, only 13 were for tropical infectious diseases that primarily affect the world's poorest people according to the 10/90 Report on Health Research (*wwwglobalforumhealth.org; British Medical Journal* 2002; 324:1114, 11 May)

Further folic foot dragging

A BMJ editorial has criticised the British government of public health malpractice for failing to make folic acid fortification of flour mandatory. It was ironically a UK study which demonstrated that supplementation with synthetic folic acid prevents about 75% of cases of spina bifida and anencephaly. Canada and the US have already enacted the appropriate legislation (*British Medical Journal* 2002; 324:1348,9, 8 June)

Fatal genetic flaws from cloning

Scientists at the University of Connecticut may have discovered why so many cloned animals are stillborn or die prematurely. The study, published in the journal *Nature Genetics*, found that nine out of ten genes examined on the X chromosomes in dead cloned calves were abnormal in the way they were activated or expressed (*The Independent* 2002; 27 May). Other researchers in the University of Pennsylvania have reported that only a small number of cloned mouse embryos properly expressed the gene which is absolutely critical for development past the 4 day stage (*British Medical Journal* 2002; 324:1236-7, 25 May) The same flaws could also jeopardise the use of stem cells derived from human embryos for 'therapeutic' purposes.

OPPORTUNITIES ABROAD

Specific Vacancies by Continent and Country

Posts often require you to be **UK-based** with your own **financial** and **prayer support**. The contact details given are to enable you to start researching possibilities. For many other posts see previous issues of *Triple Helix* and recent issues of *HealthServe*. (Contact them at Barker House, First Floor, 106-110 Watney Street, London, E1W 2BR. Tel: 020 7790 1336 Email: info@mmahealthserve.org.uk Website www.healthserve.org)

AFRICA

Cameroon (North)

Meskine Hospital still needs a **physician/GP** willing to include simple on call surgical cover, and a **surgeon** willing to include medical cover, an **ophthalmologist** and **other health care professionals**. Need flexible attitude, basic French (training available) and a short tropical medicine course. Community relations excellent. Family environment with school on site. **Contact:** Personnel Department, Action Partners Ministries, Bawtry Hall, Bawtry, Doncaster DN10 6JH Tel: 01302 710 750 Email: personnel@actionpartners.org.uk

Malawi

Livingstonia Hospital continues to need a replacement **Medical Officer** for Dr Donald Brownlie who is due to retire. Livingstonia is a 100 bed general hospital with a strong community health programme and is under the control of the Livingstonia Synod, CCAP. **Contact:** Donald Brownlie, P O Box 5 Livingstonia, Malawi Tel: 00 265 368 207, or Rev Terry McMullan, Overseas Board, Presbyterian Church in Ireland, Fisherwick Place, Belfast BT1 6DW Tel: 028 9032 2284 or Sheila Ballantyne, Church of Scotland Board of World Mission Tel: 0131 225 5722.

Niger

The SIM Hospital at **Galmi** is in immediate need of **doctors** - in particular a **surgeon**. The hospital has 100 beds. All of the nursing/midwifery staff and one of the doctors are nationals. The Niger Republic is largely Islamic and French speaking but enjoys freedom of religion. **Contact:** Michael Hutchinson at enquiries@sim.co.uk

Nigeria

Action Partners needs general duties **medical officers** to work in rural health centres, a church-based hospital and in leprosy and rehabilitation work. The work would involve the training of local staff and supervision of outlying clinics. Some language study would be necessary before appointment. **Contact:** Personnel Department, Action Partners, (as above).

Uganda

Medical Superintendent needed for **Kiwoko Hospital** in Luwero ideally to be in place by April 2003. Needs to be a registered practitioner with at least 5 years experience. Ideally a community orientated GP. The job involves supervision of all the hospital activities including community care, supervising junior doctors and chairing the management team. The hospital comes under the Church of Uganda and while the candidate would not need to be an Anglican, he/she would need to be in sympathy with it. **Contact:** Nick Wooding, Kiwoko Hospital, PO Box 149, Luwero, Uganda. Tel: 077 588 606 Fax: 041 610132

ASIA

India

The Leprosy Mission are looking for

- **Consultant Physician (Tropical Medicine)**

To examine and assess their current medical work in India and South Asia. It will also be necessary to accompany the mobile medical team to the field, conduct training sessions for staff and help upgrade the laboratory work.

- **Anaesthetist**

To train staff 'in the art of anaesthesia', and be willing to provide simplified training in CPR and advanced life support systems.

Contact: Vanessa Lillingston-Price, The Leprosy Mission International, 80 Windmill Road, Brentford, Middlesex TW8 0QH Tel: 020 8569 7292 Email: vanessa@tlmint.org

The **Emmanuel Hospital Association (India)** are looking for

- **Orthopaedic Surgeon** (6-12 months) - able/willing to undertake a wide range of orthopaedic procedures with limited facilities! To be involved in the training of EHA surgeons in such procedures and to assist in the setting up of orthopaedic departments in EHA hospitals

Papua New Guinea

Medical Superintendent needed at the 90 bedded **Tinsley Hospital** in the Western Highland Province. This is a rural community of 26,000 people. Experience in general surgery and obstetrics essential Approx 40,000 outpatients and 4,000 admissions are dealt with annually but much of the routine work is carried out by the nursing and community health workers. Housing, return air fares (every 2 years), car and salary in line with that of a national doctor provided. The appointee is expected to be involved in the work of the local church and in encouraging the hospital staff in their Christian life and work. **Contact:** David Symmmons PO Box 16, Mount Hagen, WHP PNG Email: abmshgn@datec.com.pg

EVENTS

Overseas Update, Residential Refresher Course 2003 is provisionally booked from July 7-18th 2003

Programmes for Missionary Kids

Re-konnect - A summer re-entry holiday programme for **MKs aged 6-12 years** involving lots of fun and games and other activities. Held in Slack Top Centre, Heptonstall, West Yorkshire. 29 July to 2 August. Cost - £50 per child. **Contact:** Janet Brown at Global Connections. 186 Kennington Park Road, London SE11 4BT Email: info@globalconnections.co.uk

MK Re-konnect – Another programme designed for **16-24 yr old MKs** who have recently returned to complete their education in the UK. To be held at Oak Hill from 17-24 August 2002. Cost - £100 per person. 'An action packed programme – designed to equip and prepare for the next strategic phase of their lives'. **Contact:** Marion Knell also at Global Connections (Email as above).

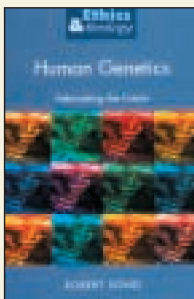
ITEMS NEEDED

Dr Anne Merriman of Hospice Uganda is looking for recent past editions of the BNF for 20 students undertaking a Distance Learning Diploma in Palliative Care. This is an ongoing need and she could probably use more for other trainees. If you can send her your past editions she would be most grateful (and so would her students!) Send then to: Dr Anne Merriman, Hospice Uganda, PO Box 7757, Kampala

We also have a member working in **Zimbabwe** who is looking for a number of items of medical equipment. These include: glucometers and standard BM strips, non mercury sphygmomanometers, automatic BP monitors, infusion drip counters, pulse oximeter, sonicaid fetal heart detectors, CTG monitor, suction pumps and a simple ECG monitor and infant resuscitation trolley. If anyone knows of any of these items going spare, please contact Peter Armon at the CMF Office.

BOOKS

Human Genetics – fabricating the future



Robert Song
Darton, Longman & Todd 2002
£8.95 Pb 143 pp
ISBN 0 232 52393 2

This book by a lecturer in Christian ethics at the University of Durham is a scholarly work, providing an accurate and realistic evaluation of the current and future promise of molecular technologies in health care. There are some excellent sections, particularly the review of the twentieth century eugenics movement and the current research in behavioural genetics. There are clear accounts of the issues involved in gene patenting, genetics and insurance, and throughout, the author reflects a positive attitude to disability.

Why has so much attention been paid to the potential dangers of the new genetics? Song argues that such fears are not based on ignorance, prejudice, the 'yuk factor' or a fear of the future but rather on concern about 'interfering with nature'. Whilst pharmacogenomics and somatic gene therapy do not raise distinct moral issues, Song highlights pre-implantation diagnosis, germ-line therapy, reproductive cloning and stem cell research for detailed discussion. He rehearses the arguments in all of these areas and concludes with the most important moral consideration in these debates, namely the status of the embryo.

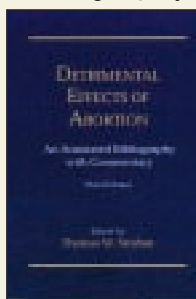
Song argues that the desire to have a healthy child genetically related to oneself, coupled with the desire to give one's child the best possible start in life will inexorably lead to the acceptance of genetic enhancement, as the technology becomes possible - so is it wrong? Is there a Christian alternative perspective? He reminds us that the Christian hope is not based on efforts to improve our individual genomes but on the transformation of our bodies into a resurrection body. He calls for the church to witness to an abundant life freed from the compulsions that make genetic enhancement seem inevitable.

Could genetic knowledge widen the gaps in society? The Christian community is called to carry one another's burdens. Song places this view alongside the potential for discrimination on the basis of a person's genetic make-up. This subject is timely, given the recent report from the WHO commenting that poor countries could lose out on the benefits of genome research.

Although there are occasional grammatical errors, these are only minor irritations in an otherwise well structured and thought provoking book that I fully recommend.

Alan Fryer is a Consultant Clinical Geneticist in Merseyside

Detrimental Effects of Abortion: An Annotated Bibliography with Commentary



Ed. Thomas Strahan
Acorn Books
2001
£24.95 pb 261pp
ISBN 0 9648957 0 6

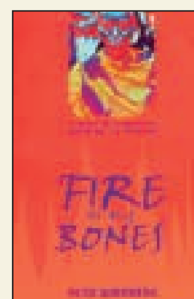
When abortion was decriminalised in the UK in 1967 its supporters argued that it should be more widely available because it was safer than a full term pregnancy. For decades this idea persisted. Slowly but steadily evidence has been accumulating that there are considerable health costs built into an abortion decision and many of these are not at all well known. Thomas Strahan, a Minnesota lawyer, has published a bibliography of evidence on the detrimental effects of abortion with a brief commentary on each entry. With approximately 1,300 references the scope of this work is vast. Most of the references are from mainstream journals including the social sciences and psychology but he has also included material from the grey literature such as PhD theses and medical bulletins.

There is no index but in order to facilitate searching Strahan has divided up his book into 140 section headings. Inevitably there is sometimes overlap. There is a large section on how abortion affects adolescents and there is coverage of subjects as diverse as placenta praevia, domestic violence, rape, incest, substance abuse, suicidal ideation, breast cancer, and the impact of abortion on marriage and family.

This project is ongoing and the author invites correspondence at *Strahan @pclink.com*. Information about studies that are not included in the publication is always welcome. The publishers intend to produce updates periodically and news about these will be published on their web site *afterabortion.org*. The book is also available in searchable electronic form. As a reference book it should have a place in most medical libraries but would be of help to anyone wanting to learn more about the latent pathology of induced abortion.

Gregory Gardner is a General Practitioner in Birmingham

Fire in my bones



Dick Anderson
Christian Focus 2001
£6.99 Pb 230 pp
ISBN 1 85792 676 5

'A tiny needle in the almighty hand of God' – this phrase captures the wonder of this challenging story. I really enjoyed the overview of decades of service, illustrating the fruit that comes from prayerful passion for mission. However, it is long after the seed is sown that any fruit appears and Dick Anderson is very honest in sharing the buffetings and personal struggles as well as the blessings he and his wife, Joan, experienced along the way.

Going to work among the Turkana in a remote part of Kenya, the barriers of culture, language, discomfort and misunderstanding seem huge. Add the spiritual battle and the need to subject his family to a multitude of risks (there is a heart-rending account of his daughter nearly dying) and the chance of establishing a new church appears hopeless. Yet, the thrill of the book is to revisit the same area decades later and to see the fruit of vibrant fellowships and growing maturity.

In addition to his account of pioneering work for Africa Inland Mission in Kenya, Mozambique, Comoro Islands, Sudan, Seychelles and Chad, there are honest and helpful chapters on leadership (a really tough period of being criticised), team working and the impact on his family. Heart-warming pen portraits of Africans, both patients and fellow-workers, move the story from mere history to mission with all its tides of encouragements and disappointments.

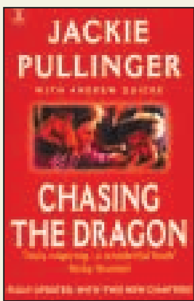
From the colonial era to the present, the context changes but the challenges remain. Poverty and treatable diseases confront our complacency, whilst the call to share the good

BOOKS

news of Christ is still compelling. Be challenged: 'when the offering reached 105 shillings [about £1.20] their joy knew no bounds'. Be inspired: 'precious saints, often unshod and clad only in rags, lifting hands to God in joyful worship'. May this book fan into flame the fire in our bones too!

Ian Spillman, Consultant Paediatrician, Cheshire; previously Medical Superintendent Kisiizi Hospital, Uganda with Tear Fund.

Chasing the Dragon



Jackie Pullinger with Andrew Quicke
Hodder and Stoughton 2001
£5.99 Pb 254 pp
ISBN 0 340 78569 1

This is a remarkable and exciting book, filled with episodes of adventure, intrigue, crime, unspeakable cruelty and violence. For the medical reader there is much description of disease, addiction and appalling poverty. There are vivid descriptions of court cases and prison life.

Chasing the Dragon is also a chronicle of the amazing work of the Holy Spirit in healing bodies, teaching minds, saving souls and changing the lives of individuals, communities and deprived and depraved societies.

This book is the thirty year story of a young English woman, Jackie Pullinger, who was led by God to Hong Kong and its infamous Walled City and who, despite many difficulties, discouragements and set-backs, was and is the conduit for an amazing work of the Holy Spirit in spreading faith in Jesus to drug addicts, prostitutes, pimps, pushers and Triad gang leaders. The reader is enthralled by the wonderful stories of Goko, Winson, Geui Jai, Johnny and many others who have been brought to Christ, sometimes instantly with an outpouring of the Holy Spirit and sometimes after much delay.

The book includes many cases where heroin addiction was instantly 'cured' without withdrawal symptoms, but with the addict immediately praying confidently in tongues and often receiving knowledge of Jesus despite barriers of language and literacy. Such accounts are a challenge to those of us working with addicts on a daily basis and who long to see such 'miraculous' cures, yet only occasionally do so. There is, however, running through this challenging book, a down to earth sense that a mission such as Jackie Pullinger's is not one of quick fixes by a God who is putting on a show for visiting (short term) missionaries. It is, rather, an account of long haul work for the Kingdom where, despite many disappointments and apparent failures, faith and an almost naïve trust and complete reliance on the Holy Spirit's power push back the influence of evil and deprivation.

Having read the first edition about 18 years ago and been enthralled, I can say only that the second edition with two new chapters to bring us up to date is even better. Go get it!

John Latham is an Inner City General Practitioner in Dublin

Thinking About Patients

David Misselbrook
Petroc Press 2001
£29.95 Pb 214pp
ISBN 1 900603 49 7

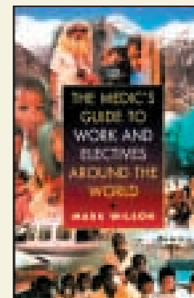
This book, by a Christian GP and VTS Course Organiser in South London, is written to promote a multi-dimensional model of medicine. The first four chapters explore the changing role of medicine in society, looking at its scope, achievements and problems as we find them at the beginning of the twenty first century. The doctor's model of disease is contrasted with the patient's model of illness, and there is a discussion of how the doctor's world is constructed. The ways in which the patient's world differs from this construction is considered at some length.

The next four chapters describe the non bio-mechanical elements of a multidimensional medical model, and how disease, illness and medical activity can only be truly understood when our social and cultural programming, as well as our individual thinking, are included in the total picture. The final chapter poses questions about the role and future of medicine.

It is an enjoyable book to read, well structured with clear summaries at the beginning and extensive references at the end of each chapter. Brief book reviews are scattered throughout. The author's wit and humour, as well as his impressively wide reading, are also evident. Although it covers little new or original ground, it contains comprehensive references to key source material that would be very helpful for someone less familiar with this terrain. It will be of interest to all Christian GPs as it is encouraging to read the thoughtful reflections of other Christians struggling with the demanding realities of life in the National Health Service today.

Huw Morgan is a General Practitioner and GP Trainer in Bristol

The Medics' Guide to Work and Electives around the World



Mark Wilkinson
Arnold 2000
£14.99 Pb 480 pp
ISBN 0 340 76098 2

This is a book that should prove to be of great value to students or junior doctors looking for ideas about electives or work overseas - in the developed or developing world. It is full of useful information. Users are encouraged to contribute further ideas and updates on places visited with the tempting offer of a £200 prize for so doing.

Divided into 3 sections, the first talks about 'Getting ready' but the last is no more than an appendix containing the addresses of nongovernmental organizations (CMF included) and embassies in the UK, USA and Australia. There is a helpful summary of travel vaccinations and a list of organisations that might contribute funds to the trip.

Website and email addresses are given for most embassies, but not for the individual NGOs and hospitals. This may be deliberate. The author suggests that it is better to write a personal letter, as this is considered 'more polite' in many cultures, than to make initial contact by email. Furthermore, the recipient of a letter is less likely to dispose of this than an electronic offering.

By far the longest section is on 'Destinations'. Countries get a very brief introduction (population, language, capital, currency and international telephone code) and a slightly longer comment on the medical scene, need for visas, climate and crime rates. The amount of information given relates more to the popularity of a destination

than its size or importance. In some instances there are simply lists of medical schools or hospitals. In others, eg Gibraltar, places are mentioned but addresses are not given, which will prove frustrating.

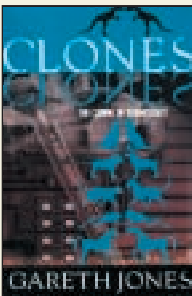
Countries are grouped under continents, which is fine if you have a good grasp of geography, but where exactly are the Maldives? The author could take a leaf out of the new edition of Operation World that now lists countries in alphabetical order. Not every country is mentioned, Yemen, Somalia and the Central Asian Republics for example. The index lists countries but not hospitals and European countries are found under 'Europe' rather than their own names. Myanamar is still called Burma.

Throughout the book the writer is very even handed in his comments about mission hospitals, most of which he feels offer an 'excellent' elective experience. In one place he comments, 'they are more efficiently run …and often have a better social life'! Of Kisiizi (Uganda), he writes, 'you will have to work hard' and it is 'very Christian but no-one holds anything against non-Christians'. I discovered one which requires the applicant to get in touch with me to be interviewed to ensure that he/she really is a Christian.

All in all, this book is a good buy but watch out for the new edition of CMF's own guide on the subject.

Peter Armon is CMF Overseas Support Secretary

Clones – The clowns of technology?



Gareth Jones
Paternoster Press 2001
£12.99 Pb 192 pp
ISBN 1 84227 086 9

Lighten up, says Gareth Jones. Don't take ethics so seriously. Think about it, yes. Work hard with it, yes. By all means be intellectually rigorous, but then add a dash of humour.

His title poses a question: *Clones – the clowns of technology?* Clowns, he says, are eccentrics who live on the edge of society and entertain by invoking introspection: 'Their inconsequential bumblings are caricatures of our own folly; they reveal what we seek to hide… they help us laugh at our failings, and laughing to realize that humans are sometimes stupid and often frail.'

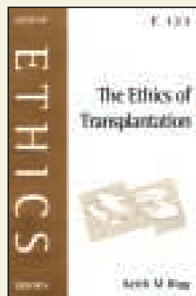
In rehearsing the arguments about the excessive hype surrounding biotechnology and the need to form a biblically inspired view of what it is to be human, he develops two themes. One is that human reproductive cloning is exceptionally unlikely to take place, and the other that even if it does occur, it shouldn't be seen as shocking. He even opens the book with an imaginary view of life in 2050 in which the majority of Christians have accepted reproductive cloning, but sadly, he presents no potential chain of events that lead to this change in opinion.

Jones' enthusiasm for therapeutic cloning is evident throughout the book. The centre of the book provides a simple guide to some of the techniques involved, but more usefully presents a run through of various strands of ethical thinking from many secular and religious points of view. This makes it a useful read for anyone wanting to discover the historic context underlying current debate.

For Jones, a key characteristic of humanity is our freedom, and he maintains that cloning will not alter an individual's ability to be free. Jones' aim is to bring us face-to-face with the clone, to force us into asking what we make of him or her, and what that person tells us of ourselves. His or her presence may make us laugh at ourselves, at our pretensions and extraordinary belief in our own abilities. From Jones' original definition, this may make clones clowns, however, Jones concludes that clones would not be clowns but rather, normal people living at the centre of society. So, who is the clown and who is laughing?

Pete Moore is a Freelance Science Writer and Editor of the CMF Files

The Ethics of Transplantation



Keith Rigg
Grove Books Ltd 2001
£2.50 Pb booklet 24pp
ISBN 1 85174 479 7

Keith Rigg is a consultant transplant surgeon in Nottingham and Reader at one of the local churches. He is well placed to write this 24 page booklet on the ethics of transplantation. Transplantation is here to stay and most members of the Christian community, as well as other religious groups, welcome it. However, there are many different ethical questions that need to be discussed and it is important that all members of the medical profession are aware of them.

This booklet, one of the excellent Grove series, looks at transplantation under four main headings: 'Outlining the issues', 'The donor perspective', 'The recipient perspective' and finally asks: 'What next?' The first area introduces us to an overview of transplantation, and outlines the ethical principles used to develop a framework for our thinking. There is then a section on the definition of death and what happens to the body after death, followed by introductory paragraphs on donation, informed consent, funding and the supply of organs.

The donor perspective looks at both cadaveric, living related and unrelated donation, while the section from the recipient's perspective looks at the benefits, risks and allocation of organs. The final two pages look towards the future with a brief introduction to anencephalic donors, xenotransplanation and genetic engineering.

This booklet provides an excellent introduction to the field. Inevitably, within 24 pages much of the discussion is painted with broad brush-strokes, omitting detail. This is of itself no criticism of the work, but apart from the references cited in the text, there are no specific guides to further reading, which would have been helpful. All the same, this booklet provides an excellent starting point for discussion of some of the issues surrounding transplantation.

David Cranston is a Consultant Urological and Transplant Surgeon in Oxford

The CMF Website on CD-ROM £3 (Special Offer)

The CMF website is still available on CD-ROM: over 30 back issues of *Nucleus* and 10 issues of *Triple Helix* together with ten years of CMF government submissions on ethics, the full set of *CMF Files*, a year's supply of daily devotions, the *Confident Christianity* evangelism training course, *Cyberdoc* web reviews, a quarterly newsround of issues in medical ethics and much more. Most queries can be answered within two or three mouse-clicks from the homepage. To order see the insert.

LETTERS

Richard Scott's article '*Good news in the Surgery*' (*Triple Helix* 2002; Spring: 6-7) prompted an article by Derren Hayes in both *Doctor* and *Hospital Doctor* magazines on 2 May 2002.

Hayes' 'Working Practices' piece began by saying that the *Triple Helix* article had prompted the BMA to warn doctors not to abuse their position of trust by forcing their own religious beliefs onto patients. But Dr Michael Wilks, chairman of the BMA Ethics Committee, also said that an element of 'spiritual' healing could help recovery if introduced in a sensitive way. 'The key to this is to tap into patients' own values. It's inappropriate to impose a moral or religious view onto somebody who doesn't share it.'

Hayes conceded that there are no rules preventing doctors discussing religion with patients, but added that 'under GMC guidelines if a doctor has a belief that can affect the way a patient is treated, the patient should be passed on to a colleague'.

Dr Emma Sedgwick, medico-legal adviser at the Medical Defence Union, said doctors needed to use judgement when deciding if it was appropriate to ask patients abut their religion.

'Some doctors have strong beliefs and part of that is to spread the word, but they are in a privileged position and need to be aware their primary role is to treat people as necessary.' She added that doctors would 'ultimately be judged by the GMC'.

Subsequently *Doctor* printed several letters, extracts of which are reproduced here with permission.

*Sheffield GP **Graham McAll** commented:*

A God-fearing doctor will believe that the patient is made in God's image, belongs to God and is uniquely precious.

Being made in God's image means that the patient has God-given autonomy and responsibility which the doctor must respect.

So forcing religion on a patient suggests to me a lack of belief. Furthermore, a God-fearing doctor will believe that he or she will one day have to give account to God Almighty – an even more awesome and ultimate prospect than a GMC hearing!

Surely a lack of personal belief on the part of the doctor is more likely to prejudice patient care – because why else would we consider valuing people equally?

*Isle of Harris GP **James Finlayson** said:*

It was unfair and disingenuous to imply that an article in the Christian doctors' magazine *Triple Helix* encouraged doctors to 'preach' and 'force' Christian religious beliefs on their patients…

I cannot be the only doctor who finds it ironic that it is considered quite appropriate to encourage patients to use instruments such as yoga – derived from eastern religions – while it is completely forbidden to point our patients towards Christian help.

*GP Registrar **Sarah Tregaskes** of Bethnal Green, London added:*

The article in *Triple Helix* mentioned the possibility of referring to Alpha groups, which are social evenings during which there is the opportunity for people to ask questions about Christian beliefs. It was stressed that our attitude should be one of 'gentleness and respect'.

I agree that doctors are 'in a privileged position and need to be aware their primary role is to treat people as necessary'.

Sometimes this includes referring to organisations that can offer support. If the only support available is from a group with religious beliefs, is it wrong to inform the patient that this exists?

*Coventry GP **Tony Feltbower** remarked:*

It is quite natural and good practice to ask depressed patients what other means of counselling or support they might have, such as through a church or other faith, and also to comment on any symbol they might be wearing...

We should not be afraid to suggest that faith can be important in a person's well-being or ill-being, especially when discussed as part of a routine history taking.

Clearly, it is inappropriate to focus on religious issues to the exclusion of other therapies, or if a patient rejects such issues.

It is, however, appropriate to refer patients on to other agencies (as required in our terms of service). Even if referred, a patient has the choice whether to attend or not.

***Dr Diana Lowry**, a GP in Essex wrote:*

… patients come to me for medicine, not preaching. I can help them best by listening to them, caring and even sharing their suffering… If we were to start such discussions and they did not prove fruitful, the patient would find it hard to come and see me as a doctor, frightened that I may start to question how their beliefs had 'progressed'.

Having said that, I have been discussing with the local rector whether a priest might do a surgery in our practice building to meet spiritual needs.

*CMF General Secretary **Peter Saunders** wrote:*

While doctors must never abuse their position of trust by 'forcing religious beliefs on patients', the GMC itself (*Annual Report*, 1993) rightly takes the view that they are free to express personal religious views to patients as long as they do so in a way that is not 'inappropriate and insensitive'.

A recent major review[1] has concluded that Christian faith confers 'longer life, less illness, better physical and mental health, more marital stability, less divorce, less suicide and less abuse of alcohol and other substances'.

Such information should not be withheld from patients who might benefit from hearing it.

1. Chamberlain T, Hall C. *Realized Religion: Research on the Relationship between Religion and Health*. Templeton Foundation Press, Philadelphia and London, 2000.

***Peter Armon**, CMF Overseas Support Secretary, wrote to Triple Helix:*

Almost as an aside Richard makes the comment that 'having prayed for discernment and his words at the beginning of the clinic, God speaks quietly to us about whom to present the Gospel to'. Surely that is the key that will settle this controversy… we need to ask for opportunities, for discernment when (not if) to speak and to whom, and for an appropriate word to give and we need to do so at the beginning of the day. We may find we have less regrets at the end of the day if we made it a regular habit.

Doctors are indeed, as Richard says, 'in a position second to none to reach the lost' and Paul (2 Timothy 4:1) reminds us that we should take every opportunity to do so. While not abusing our position we should seek and use God given opportunities. Carpe Diem. Richard quotes the prayer of Jabez (1 Chronicles 4:10). We also read that God honoured Jabez's prayer and he will honour ours – if we take the time to do so.'

See also 'Lessons in Spiritual History Taking' (p17)

Photos: Church Mission Society/John Martin.

John Martin discovers beacons of hope in Kenya

On Safari

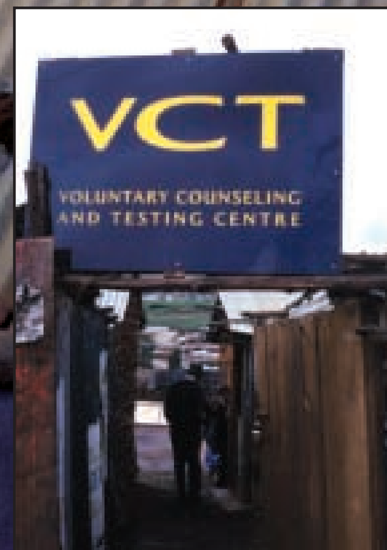
I've just spent ten days in Kenya, my third visit but the first for nearly 20 years. I'll never forget flying from the capital Nairobi over Kenya's luminous tropical green countryside, the breathtaking Rift Valley, seeing Mount Kenya, and moving on to Marasbit, an oasis town amidst a huge desert region bordering on Somalia.

It was a special privilege to spend half a day with local evangelists who had come in for a training school. These valiant local Christian leaders lead one of the toughest lives imaginable. Most cover huge distances on foot or bicycle, sharing the gospel with nomadic cattle herders. One of their inspirations is the late Andrew Adano who had a unique take on 'tentmaking'. As a 'camel doctor' he conducted an itinerant ministry via camel transport, supporting himself and his work by treating ill or injured camels among the communities he visited. In the same way now, some of the evangelists I met keep themselves on the road by offering bicycle repairs.

A spectre that haunts Kenya is the collapse of its famous coffee-growing industry. Small-scale Kenyan growers cannot compete with the low prices at which larger scale growers can produce their coffee beans and unlike other economies, there is no government protection for them. This in turn is accelerating the drift of people from rural areas to the cities, leading to the growth, especially in Nairobi, of what are euphemistically called 'informal settlements'.

I had the privilege of spending a morning walking through one of them, named Kibera. No one knows exactly how many people live there. It's not necessarily in the interests of the politicians to take an accurate census. But it's a place where hope has not died. I found it a whole lot friendlier than the London underground.

Kibera is hardly the archetypal secular city. Dotted throughout are churches of all shapes and sizes. Kiosk-sized shops carry signs telling that a church community meets there on Sundays. The great majority are indigenous, homegrown African churches and their worship is lively and enthusiastic. What they struggle with most is being able to offer something tangible in the here and now to people who, like Dick Whittington, have come to the city full of hope only to realise they are on the lowest rung of the economic ladder. Many of them will see their hopes crushed.



V.T.C. Clinic, Kibera.

It was heartening, therefore, to see in the centre of Kibera a simple building that serves as a clinic as well as a church. Its main source of support is not some distant NGO but Nairobi Chapel, a large city centre church. Here mothers can bring their babies for lessons in nutrition and basic healthcare. Here people can get advice about Aids prevention and the drugs and medicines they need at a price they can afford. It's a real beacon of hope and it demonstrates yet again why healthcare has such a crucial part to play in God's mission.

Seeing it reminded me of a comment from Archbishop Desmond Tutu. He once said that it was far easier to be a Christian in his native South Africa than in the West. The reason, he said, was that the issues that defined what being a Christian was all about were much sharper and clearer in his home community.

Kenya certainly has its problems but it's not the basket case that the propaganda of the aid agencies has prompted many of us to believe. And there are Kenyan Christians who have on their doorsteps communities like Kibera that beckon them to offer practical love in the name of their Lord and Saviour. And they are, generously and with great enthusiasm. I felt just a little envious of them.

John Martin is Associate Editor of Triple Helix and research adviser to the Church Mission Society

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