TRIPLE HELIX

Summer 2004

For today's Christian doctor

MARRIAGE & HEALTH

MORNING AFTER PILL

REACHING OUT AT WORK

HEALTHCARE IN EGYPT

REIKI

MIRACLES

CLERKING FOR TERMINATIONS

NIGHTMARE SHO

OVERSEAS OPPORTUNITIES

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Christian Medical Fellowship
157 Waterloo Road
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Tel 020 7928 4694
Fax 020 7620 2453

Email admin@cmf.org.uk
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EDITORIALS

Gender Recognition Bill

Compassion and honesty are both required

The Gender Recognition Bill has completed its Parliamentary process and will become law next year. Under its provisions a Gender Recognition Panel will have responsibility for issuing new birth certificates for transsexual people. The Bill proposes a potential legal threat to churches, Christian organisations and sports clubs who may be open to litigation for refusing to treat transsexual people as members of their chosen, rather than biological sex.

The belief now enshrined in statute, that gender is determined by a person's personal convictions rather than objective fact, fits easily with the postmodern notion that 'we are what we think we are'.

The reality is that Gender Identity Disorder is a disorder of thinking characterised by an unshakeable false belief that one has been born with a body of the wrong sex.[1] Surgical, hormonal and legal fixes do not deal with the real problem.

Rather than rubber-stamping radical irreversible surgical procedures, people in the caring professions need to provide compassionate professional support for people that does not involve any form of deception. As Christian doctors we must affirm the dignity of transsexual people and protect them from discrimination, but we must also be honest and professional.

Peter Saunders is CMF General Secretary

1. Sims A. Gender identity disorder. *CMF Files* 2004; No25.

Mental Capacity Bill

A potential back door to euthanasia

The long awaited *Mental Incapacity Bill*, now repackaged as the *Mental Capacity Bill*, was finally published on 18 June, and is to be accompanied by a *Code of Practice* that is still being developed.

It seeks to provide for decision-making on behalf of people with mental incapacity and is the culmination of a long consultative process that began in the early 1990s with the government discussion documents *Who decides?* and *Making Decisions*. CMF was actively involved in the early consultation process.[1]

The Bill, which is now due for debate in both Houses of Parliament introduces many necessary measures but there remain very real concerns about its definitions of 'best interests' and abuse of its provisions for legally binding advance directives, proxy decision making, and research involving mentally incapacitated people.

The prime purpose of this law must be to protect vulnerable people, but sloppy or deliberately ambiguous wording in the wrong hands, could be a tool for inappropriate withdrawal of food and fluids from patients with no capacity to protect themselves. The vociferous support for the bill from pro-euthanasia groups suggests that they see it as the camel's nose for further slackening of laws that stop doctors actively taking life.

We must pray for wisdom for those involved in the debate.

Peter Saunders is CMF General Secretary

1. *www.cmf.org.uk.ethics/submissions/index.htm*

US contraception furore

Despite the hype, abstinence works

The American College of Obstetricians and Gynaecologists called it 'morally repugnant'. In an editorial the *New York Times* called it 'politically motivated'. The *BMJ* couldn't say a word in its favour.

The USA's Food and Drug Administration's refusal to permit sales over the counter (without a prescription) of an emergency pill called *Plan B* certainly caused some shock waves in the family planning establishment. The reason given was that Barr Research, the company applying for OTC status, had not shown that adolescent women could understand the product instructions. The *BMJ* wryly commented that 'The FDA has never previously required such information before granting over the counter status'.[1]

This decision coincided with a great deal of mostly negative UK media comment about advocates of 'The Silver Ring Thing'[2] crossing the pond to peddle their dangerous brand of virginity over here. Gill Frances the deputy chair of the Government's Teenage Pregnancy Unit (TPU) wasted no time in labeling the scheme as 'potty'.

In fact 'Silver Ring Thing' is not an educationally designed sex education programme anyway but a one night road-show aiming to encourage teens to pledge to remain virgins until they marry. Its advent in Britain however did provoke a lot of cant from sex educationalists about how badly the USA is doing in terms of teenage pregnancies. The usual bar-charts appeared in the *BMJ*[1] and *The Economist* (15 May) showing the USA teen birth rate is over twice that in the UK.

The birth rate however gives a very misleading picture of teen sexual health unless you believe that abortion is healthy. In fact, the USA is doing rather well and certainly better than we are doing over here. Over the period from 1990-2000, the conception rate for 15-19 yr olds per 1000 in the UK[3] fell by 7.6.% from 68 to 62.8; in the USA[4] it fell 28.8% from 120.2 to 85.6. The abortion rate for 15-19 yr olds in the USA[4] has fallen even more steeply by 40.9% over the same period (from 40.5 to 24) whilst in the UK[3] it remained virtually unchanged, falling only 2.6% (from 26 to 25.3).

In an unpublished paper by Rebekah Saul,[5] the Alan Guttmacher Institute attributes 80% of this success to increased use of contraception and is quick to denounce as 'methodologically flawed' another unpublished paper[6] that had attributed it to an increase in abstinence amongst teens. In the only peer-reviewed paper of which I am aware, the methodological flaws in the Alan Guttmacher Institute's own paper are systematically identified and corrected and this more recent research[7] attributes 67% of the decline in teen conceptions among single 15-19-year-olds to increased rates of abstinence.

It seems to me that, even without OTC emergency pills, the USA has a lot to teach the TPU about reducing teen conception rates.

Trevor Stammers is a General Practitioner in West London

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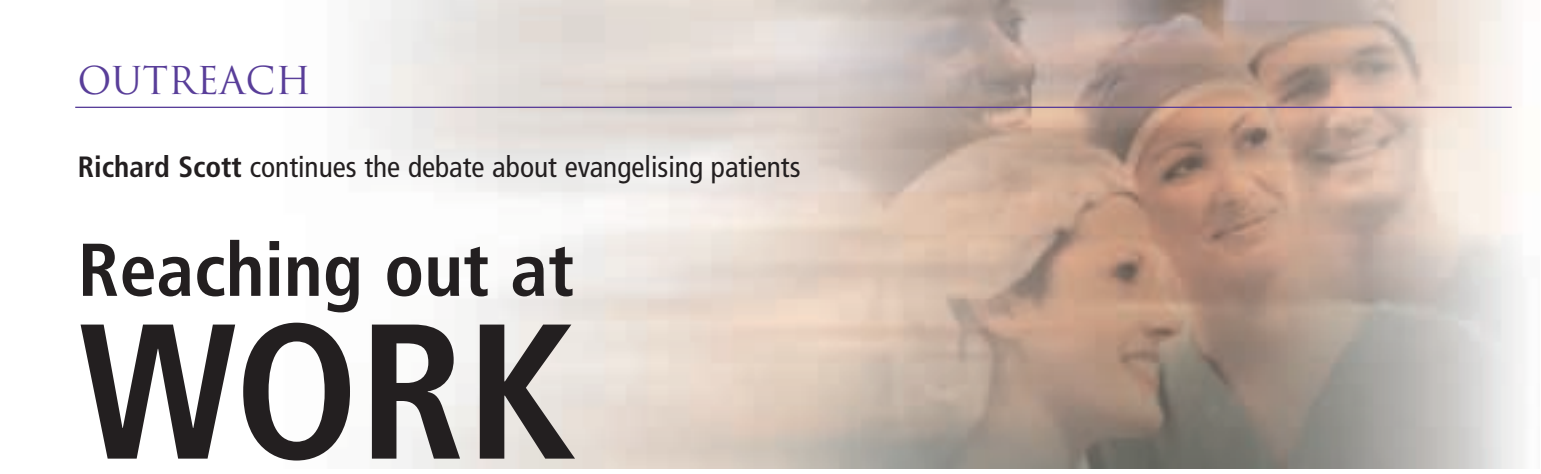

Richard Scott continues the debate about evangelising patients

Reaching out at WORK

In medicine we use statistics to research the effectiveness of any 'treatment'. Let me offer a statistic from my experience of evangelism. For every eight patients I invite onto our church *Alpha* courses, two come and one becomes a Christian. Over the past four years, in excess of 60 patients have made significant progress in faith through *Alpha*; of those who attend a course, the great majority has admitted to coming as a result of a personal invitation.

In a previous article[1] I sought to encourage doctors, especially GPs, to evangelise at work. I looked at reasons why Christian doctors may be reluctant to share Christ in their surgeries, such as perceived abuse of trust.

Many of us would love to share the gospel naturally at work and to pray with patients but wonder whether doing so might, in some way, be 'wrong'.

A lot of reaction

Clearly, this is a hot topic, not least among Christian doctors. Comments on my original *Triple Helix* article appeared in *Doctor* over the following three weeks and there was further reaction in this magazine.[2] Later I ran an inter-church seminar on evangelism at work attended by five GPs amongst other working Christians. In the group work following my address it was tremendous to hear how employees of a bank and a garage had led colleagues to the Lord.

This bold but potentially risky ethos delighted some of the delegates but others weren't so sure. The major concern was about possible abuse of position. Many doctors are keen to reach out but are concerned about the reactions of their colleagues and patients.

Peter Crookall spelt out his own personal concerns in *Triple Helix*.[3] He stated: 'Evangelising patients is fraught with difficulty. So many patients clearly need to encounter God but confronting this directly could be considered an abuse of our position. There are subtle ways of introducing them to God'. He looked at practical Christian compassion and offered a different approach, that 'faith in the consulting room is demonstrated by attitude and action rather than words'.

I'm grateful to Dr Crookall for his honesty, his willingness to speak publicly about his doubts and his willingness to admit 'failings' as a Christian GP. These are sentiments that I'm sure all of us could echo. In common with myself he is clearly keen to reach out at work, declaring, 'I would welcome a natural opportunity to share the gospel'.

In mentioning 'confusion' in relation to praying with a patient, however, I feel he has hit the nail on the head. Many of us would love to share the gospel naturally at work and to pray with patients but wonder whether doing so might, in some way, be 'wrong'. We're aware of all the theory and what Scripture teaches, but the practicalities and ethics about putting this into practice at work trouble us. Talking to other Christian doctors with similar misgivings fuels our hesitations and we remain confused as to the way ahead. What is the source of this confusion?

Not Jesus! He commanded us not to be ashamed of his words[4] and to preach the gospel everywhere.[5] Paul requested prayer that he might do so fearlessly.[6] We're told that 'faith comes from hearing the message'[7] and to 'pray in the Spirit on all occasions with all kinds of prayers and requests'.[8] Prayer and evangelism are therefore appropriate for all situations and all people. Indeed, as 'many Christians encounter the largest number of non-Christians in their lives at work',[9] the 30-50 patients seen per day surely represent our peculiar mission field.

Changed thinking

One aspect of Christianity in the UK that distresses me is a 'can't-do' mentality. Christians, including doctors, find reasons not to do things, fearing possible outcomes and, as a result, miss out on the many blessings God longs to give us. Instead, let's be visionary, prayerfully wondering what God has in mind for us and for our practices. I long for a 'can-do' mentality, one in which anything is possible with God and in which we reach out unequivocally. Changed thinking will require personal prayer and determination but also some practical help.

Training is important in any medical discipline and evangelism is no different. My own ability in spiritually 'opening up' consultations was greatly enabled by going on missions. Each year since 1999, I have been on a week's mission in the UK in addition to two longer missions with the Walk of 1,000 Men preaching the Gospel in Maasailand, North Kenya. Missions provide training. So, consider *regular mission work*.

In our practice, we set aside one week per year for Christian study leave, which I use in this way. In designing your PDP why not focus on personal spiritual development and plan a period of study and mission activity accordingly. I am currently undertaking a two year distance-learning course in evangelism, have written this into my PDP and will be explaining this to my GP appraiser.

Pray alone and with the staff, not only for but also with the patients. Enlist patients' help in praying for the practice. My wife organised a prayer walk around our new practice building in December 2003. A hundred came including many patients. Three of our patients, drug addicts, a prostitute and an alcoholic testified to a private school assembly last month on the difference Jesus has made to their lives. As we reach out, lives are changed and our patients can then lead others to Christ.

Reaching out at work is not an abuse of our position but the very use for which God placed us where we are.

Richard Scott is a General Practitioner in Kent

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Jason Roach asks if ordained ministry is the only career path for those wanting to see a world won for Christ

Making Christ known

A medical student thinking through his career options told me recently, 'The overriding need in this world is for people to hear the gospel; therefore the only thing worth doing with my life, if I am able, is to become an ordained minister.'

For me this begs important questions, for example, what proportion of the time of an ordained minister actually involves evangelism, direct or indirect. But the issues go deeper than that. Many will intuitively sense that something is awry with my friend's statement. How does one respond theologically to what can seem for many a powerful argument?

Evangelism is undoubtedly the *logical priority of Christianity*.[1] A question for me is this: does this make it *our only responsibility*? It is our Saviour's intention that our whole lives, our worship, might reflect God's sovereign rule over every area of life - as salt sustaining, light shining[2] agents of his common grace in the world.[3] We are created 'to do good works'[4] *as well* as to be agents of his saving grace through Christ. As John Stott has suggested, 'We have all been prodigals; God wants us all to be Samaritans too.'[5]

Loving our neighbours

Jesus tells us that the law can be summarised in the two commands to love God and to love our neighbour.[6] And as the parable of the Good Samaritan shows, our neighbour is simply anyone in need, made in the image of God.[7] Practically, Jesus demonstrated this in his actions as he 'went round teaching'[8] and 'went around doing good and healing'.[9]

As with Jesus' ministry, the expression of this love over a period of time, should rarely be less than evangelism, but will undoubtedly involve other areas of service as our individual gifts and opportunities are carefully weighed and reweighed throughout our lives. They are partners not enemies. For example, social responsibility is a biblical requirement, but can also be a bridge to evangelism, by removing prejudices, and opening doors that were previously closed. There are also diverse specialised ministries for which wise and spirit-filled Christians, like the seven in Acts 6, are required.

Proclaiming Christ

I believe that we demonstrate love supremely by proclaiming the gospel of the Kingdom.[10] But the proclamation is not just that 'Jesus saves', but that 'Jesus Christ is Lord'. This implies three things:

1. Demonstrating his rule in our own lives - by obeying his will irrespective of what the world around us does.
2. Knowing what God's will is - by actively seeking the 'renewing of our minds'.[11]
3. Evangelising - because God's will and rule in the world will only be demonstrated by a people equipped with the Holy Spirit.

We can strive for these ends in many contexts, from campaigning and curing to oratory or operating. Where we have gifts and influence and opportunity to make the fruit of the renewal of our minds a reality in the world as well, we should seek to do so. As Martin Luther King said: 'Morality cannot be legislated, but behaviour can be regulated. Judicial decrees may not change hearts, but they can restrict the heartless.'[12]

Making choices

As doctors, we will want to see God's will done in many different spheres: bioethics, health care rationing, global health or faithful preaching. All these need people uniquely gifted to serve in their particular fields.

We do need to make life choices carefully in full submission,[13] prayerfully,[14] with wise counsel[15] and with our minds.[16] However, we need to remember that nothing we can do can *affect* the plan of he who 'works out everything in conformity with the purpose of his will'.[17]

Even if we make what we think is the 'wrong' choice, God will use us to *effect* his plans if we submit ourselves to his will. This means that it is unhelpful to think of the offices of teacher or preacher or missionary or doctor or nurse as 'rankable' in terms of import in the eyes of the Lord. Our task is in whatever we do, wherever we are, to 'work at it with all your heart, as working for the Lord, not for men… It is the Lord Christ you are serving.'[18] Our service should be joyful, not reluctantly calculated, as this will not be worship. The Lord cares less where we serve him, but *that we serve him*, with everything, and in everything, for he is everything.[19]

Jason O'Neale Roach is working full-time with a church in London

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Mar and heal

KEY POINTS

The health benefits of marriage and the adverse effects of family breakdown, both for individuals and society at large, are well documented in the medical literature, and yet the message that marriage is good for us is not getting out to our non-Christian colleagues. Christian doctors have a responsibility to be familiar with the facts and active in making them known. Community Family Trusts are in their infancy in the UK, but are one very positive way of bringing churches together to promote and strengthen marriage. Marriage is God's invention, and through seeing marriage work, non-Christians can be drawn to Christ himself.

In a recent morning surgery family breakdown was a significant factor in five of six depressed patients, one of six with physical problems, one of two for medication review and two DNAs. How different the morning could have been had relationships been intact, and how many more quality points I might have been able to earn! Studies back this up. Mental health improves after marriage and deteriorates after divorce or separation.[1] Even taking demographic factors into account children from single parent households are twice as likely to be unhappy, have low self-esteem, or mental health problems.[2] Single mothers have poorer health than their married counterparts.[3]

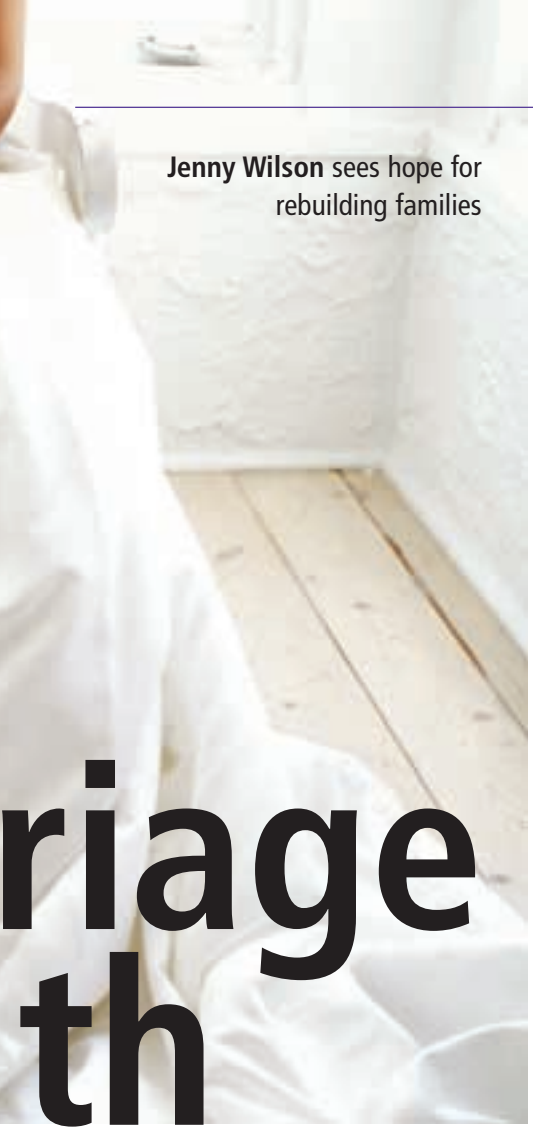
Throughout the Bible marriage and family are constantly affirmed. Christ himself was born into a family and knew what this involved. We are also encouraged to welcome strangers and the lonely into the Christian family. Family is the building block of society throughout the world and yet it is crumbling around us.

The message that marriage is good for us is not getting through to our non-Christian colleagues; and there are also many Christian doctors who don't know about the statistics surrounding family breakdown in Britain today. Although divorce rates have increased, once a couple have married they are far more likely to stay together than if they co-habit or if they marry prior to having children.[4] The health benefits of marriage, and the adverse affects of family breakdown are well documented (see box).

Family breakdown has huge financial implications too. In 2000 the direct cost to the UK government of family breakdown was estimated to

The health benefits of marriage

- 52% of co-habiting parents have split by the time their children are five, but 92% of married parents are still together.[8]
- 70% of children born to married parents expect to spend their entire childhood with both natural parents, but only 36% of children born to cohabiting parents do.[9]
- Divorced or co-habiting men aged 20-60 have 70%-100% higher mortality rates than married men. For women the figures are 35%-58%.[10,11]
- Sudden Infant Death Syndrome (SIDS) is three times more common in cohabiting mothers than in married mothers, and seven times more common in single mothers than married mothers.[12]
- Child abuse is six times more common in stepfamilies, 33 times if mother has a live-in boyfriend, and 20 times when both biological parents cohabit.[13]



Jenny Wilson sees hope for rebuilding families

riage th

- Divorced fathers misuse more drugs and have more unsafe sex.[14]
- Divorced young people are twice as likely to drink more alcohol.[15]
- Married men earn 30-40% more than divorced men over a lifetime.[16]
- 69% of single mothers live in the bottom 40% of household income, compared with only 34% of married couples with children.[17]
- Single parents are eight times more likely to be out of work and twelve times more likely to receive benefits than married parents.[18,19]
- Children from broken homes are nine times more likely to become young offenders – and make up 70% of all young offenders.[20]

be at least £15billion per year (£11 per week for every taxpayer).[5] An accountant friend worked out that a doctor who earns £70,000 a year will contribute at least £35 a week to sorting out the problems of family breakdown, the major components being for social benefits and welfare, the criminal justice system, extra costs of education, free prescriptions and lost productivity.

As Christians we have a responsibility to be aware of the problems in our society. It is not our place to judge those who are in difficulty but to approach their problems as Christ would have done. As Christian doctors we are not immune from relationship problems ourselves and perhaps even more prone as we take on others burdens.

As Christians in the UK have begun to pray about the dire situation within families things have started to happen. Some towns and cities have set up Community Family Trusts,[6] charitable organisations that work with registrars, religious organisations, health services, education authorities and debt services in order to provide simple relationship education.[7] Communication in relationships is vital as communication problems invariably lie at the heart of most of society's difficulties.

IN 2000 THE DIRECT COST TO THE UK GOVERNMENT OF FAMILY BREAKDOWN WAS ESTIMATED TO BE AT LEAST £15BILLION PER YEAR[5]

Community Family Trusts are in their infancy in the UK but already there are glimmers of hope. Marriage preparation classes are being set up and relationship education is starting to be seen in our schools. Trusts are bringing Christians together from different denominations, and hence churches are coming together as they look to ways of promoting marriage in their communities. The benefit is not just for Christians; non-Christians are being drawn in too. Hopefully as they see marriage working they will start to see something of Christ himself. It is a small step forward to solving a huge problem but there is hope of seeing a positive change in our society.

Jenny Wilson is a GP principal in Bedford and Trustee of Bedford Community Family Trust

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Clare Cooper reports on how CMF is equipping Christian doctors for the vital task of handling the media

Photo: PA

A word in season

With healthcare issues in the news almost every day, it's vital that the voices of Christians in the medical profession are heard in public debate. Some Christians have a natural aptitude for working with the media. For most of us, however, some basic training can make a huge difference to our effectiveness. And there is scope for even the best 'naturals' to sharpen their skills.

IT'S VITAL THAT THE VOICES OF CHRISTIANS IN THE MEDICAL PROFESSION ARE HEARD IN PUBLIC DEBATE.

CMF offers media training to encourage and equip doctors to get across the message of Christian medical ethics, on radio as well as television. This training enables them to speak confidently from their professional experience and Christian understanding. Since the project began in 1998, over 120 doctors have participated in media training days and a small number have had advanced training over two days. Courses are held in various parts of the country each year. Recent venues have included Aberdeen, Birmingham, Bristol, Cardiff, Dundee and London.

Basic media training

The basic media training day is led by Andrew Fergusson (former CMF General Secretary) along with John Forrest and Andrew Graystone (TV and radio producers). Teaching is informal and relaxed. The tuition style is intended to be encouraging and is suitable for those who are unsure of their abilities in front of the camera as well as for those who want to test out their ability to do more. Participants are able to practise interview techniques by means of simulated radio and television interviews. Useful tips for radio include sitting still in your chair (it might be squeaky) and smiling at the microphone as the effect comes across to your audience. Hints for appearing on television include talking to the interviewer rather than the camera and avoiding glancing to the side, as this appears shifty.

Group members learn how to deal with a request for an interview, which may be at very short notice with little time to prepare. They learn how to appear interesting and authoritative without putting others down. Stories come over well but statistics should be used in moderation. The interviewee needs to know the message he wants to get across; he can push his agenda and repeat the message if necessary. The interviewer may be nervous, inexperienced or poorly informed but these won't be problems if the doctor has the interview under control. It's important to be yourself. Some questions may be difficult or irrelevant but there are ways of handling these.

Future opportunities

The media training days have been greatly appreciated by attendees and some have subsequently given radio or TV interviews on medical ethics topics. Over 20 trained people have offered to be available for contact by journalists. CMF is developing a confidential database of doctors who are keen to get the Christian message across on medical and ethical issues, by radio or TV, on a regular basis (probably no more than three or four times a year).

The database indicates the topics on which each doctor is prepared to speak and where they work. Allen Moxham, CMF's press officer, provides the link with the media and refers radio, television or newspaper inquiries to CMF contacts as opportunities arise. Some participants have not intended using their media training skills but have then found themselves in the media spotlight and were glad of their training.

Advanced training

Three advanced training courses have been run so far with an exciting programme including a day at Bushey studios. Interviews are more demanding and more time is spent on improving television skills. Participation is by invitation and each course focuses on a particular topic. The courses have covered teenage sexuality, end of life issues and begining of life issues. Doctors with an interest in these fields were invited and these courses have proved very popular. Further advanced courses are planned. The next will focus on international health.

One GP participant commented after her first television appearance: 'The thing that really struck me was being part of the body of Christ. It felt as if I was there for all to see and yet the whole time I was being supported in an amazing way by the rest of the body praying for me and supporting me from the background.

Quite amazing - and without the CMF training - I don't think I would have been asked, let alone have felt like saying yes.'

Clare Cooper is CMF Medical Secretary

Are you interested?

The next Basic Media Training course will be 22 October in Manchester.
Contact:
judy.wilson@cmf.org.uk
for more information.
Cost is £50 for doctors and £25 for students.
The course is eligible for PDP.

Christians may be a minority in this ancient land but the offer of medical care is ensuring not only that they are respected, but also that the church is growing

Out of Egypt


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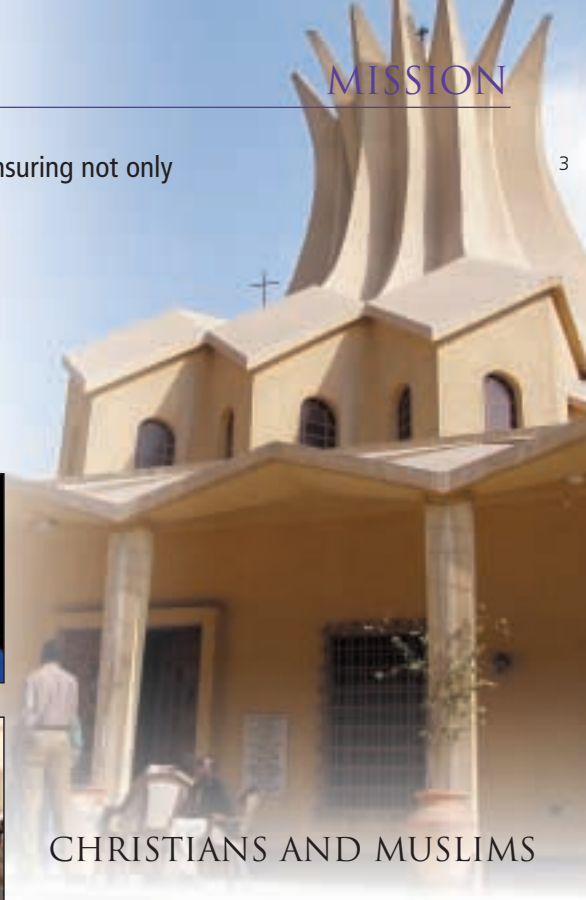
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In the compound of Cairo's Episcopal (Anglican) cathedral there is an inscription that witnesses to the place of Egypt in the unfolding of Christian history. It declares: 'Out of Egypt I have called my son.' What a lot of people don't realise is that while Egypt today is a predominantly Muslim nation it contains vibrant Christian communities with deep historical roots.

But it's a tough call being a Christian in Egypt today. Prayer calls from literally hundreds of minarets drown out the bustle and traffic noise of the sprawling capital city. Hastily built slum apartments are a breeding ground for Al Qaeda-style groups. The Iraq war has strengthened anti-Western feelings and the Christian presence is inaccurately perceived to be Western.

Religious freedom watchers deliver regular reports of Christians at the receiving end of harassment and imprisonment. However, co-existence between Christians and Muslims is possible, even essential, for the good of both communities. A senior Anglican priest told me, 'Christians and Muslims have no choice but to live together here and we have no choice but to do our part to try to make this happen.'

While not the largest Christian community the Episcopal Church plays a catalytic role in enhancing relations between Muslims and Christians. This was illustrated by the signing of the historic dialogue agreement between the Archbishop of Canterbury and the Grand Imam, Sheik Tantawi, of Al Azhar in Cairo, the intellectual centre of Sunni Islam. A key local player was the Bishop in Egypt, the Right Rev Dr Mouneer Hanna Anis.

When I entered his office just about the first item I spotted on his coffee table was a copy of *Triple Helix*. Dr Mouneer is a medical doctor who for many years was director of the famous Harpur Memorial Hospital, Menouf, 70km north west of Cairo, in the green delta of the Nile. In 1889, Dr Frank Harpur, an Irish missionary was sent by the CMS. One suggestion was that he should work in the Suez Corridor region. Harpur reasoned, however, that this would lock him into treating expatriates whereas his heart was with the ordinary people of Egypt. He started work among the villages of the Nile Delta, using a houseboat. He received an especially warm welcome from the people of Menouf. They gave him a piece of land on which he started the Harpur Memorial Hospital, in 1910.

Dr Mouneer is a leader who combines a strong strategic sense and professionalism with Christian compassion. 'The thing we can offer Muslims here in Egypt is love,' he says. It was no real surprise that he was fast-tracked through the various stages of Anglican ordination in order to succeed Ghais Malek as Bishop of the Diocese.

Under Dr Mouneer's leadership and helped by his long-established connections, it has been possible for the Church to expand through the offer of medical work. Two slum clinics have been set up in the last two years and Dr Mouneer has gone out of his way to ensure that Christian witness is by word as well as deed. Another huge area of growth is the combination of welfare and medical work to the thousands of Sudanese refugees for whom Egypt is a safe haven.

Provision of medical work earns the respect of both the authorities and local people. If you look around Cairo there are no shortage of specialist institutes, clinics and hospitals. Muslim doctors generally aspire to some sort of specialisation. So for ordinary people getting the right treatment is hit and miss – and expensive. It is here that the willingness of Christians to offer GP services and work in hard places comes into its own.

> CHRISTIANS AND MUSLIMS HAVE NO CHOICE BUT TO LIVE TOGETHER HERE

Sadat City, built in 1986 to honour the former Egyptian president, was for many years a neglected eyesore. The Egyptian government has determined to remedy the situation and is attracting vast international investment. It now contains 155 plants and factories ranging from are engineering, chemical and food industries, textiles, construction materials and metals. The city is expected to expand even further with 100 new plants under construction.

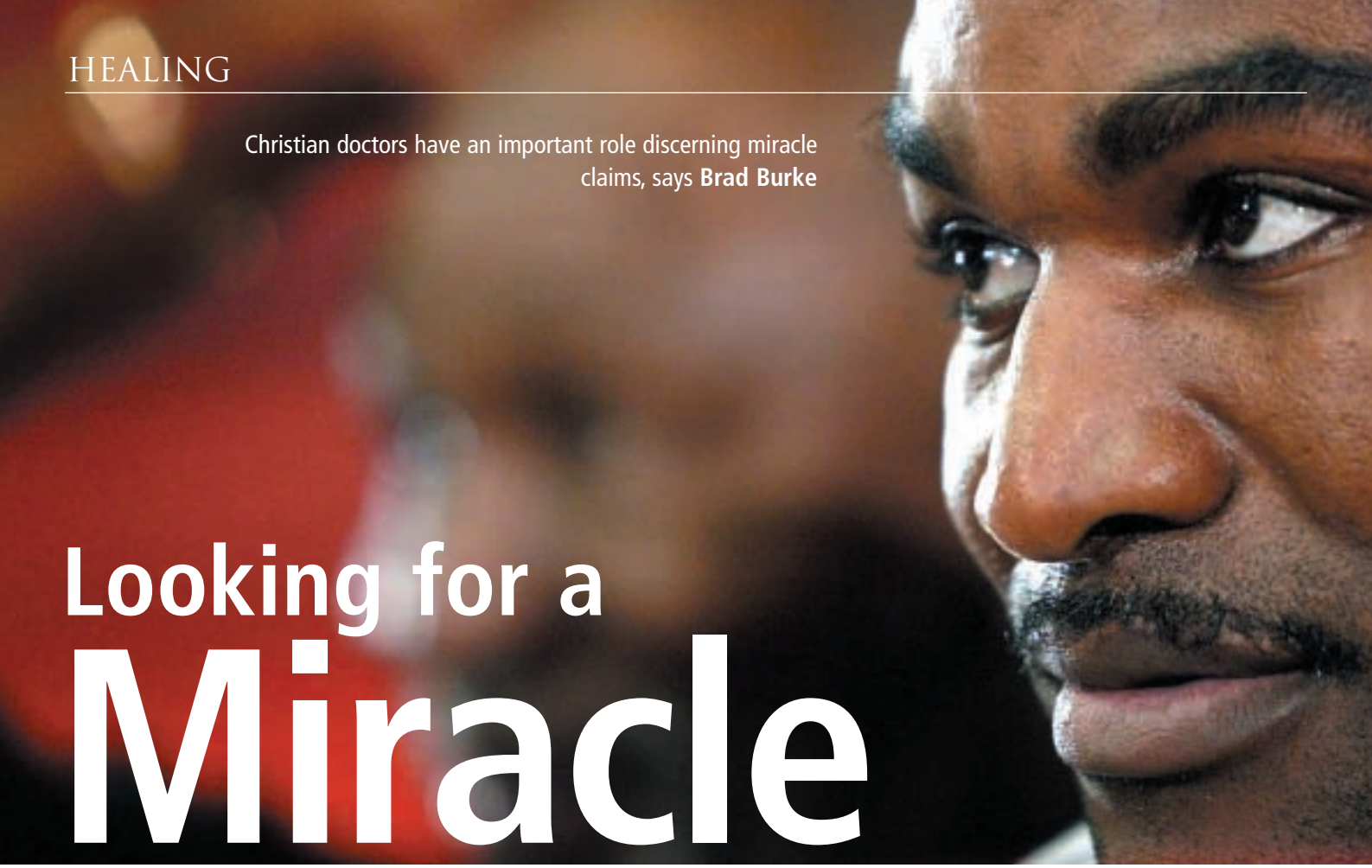
On the edge of Sadat City is a site reserved for a large, purpose-built medical facility that will be linked to Harpur Memorial. When I visited construction had just begun. The Diocese had already raised substantial sums for the project that it hopes will receive matching funds from a combination of the Irish government and the European Union.

This sort of provision comes at a personal as well as financial cost. I visited a young Christian doctor and his wife who live nearby and occupy a duplex apartment, one part of it served as the clinic and the other as their flat. It was a lonely life. They were on duty on an almost 24/7 basis with limited relief. Just as we'd settled down to talk he was summoned urgently to an industrial accident.

Dr Mouneer likes to encourage doctors like this by sharing a spiritual principle he learned from Dr John Coleman, the missionary doctor taken hostage in Iran who later became his mentor. 'There can be no greater honour than to become tired in the Lord's service.'

John Martin, Associate Editor of Triple Helix, visited Egypt in February 2004. Contact CMF for information about opportunities for service in Egypt.

1. The Rt Rev Dr Mouneer Hanna Anis
2. Patients at the Harpur Memorial watch a Christian TV programme from SAT-7
3. Cairo Cathedral



Christian doctors have an important role discerning miracle claims, says **Brad Burke**

Looking for a Miracle

KEY POINTS

Many doctors believe that God still performs miracles of physical healing that defy natural explanation, but claimed contemporary miracles are often not miracles at all. Much of the confusion arises from the loose use of terms like 'blind', 'paralysed' or 'confined to a wheelchair' but misunderstanding of doctors' explanations, medical errors and cyclical or self-limiting diseases also contribute to false claims and unrealistic expectations, which are in turn further inflated by hearsay. Answers to prayer are always wonderful but we must also be truthful about the results, and Christian doctors have an important role to play in discerning the validity of miraculous claims.

Not long ago I heard the story of a woman whose teenage daughter was severely disabled with cerebral palsy. For several agonising years, the mother prayed that God would work a miracle and heal her daughter. Nothing happened. Then, a friend and two other Christians approached the mother. 'God gave me a vision that your daughter will soon be miraculously healed,' one said. Another said she had a dream that the daughter walked upright.

The mother's hopes lifted. But the days slipped into weeks… the weeks into months… and still, no miracle. To date, this woman's daughter remains terribly crippled with cerebral palsy; I can't help but wonder whether this woman's faith has remained resilient despite the false hope given by so-called friends.

Perhaps, like me, you've had patients who have prayed for a miracle from God. Maybe you've sat motionless by their bedsides, unsure of what to say, as tears streamed down their cheeks. They've read book after book heralding miracles. They've heard incredible stories of divine healings. All the while their spirits spiral downward as they wonder why God won't intervene on their behalf.

A full examination

Christian doctors have an important role to play in discerning the validity of miraculous claims. Many, including myself, believe God still performs miracles of physical healing that defy natural explanation. But are the hosts of 'miracles' we hear about so often truly miracles?

Paul writes, 'Test everything' (1 Thessalonians 5:21). I did just that after reading the account of a three year old girl who suffered a broken leg along with brain and abdominal trauma in a horrendous car accident. The author wrote that the girl had 37 tubes in her body and that the doctors told the parents on the fourth day that she would need to remain in intensive care for at least two months, followed by six to eight months in the hospital learning to walk again.

When the child was discharged from the hospital eleven days later, the author labeled the healing a genuine miracle. He went on to write of other events, including the miraculous healing of her leg curvature and limp.

I called the author and asked him for additional details. 37 tubes in a three year old child with blunt trauma and no abdominal surgery is an absurd number. Also, a medical specialist cannot - and would not - predict on the fourth day exactly how long it would take for a comatose three year old to be discharged from the paediatric intensive care unit and begin walking again. The doctors might have given a worst-case scenario, but the author's wording never implied this. Furthermore, orthopedic surgeons are seldom worried about curvatures and leg length discrepancies in young children who have recently suffered a broken leg. Why? Children's bones usually grow out to correct for such deformities.

Terminology turmoil

A significant factor in play in the confusion over miracles is the words and phrases used by non-medical lay people in books and in healing services.

- 'Blind' for example, can mean total blindness,

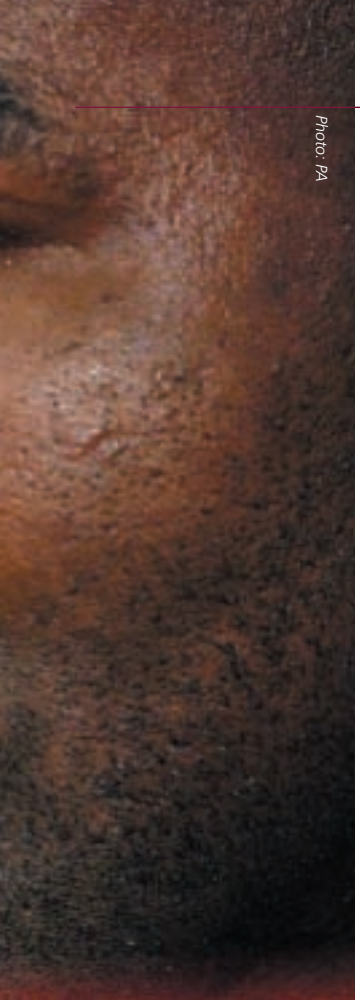


Photo: PA

If your patients are eagerly awaiting a healing touch from God, remember that answers to prayer are always wonderful, whether they can be explained by natural forces or solely by divine intervention

legally blind, tunnel vision or just plain rotten eyesight.
- 'Paralysed' can mean anything from 50 to 100 percent loss of strength in a limb.
- 'Confined to a wheelchair' is a phrase that has been applied to patients who can stand up only to transfer into bed, can walk 20 feet with a walker, or can walk unassisted within the home but need a wheelchair in public places.

For a 'blind' person to see vague images, a 'paralysed' person to perform deep knee bends, or a person 'confined to a wheelchair' to get up and walk is rarely a miracle.

The doctor said so

Unfortunately, many people, doctors included, tend to throw around the word miracle at will. For example, if a patient narrowly survives a life-threatening sickness when there was only a five percent chance or less of living, the doctor will usually agree with the family that it's a miracle. But if you were to sit down with the doctor for half an hour, he or she could probably supply at least one rational theory of how natural forces contributed to the healing process.

The unexplainable

I hear the phrase, 'The doctors couldn't explain it!' used quite a bit. The truth is that doctors can't fully explain a lot of things. Why someone catches a cold and recovers in six days while someone else catches the same virus from the same person and recovers in only three days is a bit of a mystery. It doesn't make the case a miracle.

Medical errors

When boxing champ Evander Holyfield (pictured above) was supposedly healed of a noncompliant left ventricle at a Benny Hinn crusade, Hinn labeled it a miracle. Later, it was discovered that the cardiologist had misdiagnosed the problem because he was not informed of the whopping amounts of morphine and fluid Holyfleld had received post-fight, which made it appear as if his heart were malfunctioning. As reported in *The Atlanta Journal and Constitution*, Holyfield later admitted, 'I don't think there was anything wrong with my heart to begin with'.

Vanishing diseases

Fortunately for us, most diseases we acquire are cyclical or self-limiting. The symptoms of diseases such as allergies, arthritis, lupus and multiple sclerosis tend to fluctuate like the stock markets - down one month, up the next. Most episodes of joint pain, nausea, headaches, abdominal cramping and skin rashes often disappear over a period of days or weeks. God has ingeniously hardwired our bodies to heal themselves. While rare, the spontaneous remission of cancer is well documented. In 1999, *Scientific Review of Alternative Medicine* cited a veteran oncologist who, in treating 6,000 cancer patients, observed twelve cases where the cancer suddenly and mysteriously disappeared for good.

Can these spontaneous remissions be attributed to a biological mechanism? Perhaps, states a 1998 *In Vivo* article, indicating that this phenomenon is reported most often in certain cancers: neuroblastomas, malignant melanomas, renal cell carcinomas and lymphomas/leukemias.

Hearsay

The Agony of Deceit includes a chapter by retired US Surgeon General C Everett Koop MD, who described a conversation he had with a woman following a church service:

'God can do anything!' [she proclaimed.] 'I once knew a woman who went into the hospital to be fitted for a glass eye, and while the surgeon turned his back to get an instrument, he turned back to find a new eye in the empty socket where there had been nothing before, and the woman could see!' I said, 'Did you say you knew this woman?'

'No. I knew someone who knows her,' she conceded. 'Well,' I said, 'could you tell me who he or she is? I would like to have a conversation with that person.' 'Well, I don't really know that person either but I know someone who knows her.' 'Even so,' I persisted, 'I would like to meet that person.' 'I don't really know that person, but she knows someone who knows someone…' And so it goes.

If the woman's story actually happened as she insisted, the patient, the patient's family and the doctor would all be on a major network TV station the next day. Why do we never read in reputable newspapers, or see on reputable news networks, stories of eyeballs instantly appearing in previously empty eye sockets?

Proceed with caution

When you next hear the word 'miracle' I encourage you to keep these points in mind. Could the astonishing healing be hearsay? Could the human body have healed itself - temporarily or permanently - from a cyclical or self-limiting disease? Did the doctor truly believe that natural forces could not explain the healing in any way? Is the layperson's information surrounding the 'miracle' medically accurate?

The amount of medical confusion and misinformation in books, magazines, television, newspapers, the Internet, church services and on the street is staggering. If your patients are eagerly awaiting a healing touch from God, remember that answers to prayer are always wonderful, whether they can be explained by natural forces or solely by divine intervention. Our duty is to respect our patients' personal beliefs while lovingly conveying the truth.

A longer version of this article was published in Physician Magazine (March/April 2004)

Brad Burke is a specialist in Physical Medicine and Rehabilitation in Bancroft, Ontario

Photo: PA

Reiki

George Smith investigates this emerging healing practice

KEY POINTS

Reiki is an increasingly popular 'therapy' recommended for a variety of acute and chronic conditions. Developed in the late 19th century, it is characterised by the laying on of hands, and based on an ancient Buddhist healing technique. Like other alternative therapies with New Age associations, it involves belief in an invisible life force that generates self-healing. Reiki has no credible scientific basis and there is no evidence for its efficacy in controlled trials. Although posing little medical danger, apart from causing delay in orthodox diagnosis and treatment, its spiritual roots and lack of evidence-base should ring loud alarm bells.

Reiki appears to be a relatively new form of an ancient Buddhist healing practice, characterised by the *laying on of hands*. An early survey by the Consumers' Association in 1995 found that around five percent of alternative therapy users consulted spiritual healers including Reiki therapists, a relatively small market share. Reiki has, however, since increased very considerably in popularity, particularly amongst those associated with the holistic healing approach of New Age philosophy and practice.

Definition

Reiki is also identified as the Usui system of Natural Healing. It is presented as: 'an effective system for healing and stimulating mental, emotional and spiritual growth', offering relief from stress, unhappiness, depression and disease.[1] Its essential philosophy is identified in the two components of its name:

Rei - invisible and universal source of all being
Ki - life force or energy

Ki is comparable to the chi of Chinese acupuncture and other expressions of life force in different cultures and traditions.[2]

Eleanor McKenzie, in her book, *Healing Reiki*, states, 'Reiki is primarily perceived as a practice for healing the body but it is also a method for healing the mind and spirit'.[3] Walter Lubeck, a prominent Reiki teacher, writes, '…in the holistic, natural sense, Reiki energy stimulates the body to heal'.[4]

Origins

Whilst similar practices have been traced back to Egyptian, Indian, Polynesian and Asian cultures, Reiki is based on ancient Buddhist healing technique. Mikai Usui (born 1860), a Japanese scholar and Buddhist monk, initiated the present Usui system of healing towards the end of the nineteenth century. He had become passionately interested in miraculous healing and travelled extensively in USA and elsewhere in search of answers, eventually returning to a Zen Buddhist monastery in Japan. He spent 21 days fasting at the top of Mount Kurayama, near Kyoto, and described being struck by a ray of light from heaven that he accepted as a dramatic initiation into the Healing Power of Universal Life Energy. Descending from the mountain, he put his newfound power into action, apparently with dramatic results.

He developed Reiki Healing, which gradually spread across Japan in the early 1900's. Recognising Usui as the First *Grand Master*, the secrets of Reiki were handed down in hierarchical fashion to Dr Chujiro Hayashi and from him to a Hawaiian lady, Hawayo Takata. Her granddaughter, Phyllis Lei Furumoto continued to teach and practise Reiki in many quarters of the World. Reiki Masters formed the Reiki Alliance in 1981. There are now many varieties of Reiki, with modifications and practices believed to have been received directly from the *Ascended Masters*, including Dr Usui himself; this process can be compared with the *channelling* of New Age spirit guides. Healing rays of Reiki are said to emanate directly from The Creative Force, Mother/Father God or Divine Intelligence.

Present practice

Today, practical Reiki healing is a gentle hands-on technique, said to work by channelling energy into the body by placing the therapists' hands on 12-20 specific areas, usually over energy centres called chakras, for a few minutes. Seven chakras are usually described: crown, forehead, throat,

heart, solar plexus, sexual and root, which are said to relate to all body organs but particularly endocrine glands.[5] These are clearly comparable with the chakras described in the Hindu practice of yoga and other varieties of alternative therapies based on energy concepts.

It is suggested that the healing power of Reiki can affect animals and inanimate objects; flow into walls, plants and food; improve the efficiency of household appliances and even repair computers and cars.[6] A video presentation of Reiki showed the person being *grounded* - returned to their normal state after treatment - by drinking a glass of cold water. This suggests that an altered state of consciousness or hypnosis might be involved.[7]

Reiki is recommended for acute and chronic conditions including viral infections, migraines, eczema and psoriasis, arthritis, and both mental and spiritual problems. It is increasingly used in hospices for the treatment of breathless patients.

Reiki healers adhere to strict forms of initiation from a Reiki Master through the laying on of hands, spiritual attunement and training at three levels or degrees. The first degree, usually over the course of two days, involves receiving and channelling Universal Life Force. In the second degree, Reiki knowledge and power is expanded using secret mantras and symbols. Distant healing is taught and practised, sometimes whilst holding a photograph of the sick person. The third degree primarily involves initiation as a Reiki Master and Teacher. Reiki treatment and initiation can be expensive. The UK Reiki Foundation lists practitioners and provides education and therapy.

Medical checklist

Is there a logical, scientific basis?

No credible scientific basis can be identified in this therapy. Some researchers suggest that there may be an effect through the endocrine glands, possibly stimulated through chakras (energy centres). Others suggest that endorphins may be involved. This can, however, only be speculative: no evidence has been produced for these theories. Because of Reiki's essentially spiritual nature, there has been little scientific investigation. Reiki manuals emphasise relaxation and stress reduction rather than physical healing; again, this makes scientific evaluation difficult.

Does it work?

Evaluating the effectiveness of touch and energy therapies can be extremely difficult; finding a suitable placebo for clinical trials can be especially problematic. The Department of Complementary and Alternative Medicine at Exeter University performed a systematic review of *distant healing*: only 23 out of 100 trials were considered rigorous enough to be admitted to the survey. Of these, only one included Reiki as one arm of the trial and no firm conclusions could be drawn.[8] Its teachers emphasise that Reiki does not set out to replace orthodox medical care. Therapists emphasise the benefits of following the Reiki spiritual path: improved holistic health with the expectation that this may include physical healing.

Is it safe?

The nature of this therapy does not suggest the likelihood of any specific medical dangers. Medical researchers have not found any significant safety concerns. If a hypnotic element is involved, this might bring associated dangers such as altered awareness and later personality problems. Reiki is not considered suitable for psychiatric patients. The usual warnings regarding alternative therapies must apply: delays in either orthodox medical diagnosis or obtaining effective medical treatment may be dangerous.

Christian checklist

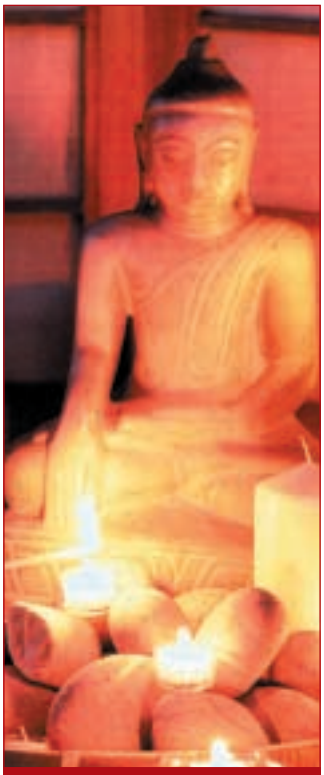
From a Christian perspective, there certainly are spiritual dangers, which cannot be ignored. The concept of *Rei* as the invisible source of all being and of *Ki* as the Universal Life Force are completely at variance with the Christian belief in God as Creator and Heavenly Father. Reiki claims to be independent of any religious belief systems but Buddhist, Hindu and Taoist influences can be clearly identified. Reiki healers often have strong New Age associations, at times using occult techniques, crystals and tarot cards. Divination, necromancy and the receiving of knowledge and power by channelling are forbidden in the Bible.[9] It has been suggested that the Reiki laying on of hands is similar to the healing miracles of Jesus and his disciples. Yet we need to ask, 'By what spirit is this being applied?'

Conclusion

Reiki claims to be a spiritual path leading to physical, mental, emotional and spiritual attunement, harmony, good health and happiness. As a holistic therapy with Buddhist roots, it clearly has serious spiritual implications but does not and cannot supply answers for the basic spiritual sicknesses of mankind such as sin, guilt, fear and the need for forgiveness and salvation. Surely healing rays or an impersonal life force cannot deal with these problems. Only the Christian gospel provides a cure for such sickness. For Christians, only the power of God's Holy Spirit can provide acceptable and effective healing. We need to be aware of counterfeits and certainly not be involved in them, however harmless they may appear at first sight.

Believe not every spirit, but try the spirits whether they are of God. (1 John 4:1 KJV)

George Smith is a Dermatologist and former GP in Berkshire



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HEAD T

Rebecca Brain and **Sharon Morad** explain their opposing stances

Should Christian doctors cler

'Yes!' **Rebecca Brain** is a part-time CMF staffworker and GP trainee

I hate everything about abortion. I hate the way it's so often presented to young women as the right thing to do. I hate the way it encourages promiscuity and irresponsible sexual behaviour. I hate seeing a woman who had a termination many years before present to fertility clinic racked with guilt and desperate for a baby. I'm sure that God feels this way too. Yet, despite my hatred of the entire system, when I started obstetrics and gynaecology as an SHO, I decided that I would, if asked, clerk and consent patients for termination and consent them for the procedure. I won't take bloods, sign the blue form or write up prostaglandins, but I will clerk them in.

The reason I do this is that I think too many vulnerable women are ushered onto a *termination conveyor belt*. From their initial visit to their GP until the time they leave hospital, all too often they are not given any information about the alternatives or any opportunity to step back and take a look at what is really involved. I write this as the newspapers are full of a story about a 14-year-old who changed her mind after beginning medical termination, too late to prevent the abortion.[1]

Clerking patients gives me an opportunity to gently probe their reasons for seeking termination. I am able to help the patient explore any ambivalence or uncertainty about going ahead with the procedure. I provide them with information about pregnancy crisis counselling centres. We discuss the support available for mums who keep their babies. I go through the possibility of adoption. None of the mothers I have spoken to so far had received such information from any other source. I always say to them, 'This is one of the biggest decisions of your life. Are you 100 percent sure that this is what you want to do?' I use the word *baby* rather than *foetus* when talking to them. Gently and non-judgementally, I try to challenge their perception that having a termination is the right thing to do. When I fill in the consent form, I carefully document all the major complications of abortion including psychological problems, infertility and depression. Only then is the woman making a truly informed choice.

What is the alternative? If I don't wade into this world's mess and get my hands dirty, who else will clerk them? It's unlikely to be someone who checks that they've thought this through properly, who's armed with adoption leaflets and information about other alternatives. It won't be someone who gently tries to help them see that there is a baby involved, not merely a piece of tissue. All too often, women are given a cursory clerk-in and consented; the only risks talked of are bleeding, infection and perforation. Yes, perhaps I am facilitating the system. Yet, without the invitation that clerking gives me, I could not attempt to persuade these women not to go ahead with their abortions.

I HATE ABORTION. I FEEL DEEP SADNESS WHEN A WOMAN DECIDES TO HAVE ONE. YET WITH THE INVITATION THAT CLERKING GIVES ME, I CAN ATTEMPT TO PERSUADE HER NOT TO GO AHEAD WITH IT

I hate abortion. I feel revulsion when I pick up the notes and deep sadness when a woman decides to go ahead with it, despite my best attempts. Yet I know that there is one baby alive today because I clerked in its mother, explained the alternatives and let her have the opportunity to choose life for her baby.

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3. John 18:36
4. 1 Corinthians 5:19
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O HEAD

k patients for terminations?

'No!' **Sharon Morad** is an obstetrics and gynaecology SHO in Leeds

Clerking a patient for an elective procedure ensures that they are able to undergo the correct procedure safely. Diagnosis and management decisions have usually taken place in the outpatient setting. The pre-operative clerking checks that nothing has changed or been overlooked.

As a SHO in obstetrics and gynaecology, I am beginning a career in a specialty where one of the most commonly offered procedures is diametrically opposed to God's loving will.[2] Abortion treats children as their mothers' enemies and diminishes all human life. However, like many other sinful acts, abortion is in fact legal in this country. God's kingdom is not a political entity.[3] Though he has not given us a mandate to coerce others into obedience, God has given us responsibility as a prophetic voice, proclaiming his justice and mercy, and the message of reconciliation.[4]

The process of having a termination of pregnancy begins in the community when a woman discovers that she is pregnant. In these first few days, she talks about her feelings with her partner, family, friends and healthcare professionals. Her attitude towards the pregnancy is established at this stage and may lead to her decision for abortion. Her GP or family planning clinic is usually the first port of call. She requests a termination and the 'blue form' is signed, referring her for a termination of pregnancy under the terms of the Abortion Act. Most hospitals have abortion clinics that supposedly offer counselling and assessment services; from there, a date for termination is set.

In my hospital women arrive on the ward at 7:30am for a day case termination list beginning at 8:30am. I believe abortion to be inherently wrong and will never believe it to be right option for any of my patients. So, my only possible objective in clerking any one of them would be to try to prevent her from having a termination. I doubt that a five-minute pre-operative clerking is the most appropriate setting to try to persuade a woman not to have her abortion. I may, perhaps, succeed in coercing one or two into not having the procedure, through fear or emotional blackmail. I suspect I would be far more likely to create anger and resentment.

Refusing to clerk patients for terminations has a secondary (and possibly more important) effect on my relationship with my medical and nursing colleagues. Since the first day of my job, I have consistently refused to do anything that will help an abortion to occur. I will not clerk or consent patients, prescribe or administer drugs, nor perform the abortion. This consistency is useful on several fronts. It helps my colleagues realise that I believe abortion to be morally repugnant. It prevents me from having to agonise over every individual situation. I am less likely to be manipulated into doing something I consider wrong. It has also helped others voice their own concerns. Several nurses - some of whom used to try tricking me into termination prescribing - have actually confided their own misgivings about abortion to me.

My stance is a constant, uncomfortable, reminder that acceptance of abortion is not the only option. This consistent refusal to harm children must, of course, be coupled with an equally consistent attitude of compassion towards mothers. Christian doctors can play crucial roles in the lives of women with unwanted pregnancies. Yet, if we wish to be heard, we must choose an appropriate place and time. The earlier you can be involved in the decision-making process, the better your opportunity for helping each woman to realise that you truly care for her. Most of these opportunities will be available to GPs.

In the hospital setting I see women who present acutely with pain or vomiting. They are often shocked at being pregnant. A woman who trusts me is more likely to consider my questions, though she may not change her mind. The difference between persuasion and coercion is the effect on the patient's desires rather than merely the change in her actions. The *persuaded* woman has listened and changed her mind about the action she wants to take. A coerced woman feels forced into an action she does not wish to take. Persuasion should be our goal. We should help each woman see God's love for her and her unborn child; then she will wish to live in accordance with his laws.[5]

Intervening at such a late, hurried stage seems doomed to failure. Few patients change their minds at such short notice unless they are coerced. So, in almost every instance, my clerking would facilitate abortion. Simultaneously, I would be losing the clarity of a consistent principled stand before my colleagues.

Information

- LIFE and CARE offer free pregnancy testing, pregnancy and post-abortion counselling, practical help, follow-up care and information for men.
- LIFE Care Centres – *www.lifeuk.org*
- CARE Centres Networks – *www.pregnancy.org.uk*
- CAREconfidential – 0800 028 2228

What position do you take? Is there a particular issue that you would like featured in Head to Head?

Write in to **rachael.pickering@cmf.org.uk** and join in the debate. In the next issue, we will publish correspondence along with the next Head to Head.

how i'd handle it!

Elizabeth Croton explains how she would tackle this complex situation

Nightmare SHO

Claire chose her first house job because she really clicked with the Christian consultant. Unfortunately, things have changed recently. The consultant has become part-time, now only covering outpatients; Claire no longer has regular contact with him. The new locum ward consultant is unapproachable and impossible to please. Even worse, Claire's SHO sits in the mess 'supervising' Claire doing all the work: she issues orders rather than requests and never says please or thank you. Whenever Claire makes a mistake, the SHO has a good laugh about it with everyone else in the mess.

Claire bursts into tears during house officer teaching, blurting out that her SHO is horrible to her. Rumours start. The SHO accuses her of bitching and then tells their Christian consultant that Claire is incompetent and difficult to work with! Claire has now lost all her self-confidence and feels inadequate as a doctor. She also feels a bad witness: she should be turning the other cheek, not grumbling. What should she do?

Rebecca Brain is a part-time CMF staff worker and GP trainee in Cardiff

I detect a murmuring of 'I've been there!' This scenario contains familiar elements that we've all faced. There are several issues here. Firstly, Claire is disappointed: two difficult bullies have replaced her idealised Christian consultant. Next is the issue of malicious gossip that, like MRSA, thrives in NHS culture and takes innocent victims. Thirdly is the issue of work-related stress: events have snowballed, resulting in Claire's tearful breakdown. Lastly is the guilt issue. Tiredness and fragmented Christian connections make us forget that we are 'works in progress'. We often beat ourselves up regarding our own failings.

Disappointing fellowship

Regular fellowship with other Christians, particularly senior colleagues, can be immensely comforting.[1] Sadly, this is not usually the case and we can really feel for Claire, being landed with these two difficult individuals instead.[2] Although often surrounded by his disciples, Jesus did spend time in solitary communion with his Father; think of his time of despair on the Mount of Olives.[3] Although Christians are sometimes without fellowship, we are never alone.[4]

Gossip

Gossip is such fun! Christian or not, we all love a good nugget of another's misfortune. Why else are chat shows like *Trisha* so popular? Still, it's not godly behaviour. Proverbs hits the nail on the head: 'A gossip betrays a confidence' but 'Without gossip a quarrel dies down'.[5] Hospital gossip is infectious: it reaps havoc and wrecks relationships. A Christian's best defence is to not partake. We need the Holy Spirit's power to be salt and light.[6]

Stress

Claire's breakdown illustrates the 'put your head down and get on with it' NHS mentality. Nipping problems with difficult colleagues in the bud is hard. Constant activity and ongoing stress can lead to such outbursts: do you remember Mary and Martha?[7] Stress is common but too much is detrimental. We all struggle in recognising when enough is enough. We should heed Jesus' advice: take time out and get some rest.[8]

A bad witness

We have clichéd ideas of the perfect Christian: a witnessing expert who faces injustices and trials with a cheesy smile! We can all sympathise with Claire's guilty feelings, which reflect her humanness and weakness. Yet she is allowing the Devil to gain a foothold.[9]

What now?

What should Claire do now? Could she get the rest of the day off and spend time praying with Christian friends?[10] She needs sound godly advice on managing this situation in a Christ-like manner.[11] She should approach her educational supervisor for help; could she take time off work, away from the situation?

It would be wise to talk to her Christian consultant as he is senior, knows Claire well and already involved. Could he act as a godly arbiter whilst they air their grievances and find a solution? Some new SHOs find having their own juniors very difficult. Claire's SHO may not even know that her behaviour is unacceptable! Also, it is important for Claire to examine herself as well. It is easy to blame her SHO but there may be aspects of Claire's personality and habits that are irritating, leaving her partly at fault. If I were Claire's consultant, I would also encourage her to develop a more resilient character. Consider the biblical example of wearing our spiritual armour in the expectation that life will be tough.[12] We must persevere through it, knowing that it is producing a stronger Christian character.[13]

Depending on how things go, it may be possible to continue with the firm's current working arrangements. At an appropriate stage, both Claire and her SHO should be encouraged to offer forgiveness wherever appropriate; from Clare's side, this is Christ-like and an important witness.[14] Sadly, reconciliation may be impossible, leaving no alternative but to work apart.

Whatever the situation, it is important for Christian juniors to have godly mentors who can act as sounding boards for problems and pray through any issues that arise. CMF runs a pastoral care scheme for junior doctors, matching them up with local more senior members. I would encourage every CMF junior to make use of this service.[15]

Elizabeth Croton is a surgical SHO in Birmingham

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2. Romans 3:23
3. Luke 22:39-45
4. Matthew 28:20b
5. Proverbs 11:13, 26:20
6. Matthew 5:13-14; Romans 8:26
7. Luke 10:38-41
8. Mark 6:30-31
9. Ephesians 4:27
10. James 5:13
11. Isaiah 11:2
12. Ephesians 6:10-18
13. Romans 5:3-5
14. Colossians 3:13
15. Contact *sandra.hartley@cmf.org.uk*

What would you have done? Is there an issue you'd like to discuss? Email rachael.pickering @cmf.org.uk

EUTYCHUS

Frozen embryos in the balance

Natallie Evans has lost her case in the Court of Appeal to have her frozen embryos implanted without her partner's consent. The 32-year-old Wiltshire woman, who became infertile after chemotherapy for cancer, had later split from Howard Johnston after the couple had undergone IVF treatment.

Whilst fathers have no say in abortion decisions, the Human Fertilisation and Embryology Act ironically requires the consent of both an embryo's parents at each stage of artificial reproduction. In making the judgement Lord Justice Thorpe also ruled that the embryos should not yet be destroyed, in order to give Ms Evans an opportunity to appeal to the House of Lords. (*BBC* 2004; 25 June, *Triple Helix* 2004; Winter:12-13)

A place for abstinence in drug misuse

Abstinence needs to be back on the agenda for drug and alcohol misuse according to the RCGP regional lead in drug misuse, Gordon Morse. Abstaining from drugs and alcohol fell out of favour with the introduction of harm-reduction programmes, which aimed to ease patients off drugs with substitutes such as methadone. But Morse told a recent sex, drugs and HIV task force group conference that abstinence programmes run by Narcotics Anonymous and Alcoholics Anonymous were cheap and potentially effective. 'I want to debunk some of the myths surrounding abstinence', he said. (*Pulse* 2004; 7 June)

Lessons from the past

Germany has overreacted to Nazi doctors' abuse of human rights by restricting embryo research, according to a leading German academic. Rolf Winau, Professor of the History of Medicine at the Free University of Berlin, made his comments at the European Society of Human Reproduction and Embryology Conference in Berlin. Procedures involving destruction of human embryos, like pre-implantation genetic diagnosis and therapeutic cloning are currently illegal in Germany but legal in the UK. Winau argued that selection and destruction of embryos with genetic abnormalities is not eugenic, and that Germany's embryo protection law should be revised to take this into account. (*The Times* 2004; 28 June)

Human animal hybrids

Creating human-animal hybrid cells is legal in Britain due to a legal loophole. Under the Human Fertilisation and Embryology Act, experiments that create hybrid cells require a licence only when human and animal gametes are fused directly, or where the result is an embryo that could develop into a human. The Human Fertilisation and Embryology Authority (HFEA), which says it would back a review of the law, commented: 'When the Act came into force (in 1991) people didn't think about how far science would have moved on by now.' (*The Times* 2004; 1 June)

Australia reverses morning-after pill decision

The Australian government is to ban sales of the morning-after pill levonorgestrel (Postinor-2) only six months after making it available over the counter at pharmacies. The decision was prompted by concerns that girls as young as 13 were using it as emergency contraception. (*British Medical Journal* 2004; 328:1454, 19 June) The pill is still sold widely over the counter in the UK, and is also available in schools.

Demographic burdens of our own making

Industrialised nations with low fertility rates and ageing populations face debt burdens worse than during the Second World War. A report by Standard and Poor's found that European countries, including Germany, France and Greece could see debt grow to over 200% of gross domestic product by 2050, whilst Japan faces a debt of more than 700% of GDP. Richard Jackson, senior fellow in charge of the demography project at the Center for Strategic and International Studies in the US said: 'In a scenario which is about as optimistic as you can get, that still leaves fiscal meltdown in just about every country in 25 years.' (*Financial Times* 2004; 1 April) The demographic changes that have created the crisis have been fuelled in large part by abortion and choices to delay childbearing and limit family size. Will the generation that saw children as a burden itself be seen as a burden by the next generation? And what solutions might be sought?

Getting that new look

Grey hair may be a thing of the past if genetic research planned by a cosmetics company is successful. L'Oreal has pinpointed genes that influence when and whether a person's hair is likely to turn white, opening the way to treatments that might reverse the process. Meanwhile a team in Louisville, Kentucky, has applied for formal approval to perform the first face transplant by the end of this year. (*The Times* 2004; 27 May)

Christian student provokes media storm over abortion

A motion proposed by a CMF student member and passed by the annual general meting of the British Medical Association on 1 July has provoked a media storm over babies being left to die after being born alive following 'failed abortions'. The motion, proposed by Cambridge student Bryony Dunning-Davies, called for such babies to receive life-saving treatment, and was originally passed by the BMA Students' Conference earlier this year. Two articles in *The Sunday Times* catalogued six cases following an investigation by journalists, and the story later made the front page in other daily newspapers. (*Sunday Times* 2004; 20, 27 June) Babies in England and Wales can be legally aborted up to 24 weeks for 'social reasons' and up to birth if there is a risk of serious handicap. 1,354 babies of 22 weeks or more were aborted in England and Wales in 2002. A recent major review has shown survival rates of 66% for babies born at 23 weeks gestation during the period 1996-2000. (*Paediatrics* 2004; 113(1):e1-6, 1 January)

Government funding debacle

The Christian charity *Love for Life*, which by invitation runs a popular and successful abstinence-based sex education programme in over 150 Northern Ireland secondary schools, has been denied government funding to support its work. Meanwhile government funding has been granted to support a campaign aimed at informing girls under the age of consent that they have the right to 'confidential advice on contraception, condoms, pregnancy and abortion'. The campaign planned by the Teenage Pregnancy Unit (TPU) will use teen magazines as its main outlet, and follows in the wake of the high profile case of a 14-year-old Nottingham schoolgirl who had an abortion without the knowledge of her mother after talks with 'advisers' at school. (*The Times* 2004; 14 May)

LETTERS

Prescribing Methadone

Methadone masks and never tackles root causes, argues ***Sophia Lamb****, a pre - registration house officer from Ireland, who previously worked in Hong Kong among people with addiction problems.*

Recently I returned to the ward to discover that one of my drug addict patients had been resuscitated after taking a heroin overdose in the bathroom with his friend. He was on methadone. He recovered and the SHO increased his methadone. Subsequently he was discharged. Problem solved?

I agree with Iain Craighead (*Triple Helix* 2004; Winter:21) that we need to help drug users and actively build strong therapeutic relationships. But I disagree with settling for methadone as treatment. Methadone may be effective in harm reduction and symptom management. It does not however treat the problem of addiction any more than morphine treats cancer. Something more radical is necessary.

Before re-entering medicine in Hong Kong I took a year out working in a 24-hour drug rehabilitation centre. The work is Christ-centred. Jesus is the only solution offered. Substitutes for addiction are not given. Our addict brothers are encouraged to look to Jesus while facing the root causes of their addictions. The work is intense, gruelling, tiring, costly and rewarding.

What's the outcome? All experience something of God's love. Some are free forever. Many relapse. Many come back. I don't think I am being naive to say that God can heal the roots of addiction that methadone only masks and never tackles.

I hate to see methadone prescribed for patients when I know they need something more costly and time consuming. They may function better but they will not find life. They need Jesus. I don't think he comes reviewed in the medical literature, but I have seen him giving life to drug addicts and their families.

Child Abuse and ADHD?

Southampton GP ***Paul Burgess*** *writes.*

Figure 2, 'The effects of abuse', in Peter Sidebotham's recent article (*Triple Helix* 2003; Autumn:8-10) lists ADHD as one of the effects of child abuse and seems to suggest that it (and two other problems) have their roots in lack of trust and hope, which in turn have their roots in the adverse affect abuse has on self-esteem. Whilst not wishing to doubt the latter, suggesting that ADHD might result from child abuse, even in only some cases, is surely controversial?

Peter Sidebotham*, Consultant Paediatrician at the Bristol Royal Hospital for Sick Children responds.*

I am grateful to Paul Burgess for pointing out the apparent controversy implied by my linking ADHD with child abuse. As a practising community paediatrician, children with Attention Deficit/Hyperactivity Disorder make up the largest single category of cases I see and methylphenidate is the most common drug I prescribe. I do so in the recognition that ADHD is primarily a disorder of brain dysfunction, for which there are clear diagnostic criteria, and that it is responsive to appropriate therapeutic intervention (both behavioural and pharmacological).

There is a substantial body of literature to support this understanding (I would refer the reader to the Royal College of Psychiatrists Online Knowledge Base [1] for the most up to date and comprehensive details). However, like most behavioural disorders, ADHD presents as a spectrum that merges with normality and for which I believe it would be foolish to think there was just a single pathophysiological pathway.

In listing ADHD as one of the effects of abuse, along with oppositional defiant disorder, depression, eating disorders and other behavioural/psychiatric conditions, I do not mean to imply that child abuse is the root cause of all ADHD, nor even a substantial proportion of it. However, if you turn the equation round, there is a lot of evidence that children who have been abused may develop features of ADHD. [2-6] For example, Cohen et al [3] found that the combination of parental marital disruption and having been physically abused increased the risk of ADHD 15 times.

In one well designed case-control study in Minesota, [4] showed that, compared to controls, physically abused children at 42 months were hyperactive, distractible and lacked self control, this persisted at 4-5 years. Similarly neglected children showed poor impulse control and were extremely distractible. At six years of age the abused children were rated by their teachers as significantly more inattentive, unpopular, aggressive and overactive. The authors found the roots of this to lie in early anxious attachments, a finding that ties in with the hypothesis that damage to a child's hope, trust and self-esteem may underlie some of the genesis of these disorders. This correlation is also supported by Haddad and Garralda. [5] Iwaniec [6] takes this theory further, identifying several developmental tasks that may be affected by abuse. These are, in chronological order, a sense of trust or security (trust), a sense of autonomy (self-esteem), a sense of initiative (hope) and in older children a sense of duty and accomplishment (hope) and a sense of identity (self-esteem). She too points out the links between abuse, insecure attachments and later educational and behavioural problems, including attention seeking behaviour and difficulties in concentrating and attending to tasks.

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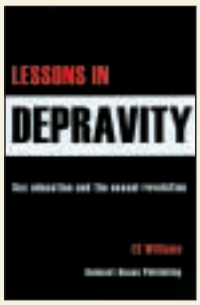
Feedback

We welcome correspondence relating to articles previously published. Space is limited and accordingly most letters are abridged.

BOOKS

Lessons in Depravity – Sex Education and the Sexual Revolution



ES Williams
Belmont House Publishing 2003
£8.00 Pb 328pp
ISBN 0 529939 5 3

The bulk of this book comprises a painstakingly detailed account of the sexual seduction of our society over the past two centuries by sexual revolutionaries from Robert Owen (1771-1858) to Gill Frances of the present-day National Children's Bureau.

It is a valuable resource book for specialist readers, tracing not only the key players but also highlighting their tactics - 'values clarification' replacing a Christian moral framework, promotion of adolescent sexual activity as a given norm, and the hijacking of terms such as 'family' to promote an overtly anti-marriage agenda. The sacrifice and personal suffering of those who dare oppose the sex education lobby also comes across very powerfully, especially in the chapter on Victoria Gillick.

Five major deficiencies of the book sadly minimise its impact however. First is the book's presentation and style. Excessive detail and page after page of dense text unbroken by subtexts or headings will put off all but the most determined of readers (or reviewers!).

Secondly, Dr Williams attacks his fellow Christians with the same apparent ease that he berates the sexual revolutionaries. Anyone who, like myself, knows the opprobrium and vitriol which the Family Planning Association (FPA) have poured upon those involved in developing CARE's sex education resources will recognise something is adrift when the author asserts, 'The British Government, the IPPF, the FPA, Brook and CARE all teach sex education in a framework that is either indifferent to, or ignores, biblical morality'. CARE is not alone in bearing William's wrath either - Oasis Trust, ACET, the Christian Institute and indeed every Christian organisation that I can think of trying to apply biblical wisdom meaningfully to sex education, is undermined by the author's failure to make any distinction between such groups and the sexual revolutionaries they oppose.

Thirdly, there is an element of implicit coercion in the book, which demonises choice. On numerous occasions, Williams castigates all who seek to help young people make 'informed choices'. He sees choice as an unbiblical concept *per se*. What then are we to make of God himself offering his people a choice between life and death and who does not makes their choices for them? (see Deuteronomy 30:19, Joshua 24:15). Surely it is better to use opportunities to inform young people about the joys of sex within marriage and the dangers of sex outside it, than to leave the field to those who will feed them the entirely opposite information that Dr Williams so rightly condemns? We cannot compel others to obey God's law.

There are also some disturbing inconsistencies in the book. For example, whilst others are chided for using medical and health reasons for promoting abstinence rather than quoting the Bible, the author himself gives many pages to explaining the failures of condoms and the havoc wrought by sexual infections and unplanned pregnancies. Quoting the Bible and using pragmatic arguments are not mutually exclusive - both are needed.

AFTER THREE HUNDRED PAGES OF CRITICISM, THE AUTHOR HAS LITTLE HOPE TO OFFER FOR ANYTHING BETTER

The greatest weakness of the book however is that after three hundred pages of criticism, the author has little hope to offer for anything better. A mere two pages at the end suggest that 'just as parents do not need to teach their children to walk or talk, for they learn these skills naturally as they grow older, so they do not need to teach children the details of sexual physiology, for children come to understand their sexual nature as they mature into adulthood'. I wonder if the author adopts the same 'head in the sand' approach about geography? We do need to teach our children about sex and we need to do it in a way honouring to Christ in a society that is increasingly hostile to biblical standards. The stark 'black and white' cover of this book suggests that the author lives in a world where everything is clear-cut. For those parents like myself, who need to find the Lord's help in many grey areas in bringing up our teenagers, this book will offer little practical assistance.

Trevor Stammers is a General Practitioner in West London who writes and broadcasts on sexuality. Reprinted with kind permission from Evangelicals Now.

Caring for Jewish Patients

Joseph Spitzer
Radcliffe Medical Press 2003
£24.95 Pb 232pp
ISBN 1 85775 991 5

An Orthodox Jewish man leaned out of a cubicle in casualty, pointed directly at me and bellowed, 'He can examine me!' As a clinical student who happened to be passing through, I felt rather bewildered when the frustrated casualty officer persuaded me to yield to this unexpected demand. The patient had not allowed anyone else to approach him. He mistakenly assumed my features were Jewish. 25 years later, I wonder about the implications of informed consent!

Dr Spitzer's excellent book explains the cultural perspective which impelled the patient to act in a determined way. It is an enlightening aid especially for those working in areas with a high concentration of Jewish patients. The author is a General Practitioner, an Orthodox Jew serving a very traditional Jewish community in North London. This volume is rooted in his personal understanding and professional experience, often punctuated with lively and revealing anecdotes.

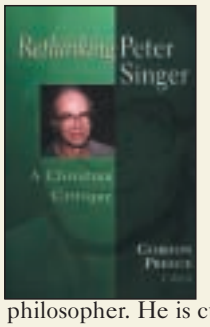
BOOKS

This account examines the attitudes and responses of Jewish patients to life, family, disease and death. Using the traditional Orthodox community as a benchmark, Dr Spitzer allows the reader to extrapolate firmly held beliefs and practices into Jewish communities whose interpretations are more liberal. We discover the profoundly religious obligation to seek medical help, often misunderstood by non-Jews as hypochondriacal or obsessional behaviour.

For those interested in biblical history and Judaism, the first part of the book is one of the best summaries of Jewish history, tradition and thought that I have read. Definitely for Christians whose theology of mission sits more easily with the Messianic end of the spectrum rather than that of 'Jews for Jesus'. Although there is some repetition and at times the prose is a little turgid, I can thoroughly recommend this book. Working in a North London Practice with Jewish colleagues and a large number of Jewish patients, I will encourage staff, students and registrars to learn from Dr Spitzer's insights.

Paul Dakin is a GP in North London

Rethinking Peter Singer



Gordon Preece (Editor)
InterVarsity Press 2002
£9.89 Pb 180pp
ISBN 0 83082 682 3

Peter Singer is arguably the world's most famous contemporary philosopher. He is currently Professor of Bioethics at Princeton University, and well known for his support of abortion, euthanasia and infanticide. He has also been vocal about his opposition to 'speciesism' - the preference of human interests over those of other animals.

Rethinking Peter Singer is a long overdue examination of Singer from a specifically Christian angle. Gordon Preece and colleagues from Ridley College, an Anglican theological college in Melbourne, Australia, attempt to engage with Singer's writings and offer an evangelical critique of his work in a series of five essays.

Singer has been praised for his adherence to his ethics. However, in the first essay Preece notes that much of his philosophy is not only opposed to our moral intuitions, but is 'unthinkable' and ultimately 'unliveable' in daily life. The book sets much of Singer's work in the context of his life, and Preece cites the often highlighted inconsistency of his refusal to agree to euthanasia for his mother suffering from Alzheimer's disease.

Although Singer's views appear counterintuitive, Andrew Sloane points out that they are consistent with his theories. Preference utilitarianism, which underpins his philosophy, deems that any action is right if it furthers the interests of as many as possible of those affected by it. However, Sloane argues that this is intrinsically unsound, and fails to defeat alternatives, advocating an objective moral order with emphasis on actions, not consequences.

SINGER'S AIM IS TO DO AWAY WITH TRADITIONAL THEORIES, SUCH AS THE SANCTITY OF LIFE PRINCIPLE, WHICH REPRESENT 'RELICS' OF THE CHRISTIAN VIEW

The two most helpful chapters are those tackling Singer's criticisms of Christianity and his views on personhood. As an outspoken atheist, his rejection of Christian scriptures is not surprising, but Graham Cole demonstrates how he caricatures the Christian position, making selective use of the Bible to support his cause.

I've heard Christians argue that it is impossible for us to engage with Peter Singer as his views are light years away from our own. However, others believe that Singer has made a major contribution to the Judaeo-Christian position by demonstrating the logical, 'unthinkable' alternative to our ethic. Indeed, Singer's aim is to do away with traditional theories, such as the sanctity of life principle, which represent 'relics' of the Christian view. With this in mind, we must understand his arguments and the theories supporting them. This is no bad place to start: as Gordon Preece himself puts it, '[this book] represents a religious determination to stay put and debate with the high priest of secular ethics'.

Helen Barratt is a clinical medical student at Imperial College, and Editor of Nucleus

Genetic Engineering – A Christian Response

Demy TJ, Stewart GP (Editors)
Kregel 1999
Price $22.99 Pb 320 pp
ISBN 0 8254 2357 0

This multi-author volume has three sections examining genetic engineering and society, the family and the individual. Each chapter can be read in isolation. Some general comments:

- The title is misleading – 'genetic engineering' implies the manipulation of genetic material but instead of considering all aspects of this (eg. the development of GM crops), this book deals entirely with human and medical genetics, specifically the potential impact of the human genome project.
- The science is a little dated (book is copyright 1999) but the principles still apply.
- Considerable space is given to reproductive issues and is therefore as relevant to the Christian obstetrician, midwife and reproductive medicine specialist as to the geneticist.
- The book is geared towards an American audience with an entire US authorship. Health insurance features prominently in the discussions of confidentiality and discrimination and

even prenatal diagnosis. Patenting is examined from theological, social and US legal perspectives. A history of the US eugenics movement is provided.

Are there issues and principles on which the authors seem agreed?

- There are real dangers philosophically and practically if genetic causes of disease and behaviour are over-emphasised.
- There was a consensus against termination of pregnancy for fetal abnormality, agreement regarding life as beginning at conception and opposition to procedures that result in the destruction of early embryos.
- In general, the human genome project does not raise new ethical issues but amplifies existing ones. The potential abuse of genetic knowledge is seen in the context of the prevailing post-modernist philosophy. The book provides no new insights to these problems but it is helpful to have the arguments (scientific, biblical and ethical) laid out clearly.

For me, there were some surprises in the book. One author would not rule out future germ-line therapy or genetic enhancement and also suggested that genetic counsellors should reject non-directive policies (admittedly her work in cancer genetics allows greater scope for being directive). Another author agreed that some types of genetic enhancement are not so serious as to warrant prohibition. As for cloning, more than one author had an open mind – one chapter ends with the statement that 'as long as there are no embryos left over to be thrown away and none destroyed in the process there is no reason why cloned embryos cannot be used to enhance infertility treatments'.

Whilst personally I have quite a few reservations about this book, it remains a stimulating read and could be used as a primer for church or Christian medical groups in discussing a number of both practical and theological issues.

Alan Fryer is a Clinical Geneticist in Liverpool

For What it is Worth: the Status of the Human Embryo

Philippa Taylor 2002
Available from the Centre for Bioethics and Public Policy and online
32pp
ISBN 0 90519 505 1

When does human life begin? What or who is a human being? This concise booklet addresses these questions, which are fundamental to the biotechnology of human reproduction, including pre-natal and pre-implantation diagnosis, assisted reproduction, human embryo research and cloning.

Five chapters examine 'The Beginning of Human Life' from different perspectives and a glossary of technical terms and appendix of further reading resources are included. Chapter 1 looks at biological aspects, giving evidence that a new human embryo comes into being at fertilisation. Chapter 2 concerns theological aspects, demonstrating that the whole consensus of biblical teaching is that human life begins at conception. Biblical theology emphasises that the status of human beings depends on the fact that they are created 'in the image of God' and not on their attributes or functional abilities. 'The human embryo, at its earliest stage in existence of the human being, already carries the rights and dignities which membership of this most special species entails. Biblical testimony walks hand in hand with the evidence of biology. The supreme man, the man who was also God, began his existence at this point too.'

Chapter 3 is in question and answer format, and addresses common objections, part A on biological or scientific grounds, and part B on the question of personhood. Objections quoted and answered include: 'Bearing in mind the high natural loss of fertilised ova, I find it hard to believe that they are of any great importance to God' and, 'An embryo is only a potential human being before 14 days, although it may be accorded "profound moral respect"'. Chapter 4 gives some applications and the question we should ask of any proposed technique: 'What is this technology doing to human dignity?'

Chapter 5 summarises the conclusions. 'There is no point from fertilisation onwards at which we can reliably conclude that a human being is not a member of the human family, and who is known and called by God, one with whom we are locked in community.' We face a battle of worldviews but we can have confidence in the Christian worldview. As John Wyatt, Professor of Neonatal Paediatrics, indicates: the Christian worldview is true, fitting with science and reality; it works, leading to beneficial consequences for individuals and humanity; it feels right, in accordance with the deepest intuitions of the human heart.

Christian thinking emphasises our responsibility to care for and protect vulnerable, weak and defenceless human beings including the embryo and human foetus (Proverbs 31: 8-9). I would highly recommend this helpful booklet to all CMF members. Even those who hesitate to accept its basic thesis will find food for thought and a challenge to apply radical biblical reasoning to contemporary bioethics.

Stephen Browne is a General Practitioner in Birmingham

OPPORTUNITIES ABROAD

Specific Vacancies by Country

Posts usually require you to be **UK-based** with your own **financial** and **prayer** support. The contact details given are to enable you to research the post. For many other current vacancies visit the vacancies page at *www.healthserve.org* which is updated weekly or see previous issues of *Triple Helix*.

Bangladesh

LAMB Hospital is an integrated rural health and development project in NW Bangladesh. This 75-bedded hospital provides medical, paediatric, obstetric and gynaecological services. **Obstetrician/Gynaecologist (female) needed from August to late November 2004**. The unit has 2,350 deliveries (60% complicated in 2003) with both inpatient and outpatient facilities and a community based work. The obstetric team consists of two British Obstetricians and four Bangladeshi doctors. **Contact:** Dr Christine Edwards, Medical Director, LAMB Hospital, PO Parbatipur, DT Dinajpur 5250, Bangladesh. Email: *chrise@lambproject.org*

Paediatrician (male or female) also needed from December 2004 to late April 2005. The post would suit a Paediatric Trainee or GP with special interest. A Paediatrician and two Bangladeshi doctors provide a busy newborn service managed with low tech. facilities; inpatient and outpatient and rehabilitation services. **Contact:** Dr Ruth Lennox, Head of Paediatrics, LAMB Hospital, PO Parbatipur, DT Dinajpur 5250, Bangladesh. Email: *ruth@lambproject.org*

Burkina Faso

A General Surgeon is needed at the Clinique Medico-Chirurgicale (ONG). The post would suit a retired general surgeon who also has some experience in O&G. The hospital complements the work of a Government run medical center nearby. The appointee would mainly be dealing with elective surgery - hernias accounting for the majority of cases. French would be a distinct advantage. Accommodation is provided but otherwise the post is self funding and for 3 months (negotiable). **Contact:** Dr Hui Tan. Email: *htan@doctors.org.uk*

Nepal

Doctors are needed (in specialty training grades or fully trained) by **Team Nepal** to work in three rural hospitals (20-50 beds). These posts provide a much needed service to poor rural communities and offer excellent training opportunities for those specialising in O&G, General Surgery, Medicine or Paediatrics. Contracts of varying length are available from between 1 - 12 months or even longer. **Contact:** Dr Ted MacKinney. Email: *mackinney@bigfoot.com*

Papua New Guinea

The Evangelical Church of Papua New Guinea along with Pioneers/UFM needs Christian doctors to join the Medical Team at **Rumginae hospital**, a 60-bed, two doctor rural hospital providing a broad range of basic services, serving at the hub of a network of smaller Health Centres and Aid Posts scattered among the remote needy communities of the Western Province of Papua New Guinea. Rumginae is also the base for training Community Health Workers. Short or long term opportunities available.

Experience or additional qualification in General Practice, Paediatrics, Anaesthetics or Surgery is desirable with at least two years' post registration experience in hospital medicine. Bible School training is preferable but not essential. **Contact:** David Brown, Personnel Secretary, UFM Worldwide, 47a Fleet Street, Swindon, Wilts, SN1 1RE, UK Email: *davidbrown@ufm.org.uk* Website: *www.ufm.org.uk*

Rwanda

Hopital de Gahini (The Rwandan Anglican Church). There is an **urgent need for a general duties medical officer for two months or more**. Surgical skills would be helpful but not essential. Free accommodation is offered. **Contact:** Dr Gunther Link, Hopital de Gahini, BP22, Kigali, Rwanda. Email: *g_link@web.de* Mobile: (+250) 08744095

Kibogora Hospital a 200-bedded facility functioning as a District Hospital in SW Rwanda, dependent on visiting medical personnel for surgical and specialist cover. **Both Generalist and Specialist doctors are needed**. Provision of Surgical cover is a priority from January 2005. Specialist short-term visits of at least one month, preferably longer, would be welcomed to mentor, support and teach local medical staff. French is spoken by most of the staff but English translation is available. **Contact:** Sheila Ethrington. Email: *sae@uuplus.com* Mobile: (+250) 08541206

Tanzania

St Luke's Dispensary in Mpwapwa (Anglican Diocese). The Dispensary is situated in a small market town and the work would includes overseeing an HIV education project, MCH and Family Planning Clinics. **This locum post would suit a General Practitioner with some maternity experience but there is no major surgery**. Now vacant but needed until January 2005. A two bedroom house is available. Swahili would be an advantage but interpreters are available. A knowledge of ultrasound would also be useful. The returning doctor is willing to remain in email contact if need be. **Contact:** *www.tarlings.com/st_lukes_clinic.htm*

A unique opportunity

There is a **vacancy for a Medical Officer on the OM's mission ship DOULOS from October 2004, for 1 - 2 years**. The ship will be sailing through the Mediterranean, along the Red Sea to the Horn of Africa and East Africa visiting some 15-25 ports in Europe and Africa over the next 12 months. Most of the 300 crew members are single people between the ages of 18-25 years. Accommodation (including family) and meals provided. There is also educational provision for children. **Contact:** Mavis Newton. Email: *mavis.newton@shipsoffice.org* or see *www.ships.de*

EVENTS

CMC Ludhiana Tour – North India - 29 October – 13 November 2004

Experience a unique 'Prayer and Awareness Tour' in NW India, visiting the Christian Medical College at Ludhiana and beyond. An opportunity to see for yourself and learn what God is doing in and through the lives of the CMC staff and students at Ludhiana and other mission hospitals. 'Come face to face with people who are making a difference, serving at the margins, getting the dust between their toes'. Learn about North India's rich and diverse culture from the people themselves. Come back with a deeper insight into CMC's ministry and with an increased desire to pray.

Led by Paul and Sue East (Paul is a member of CMF's International Healthserve Committee). **Contact:** Heather Smith at *foluk@charis.co.uk* for further details.

When God's word is EXTREME

CHRISTIANS HAVE FALLEN IN WITH THE ENLIGHTENMENT CONSENSUS THAT FAITH IS ESSENTIALLY PRIVATE

Shortly after the 9/11 attacks on the twin towers of the World Trade Centre in New York and Washington's Pentagon, an American publisher released a new Bible that it billed, 'The extreme Word of God for these extreme times.' *ExtremeWord* is a Bible aimed at teenagers. There's a flag on the cover plus notes on war, enemies, peace and nations. 'People are turning to God during this time,' the publishers explain. 'Few people realise that God has a lot to say about attack, enemies, war, nations and leaders.'

Now I'm not sure that the *ExtremeWord* Bible has got things entirely right. It may not be exactly to your taste or mine. Its temper is hardly British, but it points to something that's often lacking in Christian culture here. Britain has become a place where the name of God is rarely heard in public discourse and where the hard sayings that come with a full-blooded Christian faith get toned down. The pressure applies as much to Christian doctors as anyone else.

Part of the problem is that Christians have fallen in with the enlightenment consensus that faith is essentially private, to be kept to one's self and restricted to Sundays. I wonder how the story of Elijah and King Ahab (1 Kings 21:1-28) would have read if the Prophet had believed that religion was just a private matter and eschewed use of extreme words? Imagine. Verse 19b: 'This is what the Lord says: "In the place where the dogs licked up Naboth's blood, dogs will lick up your blood, yes yours" … *but of course to say it that way would be somewhat intemperate.*' Verse 20b: 'You have sold yourself to do evil in the sight of the Lord … *but of course religion has nothing to do with public life.*'

Is there a word here for Christian doctors? 'All my spiritual instincts tell me I should offer to pray with this patient … *but of course that would be imposing my views.*' 'I know this person could have their faith kick-started by an invitation to an Alpha course … *but of course that would be intruding into someone's private life.*'

Would acting on these instincts be all that extreme?

John Martin is Associate Editor of Triple Helix and Head of Public Affairs and Research for the Church Mission Society.

CHRISTIAN MEDICAL FELLOWSHIP

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