Summer 2005

for today's Christian doctor

triple helix

problem drinking

AIDS in Russia, brain drain, assisted suicide, the embryo, juniors' forum, David Short, mischief at the BMA, wisdom and courage, flexible working, EMFI, working abroad, obituaries

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157 Waterloo Road
London SE1 8XN

Tel 020 7928 4694
Fax 020 7620 2453
Email admin@cmf.org.uk
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Mischief at the BMA

'The greatest crime'

Photo: GMS

Bloodshed at the BMA

The whole performance raised serious questions about corporate governance, professionalism and integrity

The BMA has washed its hands on euthanasia and physician-assisted suicide and refused to support a reduction in late abortion.

Delegates at the BMA annual representative meeting in Manchester on 30 June 2005 voted 58% to 42% against legalising euthanasia but 53% to 47% in favour of adopting a neutral position, reversing a policy of opposition that had stood for 173 years.

The euthanasia motion was passed by 93 votes to 82 on the last day of conference when many delegates had returned home. Michael Wilks, who is known personally to support a change in the law, chaired the representative meeting that staged the vote, the agenda committee that framed the motions to be voted on, and also the BMA ethics committee, which provided 'expert' input. Another BMA Council and Ethics committee member John Chisholm spoke to the neutral motion.

Despite the fact that a majority of doctors remain opposed to assisted dying, and that medical opposition has actually intensified in recent years, [1,2] it is now official BMA policy that '*the question of the criminal law in relation to assisted dying is primarily a matter for society and for Parliament. The BMA should not oppose legislation which alters the criminal law but should press for robust safeguards both for patients and for doctors who do not wish to be involved in such procedures.*'

On the same day delegates rejected by 77% to 23% a motion calling for a lowering of the abortion limit for healthy babies from 24 weeks. A BMA briefing paper on abortion given to delegates claimed to give 'accurate factual information' but in fact quoted statistics about premature baby survival that were ten years out of date. The EPICure study, [3] which also featured on the recent Panorama programme *Miracle baby grows up*, gave survival rates of 11% at 23 weeks and 26% at 24 weeks from a multicentre population-based study in 1995.

Junior doctor May Moonan challenged the evidence quoting a well-publicised 2004 Minnesota study [4] showing consistent year-on-year improvement and survival rates after neonatal intensive care of 66% at 23 weeks of gestation and 81% at 24 weeks of gestation for the period 1996-2000. But senior doctors John Chisholm and Wendy Savage then further misled delegates by flatly denying from the platform that there had been any change in survival rates, without producing any evidence whatsoever to back up their claims.

The whole performance raised serious questions about corporate governance, professionalism and integrity at the BMA – but also highlighted a quantum shift in views held by doctors' leaders.

The Hippocratic Oath says, 'I will give no deadly medicine to anyone if asked nor suggest such counsel, nor in like manner will I give a woman a pessary to produce abortion.' In 1947 the BMA Council classified the 'deliberate killing of infirm or feeble-minded patients and of children in hospitals and asylums' as a 'war crime' and affirmed that, 'although there have been many changes in medicine, the spirit of the Hippocratic Oath cannot change'. It further stated that 'co-operation in the destruction of life by murder, suicide and abortion' was 'the greatest crime'. [5] How times have changed.

Many Christians will be angry that a handful of delegates can make decisions for 133,000 BMA members. But 30 June was a cruel reminder that BMA policy is shaped by those who attend meetings and get into positions of influence on key committees. Brave voices spoke out against the new orthodoxy; but when votes were counted it was clear that the apathy of those with more conservative views had played into the hands of the new liberal elite.

Doctors in this country have already shed the blood of 6 million unborn children since 1967 and will shed a lot more if, as a result of this shift in medical opinion, euthanasia is legalised. We all share the responsibility to do something about it.

Rescue those being led away to death; hold back those staggering toward slaughter. If you say, 'But we knew nothing about this,' does not he who weighs the heart perceive it? Does not he who guards your life know it? Will he not repay each person according to what he has done? (Proverbs 24:11-12)

***Peter Saunders** is CMF General Secretary*

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news reviews

Saved sex

Getting increasing support

Review by **Trevor Stammers**
General Practitioner in West London

Contraception-focused sex education had an increasingly critical press this summer. In the UK, as latest figures showed the rate of pregnancies in under-16s in England and Wales increased by 1%, Beverley Hughes, the families and children's minister admitted that Government can do no more to reduce the UK's high teen pregnancy rate without the help of parents.[1] For a Government that has hitherto done all it can to prevent parents knowing whether their children are being provided with contraception or even an abortion, this is a perhaps a welcome beginning to seeing parents reinstated. A vast amount of research over at least the past decade has shown how vital parental input is in reducing teenage pregnancy rates[2,3,4] and it is encouraging to see this now acknowledged at ministerial level.

In the USA, a paper by Bearman and Bruckner[5] on STI rates in the early twenties of teen abstinence pledgers was widely misquoted in the UK as supporting the view that pledgers were more at risk. In fact this research showed that, pledgers' STI rates were *lower* (though not significantly so). However, the study, though heavily criticised by the Heritage Foundation[6] will still be widely used by the liberal UK sex education lobby to discredit 'saved-sex' education. All CMF members with an interest in this field should study its findings at source.

The astounding effect of delayed sexual debut and increasing sexual faithfulness in reducing HIV rates in Uganda was again emphasised in a paper in the *PMJ*.[7] The article concluded, 'Given the apparent success of prevention strategies that address primary sexual behaviour, increased consideration and resources should be allocated to ABC STD prevention initiatives that include the promotion of risk avoidance through delayed sexual debut and reduced partner reduction as well as condom education.'

Finally, saved sex received a commendation from a most unlikely source. Though the declaration, 'One should propagandise total abstinence before marriage', might be assumed to come from an American right-wing fundamentalist, it actually was made by Ludmila Stebenkova of Moscow's parliamentary committee for health care, in an interview with *Pravda*.[8]

She criticised 'safe-sex programmes' as nothing more than opportunities for some agencies to steal from state coffers. Commenting on a recent programme in the Ukraine, she asked, 'Could someone tell me what kind of class on how to put on condoms could cost $300 000?' Though such stealing surely does not occur in the UK, one might well ask whether two decades of 'safer- sex' promotion has been cost-effective and why so few Christian doctors are active in promoting an alternative strategy.

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AIDS in Russia

Institutions are waking up to the churches' role

Review by **Steve Fouch**
CMF Allied Professions Secretary

At a landmark conference in April,[1] a coalition of Christian churches, faith based organisations and UN bodies called upon Russian Society, government and the Christian community to respond to the escalating AIDS crisis in that country. Along with Ukraine and the Baltic Sates, Russia is seeing the most rapid growth in HIV infections not only in Europe, but in the whole world. Between 860,000 and a million Russians are now believed to be HIV positive, and the rate of growth is rapid – having started among IV Drug users, it is now spreading to the wider population.[2] This echoes a global pattern, and where there is poverty, poor education, lack of healthcare infrastructure and social support mechanisms, that spread is more rapid.

The conference report recognises that 'the primary driving forces of the epidemic should be seen in corruption of the moral principles of society, destruction of fundamental spiritual values, growing indifference, cruelty and social alienation', and calls upon the churches to educate children and society as a whole in values of family life, fidelity, chastity and compassion. Russia needs the church in order to fight the pandemic.

What is striking about this report is that it was backed by the UNDP (one the United Nations development agencies). This is not unique – in 2004 UNAIDS called together the ever first trans-denominational gathering of Christian leaders in Africa to look at the theological implications of the AIDS pandemic,[3] and there are many more examples.

While it is easy to get too excited about this apparent acceptance of Christians in the fight against AIDS (in contrast, faith based responses to HIV prevention are still regularly attacked by various sectors of the international AIDS community) there can be little doubt that we are in a *kairos*[4] moment. God seems to be waking up the world's institutions to the fact that his people around the globe are not only having an impact in tackling the epidemic, but have the potential to achieve so much more.

We need to seize the *kairos* and cooperate where we can but we must also go further and challenge the apathy that lies within the Christian community both here and in the western nations.

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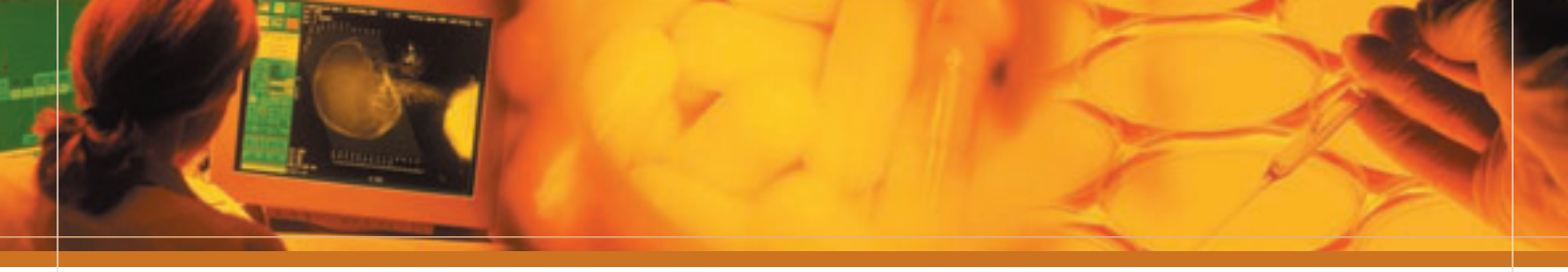

Scottish Assisted Suicide Bill

An opportunity to show that sanctity of life trumps autonomy

Review by **Calum MacKellar**
Director of the Scottish Council of Human Bioethics

When the Scottish Parliament was re-established in 1999 (having been united to the UK parliament since 1707), the *Scotland Act 1998* restored responsibility for all biomedical matters north of the border except in matters relating to abortion, xenotransplantation (but not transplantation), surrogacy arrangements, human fertilisation and embryology, human genetics and medicines for human use.

Although a number of Scottish voices can still be heard complaining about the extent of this list, these reservations to the UK parliament were prepared in order to avoid risks of bioethical tourism within the UK (such as with abortion) or issues which were deemed too complex to consider on a non-UK level (such as xenotransplantation, genetics and embryology).

In this context, it was also not long before a young Scottish Liberal Democrat MSP, Jeremy Purvis, noticed that end-of-life issues were the remit of the Scottish Parliament. As a result, he decided in 2004 to make assisted suicide his defining campaign based on the *Death with Dignity Act* (1997) of Oregon, USA.

Mr Purvis' reasons for wanting to legalise assisted suicide were presented in an interview he gave to the Scottish press in which he indicated that 'for some, the sanctity of life is absolute. Only God can take life, in all circumstances and with no exceptions. I respect this view, but I do not hold to it. Important as the sanctity of life is, it has to take second place to personal autonomy - the right of self determination.' [1]

The first shots of Mr Purvis' campaign were fired in at the beginning of 2005 when he published a consultation entitled 'Dying with Dignity'. This outlined his proposal to give a competent adult suffering from a terminal illness, who makes a persistent and considered request to die, the right to receive medical help to bring about his or her death. [2]

On a deeper reading, however, the consultation document is a 'Scotch broth' of different issues including human dignity, quality of life, dying/killing, autonomy and suffering. These are then all 'stewed' together into a sort of indistinguishable mush of arguments with no real logical consistency. The resulting mixture then tries to prop-up the main autonomy argument.

There are indeed many shortcomings with Mr Purvis' ill-prepared campaign but he does seem to genuinely encourage debate on the issues. This gives Christians an opportunity, which CMF in Scotland has already taken, [3] to define what the arguments actually are and to address the key issues while demonstrating the dangerous consequences of assisted suicide. In addition, it gives us the chance to remind the Scottish public that the sanctity of human life is indeed absolute and must not take second place to personal autonomy. Only then can we continue living in a society that believes in human dignity, a dignity that ultimately comes from God.

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The brain drain

A multilateral problem requiring a global response

Review by **Steve Fouch**
CMF Allied Professions Secretary

As we approach the Millennium Summit this November, at which the world's leaders will look again at the progress being made towards the *Millennium Development Goals*, it is salient to remember that there are still many obstacles to seeing global poverty halved, major gains in reducing infant and maternal mortality and the elimination of major infectious disease epidemics (including HIV and malaria).

One obstacle is the continual haemorrhaging of doctors, nurses and others from Africa and Asia to Europe and North America. This exodus is depleting already fragile health services at a time of great need. As has been highlighted in *Triple Helix* before, [1,2] this is a multilateral problem and one that cannot be solved by blanket bans on immigration or clamp-downs on active recruitment. It takes a global response, not just a national one.

At the recent G8 Summit in Gleneagles, CMF was signatory to a petition from the Washington based group, *Physicians for Human Rights*, [3] who are advocating for the leaders of the world's richest nations to address this crisis multilaterally. This includes stepping up multilateral aid to support health services in poor nations and helping those nations fund the training of their health professionals (in particular post-graduate training), as well as investing into the training, pay and conditions of health professionals in wealthy nations.

The UK is not alone in not training enough of home-grown doctors, nurses or dentists. The US has a projected shortfall of nigh on one million health professionals (around 800,000 nurses and 200,000 doctors) [4] between now and 2010. If that is only addressed by recruiting from overseas, the brain drain can only get worse.

The developed world is facing a number of genuine crises of our own – a dwindling health workforce, an ageing population and greater expectations of healthcare. [5] But rather than address this crisis, we have merely exported it to the poorest nations.

As Christians, we should not only be speaking out about this, but supporting the many Christian brothers and sisters from the developing world in medicine and other professions who are working alongside us. We should be looking at how we can help give back to their home countries the skilled health workforce that is so desperately needed.

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Andrew Fergusson evaluates the Oregon model of PAS

Hexham GP David Moor was acquitted at a euthanasia trial in 1997.

GOING WEST?

Should Britian introduce physician-assisted suicide?

key points

Lord Joffe plans to reintroduce his bill legalising physician assisted suicide (PAS) in England and Wales this autumn; following the Oregon model. PAS is ethically no different from euthanasia, as in both cases the intention is to end the life of the patient. Furthermore legalising PAS effectively legalises voluntary euthanasia; as some patients are too incapacitated to take their own lives, and because some PAS is unsuccessful requiring the doctor to 'step in'. So far 171 people have died under the Oregon law in six years but there appears to be substantial underreporting of deaths. Of reasons given for requesting PAS, 85% cited loss of autonomy, 22% reported inadequate pain control and 35% that they feared being a burden. The legalisation of PAS must be resisted here.

'Gone west' is a quaint description of death - the setting sun 'goes west' and then sinks below the horizon and expires. The phrase may now acquire new meaning as some in Britain look to the US west coast state of Oregon and seek physician-assisted suicide (PAS) here.

Lord Joffe's 2004 *Assisted Dying for the Terminally Ill Bill* sought to legalise 'for people who are terminally ill, who are mentally competent and who are suffering unbearably, medical assistance with suicide or, in cases where the person concerned would be physically incapable of taking the final action to end his or her life, voluntary euthanasia'.[1] It ran out of time in the last session of Parliament but Lord Joffe has promised to reintroduce a similar bill, restricting it this time to England and Wales. Northern Ireland was always excluded but leaving Scotland out is almost certainly a political manoeuvre by the euthanasia movement, as Liberal Democrat MSP Jeremy Purvis is promising to introduce for discussion a similar bill into the Scottish Parliament.

Both Parliamentary approaches begin with PAS rather than voluntary euthanasia (VE) and both look to the experience of Oregon to justify their public policy claim that PAS with VE backup can be policed adequately. With the end-of-life debate in Britain set to run and run, we must examine these issues carefully.

Definitions

CMF defines euthanasia as 'the intentional killing, by act or omission, of a person whose life is felt not to be worth living'.[2] The doctor both prescribes and administers a lethal dose of medication.

In PAS the doctor prescribes a lethal medication but the person administers the dose himself or herself.

The international experience of PAS

The Select Committee considering Lord Joffe's Bill reviewed the four jurisdictions which currently permit PAS and/or VE:

- Oregon, USA - has permitted PAS but not VE since 1997.
- The Netherlands - codified 30 years of practice in 2002 and allows both PAS and VE.
- Belgium - legalised VE but not PAS in 2002.
- Switzerland - finally legalised assisted suicide federally in 1942. Interestingly, and partly because the historic root was to facilitate duelling, assistance does not have to involve a doctor. Any citizen may help someone commit suicide provided they are acting from 'non-selfish motives'.[3]

Based on reported statistics from these countries, the Lords Committee concluded[4] 'there is a strong link between the scope of legislation in this area and its take-up by terminally ill people. In particular, where legislation is limited to

Photo: Epics

assistance with suicide, the take-up rate is dramatically less than in places where voluntary euthanasia is also legalised. If therefore a new bill should be brought forward, it should distinguish clearly between assisted suicide and voluntary euthanasia and thereby give the House the opportunity to address these two courses of action separately.'

They calculated [5] that legalising PAS alone in Britain would mean about 650 deaths a year while legalising PAS and VE would lead to about 13,000. Is this an invitation that society might find PAS more acceptable politically than VE? Given also that some doctors might feel less 'hands-on' involved, PAS could seem so much more acceptable than VE that it could be legalised.

Is PAS significantly different from VE?

1. Principles

The key concept is intention. In both, what the doctor means to do is to bring about the death of the patient. He or she is the moral agent without whom the death could not happen. Although some see philosophical counter arguments, PAS is simply 'euthanasia one step back'.

2. Practice

Three issues arise:

- **Incapacity**. Lord Joffe's Bill acknowledged that because some patients would be physically incapable of ending their own lives (eg through paralysis) VE back-up would be required.
- **Failure rates**. Even with a prescription, PAS has a failure rate. Some patients vomit, while others through tolerance acquired from previous medication fail to die despite large doses of drugs. In these situations, a doctor will always be required for the *coup de grâce*.
- **Incremental extension**. Lord Joffe has said [6] 'I believe that this Bill initially should be limited, although I would prefer it to be of much wider application, but it is a new field and I think we should be cautious'. What might begin with accepting 650 PAS deaths a year could lead to VE with 13,000 deaths a year.

In principle, PAS is merely euthanasia one step back and in practice, legalising it effectively legalises VE too. PAS must be opposed for all the reasons CMF has long argued. [7]

What is the Oregon experience?

The *Death with Dignity Act* was a citizens' initiative first passed in 1994 by 51-49% . Implementation was delayed by a federal injunction, but in 1997 Oregon's voters reinstated it, this time by 60-40%. (Many people who were opposed to PAS nevertheless voted for it in 1997 to protest at having their autonomy overturned.) The law allows a 'capable' adult patient who is a resident of Oregon and has less than six months to live to request voluntarily a prescription for lethal drugs.

The case of Kate Cheney [11]

Kate Cheney died in Oregon of PAS aged 85 in 1999 even though she was reportedly suffering from early dementia. Her own physician refused to prescribe, a psychiatrist counselling her to determine her capacity concluded she was not explicitly pushing for PAS and that her daughter was coaching her to do so, a psychologist believed she was competent but possibly under the influence of her daughter who was 'somewhat coercive', and it was finally the managed care ethicist overseeing her case who determined she was qualified so that the lethal dose was prescribed.

Information has to be collected and presented in an annual report. At first glance the statistics do indeed appear reassuring: numbers are low and have reached a plateau. There were 42 reported PAS deaths in 2003 out of about 30,000 in the state, and 37 in 2004. It is of course always dangerous to make deductions in the face of low figures, but we might justifiably be concerned that psychiatric evaluations are taking place in only 5% of patients on whom PAS is performed, that 22% of these report inadequate pain control, and that 35% of patients fear being a burden. We probably won't be surprised that 85% state fear of losing their autonomy as a main reason for requesting PAS. [8]

It is also dangerous to argue from silence, but we need to know that all this data is derived solely from those doctors who admit prescribing lethal drug doses. There are no penalties for non-reporting, and the Oregon Health Division (OHD) has no regulatory authority or resources to ensure compliance with reporting requirements. There are no checks and in any case reports can be anonymous. The OHD has said of doctors' reports, [9] 'the entire account could have been a cock-and-bull story. We assume, however, that physicians were their usual careful and accurate selves.' But we know from the Netherlands, where one of the reasons for finally legalising voluntary euthanasia was so that physicians would always report VE and PAS, that only 54% of cases are reported. [10] Under-reporting in Oregon seems certain.

What is the Oregon experience? The experience is that there is no reliable experience and we should not be hoodwinked through ignorance into accepting bland assurances that Oregon proves PAS can be policed.

Conclusion

Both the principled and practical arguments confirm that PAS must be resisted and the experience from Oregon provides no reliable reassurance whatsoever. Let's not go west.

Andrew Fergusson *is CMF Strategy Advisor on Euthanasia*

Photo: Epics

Diane Pretty sought assisted suicide unsuccessfully.

We should not be hoodwinked through ignorance into accepting bland assurances that Oregon proves PAS can be policed

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Chris Cook looks at this contentious medical and social problem

Problem drinking – the BIGGER picture

key points

The government's education-based 'sensible drinking' strategy for countering alcohol misuse is not evidence-based and is built on the false presuppositions that an intemperate minority contribute the bulk of alcohol related problems in the community and that people make rational and objective decisions about their drinking. The research shows that alcohol related morbidity and mortality are directly related to the quantity of alcohol consumed by a population, which in turn is directly related to the availability and acceptability of alcohol in that population. This means that price is the major determinant of consumption, and taxation is a very effective preventive tool. At a deeper level alcohol dependence is a bio-psycho-social example of what can happen when something other than God becomes a top human priority.

Millions of us enjoy drinking alcohol with few, if any, ill effects.

(Tony Blair, 2004)

So begins the Prime Minister's introduction to the Alcohol Harm Reduction Strategy for England (AHRSE).[1] After reminding us that moderate drinking can produce some health benefits, Mr Blair laments the fact that 'alcohol misuse by a small minority' is responsible for two major problems: anti-social behaviour including crime, and harm to health. He advises that alcohol-related harm costs the country an estimated £20 billion per year.

The implication seems to be that our costly problems with alcohol are all due to a small minority of people who misuse alcohol. Ultimately, Mr Blair concludes, it is down to individuals to 'make informed and responsible decisions about their own levels of alcohol consumption'. This emphasis carries through into the Government's more recent white paper where provision of information and controls on advertising are emphasised as preventive strategies.[2]

This seems a very reasonable – indeed, a very Christian – position to take. Surely people are responsible for their behaviour in respect of drinking alcohol, as in every other area of life? And didn't the apostle Paul offer similar advice when he exhorted Christians to avoid drunkenness?[3] AHRSE would therefore appear to be right to emphasise education about sensible drinking. However, there are a number of problems with this approach.

Problems with sensible drinking

There is virtually no supporting research evidence regarding education on sensible drinking as a strategy for preventing alcohol problems.[4] In addition, there is also the prevention paradox.[5] This is based upon the observation that, whilst very heavy drinkers do incur more alcohol related problems, they are (as the Prime Minister observes) a small minority. Alcohol related problems occur much less frequently amongst the moderate majority, but this population is very large indeed. So, the mathematics of a lower problem rate amongst a very large number of people can still result in a larger overall number of problems than does a high rate amongst a very small number. In other words, the people who do not misuse alcohol at all often contribute the bulk of alcohol related problems in a community. The paradox is that prevention of alcohol problems in a population can therefore require us to give more attention to the moderate majority than the intemperate minority.

Sensible drinking

An upper limit of 14 UK units per week for women and 21 UK units per week for men.[6] It is wise to ensure at least one or two alcohol free days each week.[7]

Another problem with the sensible drinking approach is that it presumes that people make rational and objective decisions about their drinking without undue influence or constraint. In fact, we live in a society that puts all kinds of pressures on people in respect of their drinking. That people are not well informed is only part of the problem. Alcohol is promoted by the alcohol beverage industry and social expectations. Alcohol also itself impairs people's ability to make sensible decisions. A very complex and difficult balance between the benefits and risks of alcohol consumption needs to be achieved. Advice that is right for one person will be harmful for another.

Sensible policy and practice

Happily, evidence-based strategies relying on a population-based approach could bring about great benefit. Extensive research has shown that, over time and between populations, alcohol related morbidity and mortality are directly related to the quantity of alcohol consumed by a population, which in turn is directly related to the availability and acceptability of alcohol in that population. The real price (in relation to disposable income) is thus the major determinant, and taxation is a very effective preventive tool.[8] Other strategies include licensing laws, server liability laws (where vendors become responsible for ensuring underage or intoxicated drinkers are not served), and targeted contextual policies (for example, against drinking and driving). Treatment services are also important, and early interventions are effective amongst those at high risk.[9]

At the individual level, much the same principle applies. There will always be the exceptional person who drinks enormous quantities of alcohol without harm, or the truly modest drinker who does sustain harm; but, in general, the more an individual drinks the greater their risk of the whole range of alcohol related pathologies. Therefore, when consulting with individual patients, there is a role for the sensible drinking message as a valuable guide to practice.

Abstinence

Some Christians, and others, believe that complete abstinence is the best policy to prevent problems with alcohol. Notwithstanding the possible health advantages of alcohol consumption in relation to cardiovascular disease (in post-menopausal women and men over 40 years of age), there is no reason to dissuade those who adopt such a practice. But this does not mean that abstinence will appeal to everyone. Not only does scripture appear to indicate that Jesus drank wine, but in the fourth gospel an account is given of Jesus miraculously turning approximately 120 gallons of water into wine, for guests who had apparently already had a fair amount to drink.[10] Suggestions that this was in fact non-alcoholic wine are not generally convincing, and sometimes betray prior hermeneutical assumptions. Christians are warned against judging one another for making decisions to drink or not to drink. Indeed, to focus on either drinking or not drinking is inevitably to take the focus away from where it really belongs: 'For the kingdom of God is not food and drink but right-eousness and peace and joy in the Holy Spirit'.[11]

Dependence

So far we have not touched on the important phenomenon of alcohol dependence. This is not because dependence is not important; certainly, it has great clinical significance. However, dependence can only be properly understood in its overall context as one of a series of alcohol related problems arising in populations where alcohol is consumed socially. Prevention of dependence is a part of the broader question of the prevention of alcohol related problems. But dependence does provide an interesting study of what can happen when things get out of hand. Whether primarily due to excessive consumption, social and psycho-logical pressures, or biological vulnerability, individuals who become alcohol dependent show a significant preoccupation with alcohol. To a greater or lesser extent, their lives come to revolve around alcohol. As a result, they and others suffer.

Christians believe that life is lived most fully, creatively and joyfully when it revolves around God. Alcohol can be a part of such a life, as long as it remains subsidiary – a gift for which thanks are offered to God. Alcohol dependence is a bio-psycho-social example of what can happen when something other than God becomes a top human priority. Of course, no one chooses to become dependent. It is the final outcome of a pathway, the beginning of which is often indiscernible and is embarked upon in company with others who do not look like they are misusing alcohol at all. Therefore, the only sure way to avoid dependence is not to drink at all. But alcohol is not the only thing that can usurp the place of God in human lives and worshipping God is not simply a question of avoiding all risks in life.

Conclusions

Christians may rightly emphasise proper responsi-bility in the use of all created things, not least alcohol. Therefore, we can conclude sensible drinking guidelines do have a part to play in guiding clinical practice. But it is also proper to look for public policies that are evidence based; research suggests that, for alcohol, more than education is required. Governments must not imagine that education of the individual absolves them of their responsibility to take effective action for the public good.

Chris Cook *is Honorary Professorial Fellow in the Department of Theology & Religion, Durham University; formerly Consultant Psychiatrist working in the field of alcohol misuse.*

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Governments must not imagine that education of the individual absolves them of their responsibility to take effective action for the public good

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Dr David Jones questions an influential theologian's perspective

Dunstan, the embryo and Christian tradition

Professor Alison Murdoch was first to clone a human embryo in Britain

key points

The late Anglican theologian Professor Gordon Dunstan was profoundly influential in providing a theological basis for downgrading the status of the human embryo; and his conclusions played a major part in shaping the 1984 Warnock report (which led to the 1990 Human Fertilisation and Embryology Act) and influencing the Lords' Select Committee on Stem Cell Research, leading to the legalisation of embryo cloning.
Some Christians still defer to his writings in claiming a justification for embryo freezing, research, disposal, genetic testing and therapeutic cloning.
However his conclusions are based on mistranslation of Scripture, mistaken biology and a misrepresentation of the Christian tradition.

With the debate on cloning and embryo experimentation raging on, it is more important than ever to decide how we view early embryos. Should they be protected from destructive experimentation? Or would it be a waste not to make use of them? Christians have sometimes looked to the Early Church to provide guidance on questions that are not clear in Scripture. Taking such an approach, the late Professor Dunstan offered an account of traditional Christian beliefs that seemed to justify the use of human embryos. This profoundly influenced the *House of Lords Select Committee on Stem Cell Research* in its stance on embryo experimentation. Tragically, Dunstan's account underplayed the constant care shown by Christians for the embryo. Furthermore the beliefs he invoked to downgrade the embryo relied on a flawed biblical translation and an outmoded biology.

Early Christian witness

In ancient Greece and Rome there was little regard for unborn or newborn infants. Even the most thoughtful writers of the age - Plato, Aristotle, Cicero and Seneca - defended the practices of abortion and infanticide. The contrast with early Christianity could hardly be greater. The earliest Christian writing to mention abortion and infanticide is the Didache in the first or early second century: 'You shall not kill a child by abortion nor kill it after it is born'.[1] The same teaching is found in the letter of Barnabas, the writings of Tertullian and many other early Christian witnesses.[2] Killing an unborn child seemed to contradict the acceptance of life as a gift from God, the Christian concern for the weakest and the most vulnerable, and not least, the implications of God becoming incarnate as an unborn child in the womb of the virgin Mary. Christians did not base their concern for the unborn on the basis of a single proof text from Scripture. Rather, everything seemed to point in the direction of protecting the child in embryo, and nothing pointed against.

Professor Dunstan

It is therefore paradoxical, to say the least, to find someone appealing to the Christian tradition in order to downgrade the human embryo, so permitting embryo experimentation, early abortion and the use of the morning after pill. Yet this was precisely the method of argument used by the late Professor Gordon Dunstan.[3] He drew attention to the fact that medieval Christians such as Thomas Aquinas believed the embryo did not receive a spiritual soul from God until it was fully formed. This theological opinion was dominant in the Middle Ages, though traces of it can be found as early as fourth century and its influence lingered on well into the nineteenth century. Having highlighted this strand of the tradition, Dunstan asserted: '…the claim

to absolute protection for the human embryo 'from the beginning' is… virtually a creation of the later nineteenth century'.[4] Dunstan's argument strongly influenced Bishop Harries, Chair of the *House of Lords Select Committee on Stem Cell Research*, which came out in favour of destructive research on embryos. It has even been accepted in a publication of the Christian Medical Fellowship: 'Gordon Dunstan, Professor of Moral Theology, has shown that the concept of absolute protection for the early embryo is a relatively modern one.'[5]

Mistranslation of Scripture

In order to evaluate this reading of the tradition, we need to ask why so many Christians came to make a moral distinction between the formed and the unformed embryo. Why was the idea of delayed ensoulment so compelling? It is not found in Scripture nor is it in the earliest Christian tradition. Where did this idea originate?

Dunstan acknowledges that the formed/unformed distinction was introduced into the Christian tradition through the influence of a passage in a popular Greek translation of the Bible:

And if two men are fighting and strike a pregnant woman and her infant departs not fully formed, he shall be forced to pay a fine: according to whatever the woman's husband shall lay upon him, he shall give with what is fitting. But if it is fully formed, he shall give life for life…(Exodus 21:22-23, Septuagint translation)

However, the Septuagint version of this passage is a mistranslation! It is not an accurate portrayal of the Hebrew text, which does not refer to formed or unformed, but which distinguishes penalties according to whether the departure of the infant from the womb causes serious harm (Hebrew *ason*). The term fully formed (Greek *exeikonismenon*) is not found anywhere in Scripture. Furthermore, the one reference in Scripture to the unformed embryo seems to emphasise God's concern for the human embryo and certainly does not downgrade it with respect to the fully developed foetus.[6]

Many early Christians were gravely misled by the Septuagint mistranslation of Exodus 21:22-23; even Augustine, who tended to believe that the soul was present from the very beginning, felt compelled to draw a distinction between the formed and the unformed embryo. His writings subsequently exercised great influence as he was often taken as an authority for later theologians. However, in the case of this passage, they were building on sand, for Augustine himself was reliant upon a flawed translation of Scripture.

Mistaken biology

The moral distinction between the formed and the unformed embryo, first introduced into Christianity through the mistranslation of the Septuagint, later came to be defended by appeal to the authority of Aristotle. For, in the new universities of the thirteenth century, Aristotle was regarded as 'the master of those who know'.

The embryology of Aristotle has been described as 'quaint but not unreasonable' as if to suggest that it remains valid, at least in outline.[7] However, at many points it is simply erroneous, as has been evident since the experimental work of Harvey, Stensen, de Graaf and others in the seventeenth century. For example, Aristotle believed that conception was due to the congealing of menstrual blood under the influence of seminal fluid, that the female did not produce seed but only *matter* which was then given *form* by the male seed; and that the embryo initially had no internal structure. He believed that embryonic development was directed by the male parent through the instrument of the spirit (*pneuma*) present in the seed and *not* by a power of the embryo itself. For this reason, he held that the embryo did not belong to the human species until formation was complete at 40 days for males and 90 days for females.

None of these claims are scientifically tenable. The female does produce a true gamete and makes an equal contribution to inheritance. Embryonic development is directed by the embryo itself, not by the father acting at a distance. Finally, and most significantly, the embryo is specifically human from the time that sperm and ovum fuse. Aristotle's claim that the embryo is not specifically human helped persuade medieval Christians that the soul was given later in development. However, being more critical of Aristotle, both Calvin and Luther believed that the soul was given at conception; from the seventeenth century Catholic theologians increasingly came to agree with them.[8]

Deserving utmost protection

It is worth noting that medieval Christians, so ill-served by a flawed translation of Scripture and by a mistaken ancient embryology, nevertheless retained the primitive Christian tradition of concern and protection for the early embryo. Distinctions that stemmed from the Septuagint and Aristotle had an influence on the penalties of Church law and civil law, but the human embryo was never viewed as a disposable thing or as a non-human animal. It was always viewed as deserving the utmost protection, as a living being who was being formed by God for a future he had in mind, whether or not 'ensoulment' had yet taken place. The expulsion of a human embryo from the womb was never sanctioned except when it was caused indirectly while seeking to save the mother's life. Indeed, medieval Christians regarded the deliberate destruction of the early embryo as a grave sin, if not as homicide then as something closely analogous to homicide.[9]

The argument put forward by Professor Dunstan, and perhaps naively accepted by others, is thus profoundly mistaken. The Christian tradition provides no precedent for using human embryos in destructive research for the sake of medical progress.

Dr David Jones *is Senior Lecturer in Bioethics at St Mary's College, Twickenham*


Photo Epics

Superman actor Christopher Reeve hoped embryonic stem cells might cure his paralysis

Dunstan downgraded the embryo using flawed biblical translation and outmoded biology

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Emma Hayward and **Richard Mainwaring-Burton** look at the cutthroat world of medical one-up-manship

juniors' forum

Piggy in the middle

The scenario

At times, life as a hospital junior can feel like a never-ending game of piggy in the middle. It's no picnic when you're squashed – like the meat in a sandwich – between two large personalities with opposing priorities and opinions. You know what we're talking about…The consultant who wants a CT scan versus the radiologist who insists it's not indicated…The reg who wants a D-dimer at 3 am versus that technician who won't get out of bed to do it…the scenarios are endless.

Then there's the we-ship-them-out-faster-than-you game. All the other firms are playing it. Fewer patients hanging around post-take means less work for you and shorter ward rounds for your boss. How do you play? Simple: get them investigated fastest - write whatever you have to on the request form to make sure your patient gets that precious scan slot. No, nothing so black and white as lying! It's just a bit of grey truth twisting. What, you don't want to play?..then your patients will lose out.

Dr Diplomat

Emma Hayward
Paediatric SHO on a VTS rotation in Leicester

Along with my MBBS, I often think that having a degree in diplomacy would often come in really useful! After all, juniors often have to act as go-betweens for senior staff and other departments. Certainly, most house officers spend hours relaying messages from their team to different departments and back again; often this carries on until the department in question plays the trump card and requests consultant to consultant referral!

Requests or orders?

A radiographer friend once commented on how I mentioned *ordering* a chest X-ray. When she started work, X-rays were *requested*, not ordered. Perhaps this is a good attitude to take on board. Rather than seeing pathology and radiology departments as service providers, why not view them as we do other specialties from which we wish to have an opinion? We should be requesting their help and expertise, not ordering them around!

Top tip!

To avoid problems arising from unnecessary or inappropriate requests, why not ring up beforehand to make sure that the test you have in mind will actually yield the information required? Get yourself ready first with the patient's details and a concise history. Take previous films down to the radiology department. Write requests legibly and don't miss out relevant details such as your bleep number. This might take a bit longer but may well save you time and arguments later! It's also a way of loving your neighbour in the radiology department!

Nothing but the truth?

As a Christian I try to be truthful at all times, but it is tempting to bend this rule when caught between a rock (your rather fierce registrar) and a hard place (the radiology department). Routine tests are the hardest to justify: how many normal chest X-rays have I seen on post-take ward rounds?! At times I've not been sure why my patients required particular tests, making it difficult to give relevant details on the forms and giving rise to several sticky situations. I found discussing tests with my seniors a useful learning tool: their differential diagnoses were often different to mine. Are we trying to differentiate between diagnoses, confirm a suspected diagnosis or rule another differential out?

On the defensive

The rise and rise of defensive medicine is a related issue. Requesting tests in order to rule out diagnoses is becoming more and more common. There is no easy solution to this. Increasingly, both radiology departments and labs are swamped with requests. We do have a responsibility to use tests wisely, consider costs and think about risk versus benefit for each patient. On the other hand, I have found myself considering the potential costs – financial and emotional – of complaints for missed diagnoses. If I miss a diagnosis through neglecting to request a relevant test, it won't be the radiology consultant having to explain himself!

At the end of the day, as long as the test I've

requested is relevant and has potential benefit to my patient, I have no qualms about stretching already bulging lists or getting the radiology registrar out of bed. Caring for your patient can mean standing your ground and asking your seniors to back you up.

All change?

As a haematology house officer I was ideally placed to audit blood transfusion requests. This helped change our practice, ensuring that the sickest patients received their transfusions on time and that the labs knew which other patients were less urgent. Far from being boring and pointless, a carefully chosen and well-designed audit really can help change clinical practice, improving life for you, your successors and your patients!

National Juniors' Conference

Caring for your patient can mean standing your ground and asking your seniors to back you up

Petty bureaucracy

Richard Mainwaring-Burton
Consultant Biochemist at Queen Mary's Hospital, Sidcup

A phone call during one of my weekend consultant biochemist oncalls: 'I'm having some trouble with one of your technicians – she won't let me come down to the lab and label a blood sample!' I hadn't been anticipating trouble as the biomedical scientist working this shift was one of our best team members. 'That is according to our protocols', I replied. 'How can you be sure it's your patient's blood?' 'It's the only one I've taken so it must be…' 'How many other samples do you think our lab's received today?' The discussion continued. The SHO admitted that he'd left the unlabelled bottles with a nurse, expecting that she'd label them before sending them up the chute. Clearly there'd been a misunderstanding between doctor and nurse!

Our practice must be safe at all times. Analysing a blood sample of unproven identity is not only dangerous but adds considerable doubt to the relevance of the results. Hence our apparently draconian policy: it's there to protect the laboratory, the clinician and above all the patient.

Scapegoats

Cynicism born of years of disappointment makes me suspicious that what happened next was, 'Sorry – there's been a laboratory error. We're going to have to take more blood.' It does happen. As a patient myself, I have heard reference to laboratory error. And why not? Possibly the relationship between patient and doctor is more important than my technician's integrity. Indeed, I almost regard this role as one of the responsibilities of the unseen services.

Treating doctors

A significant element of my department's function is treating doctors by reinforcing their confidence in their own clinical judgment, as well as their relationship with their patients. However, whilst recognising this as potentially true, should we allow one group, albeit a front-line team, to be dishonest about a colleague's professionalism in order to defend their own status?

Resources

Analysing unlabelled samples can be seen as uneconomic, as the results may well be ignored or repeated. Unnecessary investigations are wasteful and strain service departments' budgets. They could also be regarded as assaults upon patients! We all have a responsibility regarding proper use of the materials at our disposal and clinicians working at the coal face are not exempt from this.

The recent imposition of targets for A&E discharge times has applied substantial pressure on the service departments to produce more clinical information faster. So we have had to adapt and soften a little regarding the availability of tests.

A matter of protocol

Departments develop protocols, usually in agreement with clinical colleagues, to control inappropriate use of tests. Although these protocols should be respected, deviation from them should be flexible and negotiable, but only through proper channels. It is not appropriate, for instance, to manufacture clinical details on a request relating to a patient in order to justify access to an investigation that would normally fall outside the protocol. This is not just a problem with laboratory requests, but also applies to requests for radiological investigations. I personally regard a request for any investigation as a referral to another clinical discipline, so it would be good to have confidence in the information provided. Doctors providing misinformation on GP or inter-departmental referrals are not long in developing unfavourable reputations!

Setting an example

Unfortunately, there has been a significant escalation in defensive medicine. As in many other spheres of society, there is always a temptation to deflect blame, and we in the service departments are all too well aware of its consequences. Still, we should guard against our moral and ethical positions becoming compromised. Denying our laboratory colleagues the recognition of their professional integrity in upholding their ethical standards is representative of this.

In everything set them an example by doing what is good. (Titus 2:7)

In my experience, the majority of patients would prefer to know the truth, certainly in the longer term. Real trust is better engendered by sympathy and humility than by excuses.

Peter Brunt pays tribute to an exemplary life

David S Short
6.8.1918 – 4.5.2005

On 4 May this year following a short terminal illness, the culmination of four months with the knowledge of acute leukaemia born with astonishing positivity and courage, David Short went to be with his master. His family, many friends and colleagues and the CMF lost a true friend, a wise counsel, an unforgettable Christian role model. A disarmingly gracious and kindly character hid a steely determination and an invariably optimistic outlook, both born out of a life of discipline and devotion to his Lord. His mature faith and many achievements (for which he would never take credit) owed at least something to his Christian family and upbringing and to his devoted wife, Joan.

David Somerset Short was born in Weston-Super-Mare as the first world war drew to a close into a Christian medical family. His uncle was Rendle Short. His great-grandfather had taught at George Muller's School. He went to Cambridge on a Macloghlin Scholarship of the Royal College of Surgeons – though the surgeons never received their money's worth for he was to become a physician! He had planned to go to France for his clinical training having become fluent in French during a year spent in Chateau d'Oex, Switzerland, as a schoolboy but Hitler – and much more importantly God – had other plans. He qualified at Bristol with the Gold Medal. His postgraduate career took him to the London, the Middlesex (with Moran Campbell) and the National Heart Hospital where his research centring on pulmonary vasculature and cardiac rhythm earned him a PhD to add to his MD.

David's postgraduate career was punctuated by war service in India and Burma and, because of his pacifist leaning, as a stretcher-bearer. To show he was not a coward he one day decided to press forward into the line of action and only narrowly escaped death from sniper fire. His CO was not amused – or impressed! The long nights in tents had one silver-lining – he taught himself NT Greek.

There followed ten long years from 1949 to 1959 waiting for a Consultant post. The post-war bulge of senior registrars at the inception of the NHS caused frustration – even despair – for so many able young men. David called them 'the wilderness years' and they proved a severe trial of David and Joan's faith. But God's hand was poised and finally he was appointed Physician and Cardiologist to Aberdeen Royal Infirmary. His 22 years as consultant were challenging and fruitful. He earned the immense respect of his colleagues – though some were irritated when he took a public stand to refuse a pay rise. But David saw that as a stand for his principles and felt that it stood him in good stead in ensuing years. This faith spurred him to set up hospital services for patients recruiting Christian colleagues as the years passed. Students were enticed to help in transporting patients with the legendary Short hospitality which generations of Christian doctors since remember with gratitude. With others David's efforts led to the building of a hospital chapel. David continued to support these services almost to the end and, indeed, just before he died published an editorial on the provisions for spiritual care in hospitals.

His conviction that Christian doctors need to work together and support each other led him to establish a CMF group. He was himself a constant source of advice, help and inspiration to countless colleagues over the years, not least to the writer.

> Among the four or five mottoes he kept on his desk was, 'Everyday will I praise you and bless your name for ever and ever'

In 1977 the Queen honoured him by appointing him as her Physician in Scotland. He had, in fact, treated Prince Charles much earlier in 1964 being unsuccessful in attempts to keep this out of the media. Before he retired in 1983 the university made him Clinical Professor of Medicine. His relaxations were his family (four daughters and a medical son), music, cricket and latterly, touring with Joan in their little motor-home.

But David's influence spread very far from Aberdeen – not least in the CMF both as Chairman and President. His interest in ethics lead him to become Chairman of the Regional Research Ethics Committee and nationally in work with the Church of Scotland and others. His many writings included *Medicine as a Vocation*, *The Bedside Book* and *Pastoral Visitation* (a special interest).

For all his years in Aberdeen he was a staunch member of Hebron Evangelical Church, for many years as elder, and was much in demand as an excellent speaker. However, his Christian contacts and friendships were wide and generous; the RC Bishop Mario Conti (now Archbishop of Glasgow) was a close friend.

David served his Lord all his life on *five* firm principles: his belonging to God through faith in Christ, God's sovereignty and purpose, the promises of Scripture, his accountability before God on the Day of Judgement and God's infinite love and care. David and Joan began every day with prayer, his life was disciplined, his work for his patients was for God's glory and love. Among the four or five mottoes he kept on his desk was, 'Everyday will I praise you and bless your name for ever and ever'.

He did.

***Peter Brunt** is Emeritus Consultant Physician in Aberdeen*

David Short died shortly after completing this final article

IMITATING CHRIST
in wisdom and courage

A striking feature of Jesus' ministry is the wisdom he showed in responding to questions and in training his disciples. His example is highly relevant to us in our dual role as carers and trainers.

Wise answers

When asked difficult questions, Jesus not only answered shrewdly but invariably made capital out of them. For example, the Pharisees and Herodians sought to trick him with the question, 'Is it right to pay taxes to Caesar or not?' Jesus' challenging reply: 'Give to Caesar what is Caesar's, and to God what is God's.'[1] He was also able to discern underlying issues: he knew, without being told, what his critics were thinking.[2]

Wise doctoring

We need wisdom to live aright and make the most of our opportunities for advancing the kingdom of God. We may not have our Lord's special Holy Spirit anointing, but we do have his assurance that God will give the Holy Spirit to those who ask.[3] We also have the promise of God's Word: 'If any of you lacks wisdom, he should pray to God, who will give it to him; because God gives generously and graciously to all.'[4] Most patients have problems that lie below the surface. Many patients recovering from a road traffic accident are burdened by self-accusation as they recall that injuries sustained by others are the result of their own carelessness. A sense of guilt is also common among patients undergoing termination of pregnancy.

Wise teaching

Jesus was wise in the training of his disciples, which he made a priority. We can learn a lot from his methods. He taught through the natural flow of daily events and made effective use of questions. He showed wisdom as well as courage by giving his disciples responsibility, sending out the twelve on their own without his presence to gain practical experience.[5] On another occasion he sent 72 of his disciples out in pairs, to serve and then return for debriefing.[6,7] He did not hesitate to correct them when they displayed wrong attitudes.[8] He was also sensitive to their physical and mental needs. Once, when the pressure was particularly great, he said to them: 'Come with me by yourselves to a quiet place and get some rest.'[9] He also taught his disciples individually, particularly Peter who he marked out for leadership.[10,11] Above all, he prayed for them.[12]

There are many examples here for us: taking opportunities for teaching out of situations as they arise; being honest with our students about their mistakes; caring for their physical and mental welfare; giving them opportunities of gaining practical experience and learning on the job; dealing with them individually as well as in a group; praying for them, and teaching by example.

Courageous actions

Another characteristic of Jesus' life is his courage. There are many examples in the Gospels of his bravery in the face of hostile criticism, physical danger and frequent death threats. He showed calmness when confronting the Gadarene demoniacs, the menacing crowds at Nazareth who tried to throw him off a cliff and the soldiers who came to arrest him in the Garden of Gethsemane.[13,14,15] His courage was also shown in the way he challenged the hypocrisy of his powerful opponents.[16] On one or two occasions he physically disrupted their business in the temple by overthrowing the tables of the money-changers.[17,18]

Courageous conscience

There are occasions when healthcare workers need courage and a willingness to court unpopularity. We may have to incur the wrath of our superiors if we decline to do something our conscience tells us is immoral or unethical. I have never forgotten an incident when a fellow medical registrar was asked by the most eminent cardiologist in Britain at that time to tell a patient an untruth. 'I am not prepared to do it,' he said. 'It is against my principles.' 'Principles!' thundered the chief, 'What do you know about principles?' The registrar stood his ground - and soon gained the consultant appointment for which he was training.

Courageous criticism

We need to be prepared to speak out against shortcomings and injustices in the health service, especially as they affect patients and other members of the health team. Though we must do all we can to carry our colleagues with us, we must even be prepared, occasionally, to accept the despised title of whistle-blower. It is un-Christlike to make our feelings known only when we ourselves feel wronged or under-valued. Of course, there is one enormous difference between Jesus' authority and ours. We dare not say, as he could: 'Can any of you prove me guilty of sin?'[19] Alas, we are far from perfect, with a strong underlying tendency toward hypocrisy. Nevertheless, as servants of God, we are commanded to reprove and rebuke sin, and be salt in a putrifying society.[20,21,22] But, whenever we have to criticise others, we should always do so with a ready admission of our own imperfections.

The imitation of Christ is an ideal to which we shall never attain, but ought constantly to keep as our goal.

David Short *(deceased) was Emeritus Professor of Medicine in Aberdeen*

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Photo: Epics

Extended family: Mjiyasi Gungulou, 82, comforts her great-grand-daughter Mdakalira, 9, orphaned by AIDS in Malawi

Children living with AIDS

Martin was referred to the Mildmay Harare Children's Hospital Specialist Clinic in Zimbabwe. He was eleven years old, and had a right sided hemiplegia, the legacy of cryptococcal meningitis. He was very malnourished and depressed, having had to stop school, and move to live with his elderly grandmother who was already overwhelmed with the other orphans for whom she was caring . He had severe oral thrush which made eating difficult and he was loosing weight. His grandmother had little hope for him, but she brought him to the clinic as a 'last straw' at which to clutch, having been told that children brought to the clinic usually improved. He was admitted to the Day Care programme, where he received intensive physiotherapy, good nutrition, counselling and daily schooling to his level of ability.

A year later, he has learned to walk again, and can write with his left hand and feed himself. Counselling and spiritual support for Martin and his grandmother has given them both a new outlook on life. A school has been found that is willing to take him in spite of his continuing disability. His grandmother is grateful and has found that the support and help she has received has given her the strength to cope with both Martin and the other children for whom she cares. It is hoped that a sponsor will pay for Martin to start taking antiretroviral drugs very soon.

Children living with HIV infection or AIDS-related illnesses themselves are amongst the most vulnerable of all children. They and their families experience enormous losses as well as stigma and prejudice, which may be felt in their communities, schools, and often, even in church and Sunday school.

The latest estimate from UNAIDS (end of 2004) indicates that there are 2.2 million children worldwide under 15 years of age who are living with HIV themselves, and of these, 640,000 became infected during 2004. The number who died in the same year was just over half a million. The total number of adults and children living with HIV in 2004 is approximately 40 million.

Of the 2.2 million children who are infected with HIV, most are living with recurrent illnesses, many are severely malnourished as a result of persistent or recurrent diarrhoea, or simply because of the family's poverty and lack of nourishing food, and many are disabled as a result of opportunistic infections such as cryptococcal meningitis or toxoplasmosis. As their immune suppression worsens, cancer and HIV related encephalopathy may increase their suffering, and that of their parents or care givers. All of them are suffering emotional stress and trauma, having usually lost one or both parents, or a sibling, and they will often end up as an unwanted burden in the household of a grandmother, auntie or uncle, or in some cases, a child-headed household. Their ill-health may have lost them the ability to go to school, and with that their normal school life and circle of friends. They need a holistic approach to care which includes the following elements:

- Comprehensive, holistic medical care which offers the whole spectrum of care needed, from antiretroviral drugs (ARV's), when available, to rehabilitation, nutritional support and palliative care as necessary
- Psychological/emotional care and support to the child, the parents or care givers, in particular the grandmothers, and the siblings
- Training to care givers in simple nutritional and nursing care needed by a sick child at home
- Spiritual care and support, appropriate to the child and family background
- Social support and monitoring, including practical help, food aid where needed, training in income generation, and promotion of independence and self-sufficiency
- Sensitisation and mobilisation of community leaders and members to provide on-going support and input to children and families within their own communities identified by them as being especially vulnerable
- Development, through community mobilisation and training, of community support structures, such as children's clubs, work-shops and clubs for grandmothers and other care givers, and training in income generating activities to support families, child headed households and other vulnerable groups
- Training doctors, nurses and other health workers to provide such care, and to communicate effectively with sick children and their care givers

14 million children are estimated to have been orphaned world wide as a result of HIV and AIDS. There are many programmes that focus on the provision of school fees, food aid and clothing to families who are caring for orphans, but few are taking up the challenge to deal with the most vulnerable children – those who are, themselves, ill as a result of HIV. Mildmay International is one of the few that focus specifically on these children. It is a non-denominational Christian organisation, registered as a charity in the UK, where its work with HIV/AIDS started in 1988 at the Mildmay Mission Hospital in the East End of London. Europe's first hospice programme for people living with AIDS was set up to provide professional and Christian holistic palliative care that led in many instances to rehabilitation of the adults, and later children, for whom they provided care. This work led eventually to the development of a number of care programmes in Uganda, Kenya, Tanzania and Zimbabwe, and to the delivery of training in those and many other countries.

Veronica Moss *is CEO of Mildmay Mission Hospital (incorporating Mildmay Hospital UK and Mildmay International)*

Martin Tansworth explains how flexible working is enabling new models of medical mission

Making the most of flexible working

As a medical student I assumed that at some point in the future I would stop working in the NHS, leave the UK and serve God overseas for a period of time. Inspired by the example of others, I asked the familiar question, 'when should I go?' However, a new paradigm of medical mission may be emerging. Many are now finding ways to fulfil God's call to mission at the same time as continuing to work within the NHS. These opportunities in flexible working have been made possible by *Improving Working Lives*[1], an initiative led by the Department of Health to develop new creative ways of employing doctors and other health professionals. Part of this initiative is known as the flexible career scheme.

Exploiting the options

As a doctor on the Flexible Career Scheme[2] I work eight sessions a week for 33 weeks. Across the year, this gives up to 19 weeks broken into three sections. I use these periods to work overseas supporting Christian medical groups in the former Soviet Union and working with NGOs implementing primary care. Balancing my commitments to my overseas work and the NHS is difficult, but the benefits to myself, the patients and the practice in having a motivated doctor who is able to apply the knowledge gained overseas in the UK (and vice versa) are enormous. As Liam Donaldson the Chief Medical Officer has remarked, 'The ultimate beneficiaries from UK professional health workers gaining international experience are NHS patients in the UK'.[3]

Other examples of those using flexible ways of working amongst CMF members include CMF's own staffworkers, who continue their medical training while working four to five sessions a week for CMF. Other doctors use their sessions to serve within their local church. Some CMF members have agreed extended annual or unpaid leave arrangements with their NHS employers to enable regular teaching or medical trips. PRIME (Partnership in International Medical Education) involves many CMF members in its medical education work across Europe and beyond.[4] GPs and those with an interest in medical education make use of study and annual leave in order to fulfil the many opportunities available through PRIME.

The Flexible Career Scheme

Doctors on the Flexible Career Scheme work less than 50% of full time and come from all branches of medicine, although posts where the work is sessional with little or no on call are more easily adapted. GPs on the scheme can work a maximum of 260 sessions a year (which can be annualised instead of committing to a particular number of sessions per week) without any out of hours work. They receive an additional eight sessions of paid educational leave annually, and also remain eligible for higher professional education monies and a golden hello if they meet the set criteria. Currently practices employing doctors on the scheme benefit financially by reclaiming 50% of the salary they pay the GP for the first year of employment, 25% for the second year and 10% for the third year.

There are some potential difficulties. Since doctors on the Flexible Career Scheme work less than 50% of full time, experience gained within the scheme cannot count towards training.[5] It is also important to have understanding colleagues who are willing to accept such a flexible way of working. I have also benefited from the pastoral support of my church (who are my sending agency) and CMF.

Training flexibly

Technically, 'flexible training' means part time training which involves participation in medical activities for at least half the time of a full time trainee and can be undertaken at any stage. It was set up in order to retain doctors who might otherwise leave because they are unable or unwilling to take up full time appointments. Doctors currently training flexibly come from all specialities and include trainees with young children, those who care for a disabled relative, trainees with a disability themselves and others with religious commitments.[6] It involves doing between five and seven sessions a week, with pro rata on call, and is arranged via the flexible training dean in your local postgraduate deanery.

In addition to the schemes above, salaried posts may be negotiated with NHS employers for the number of sessions per week a doctor is willing to work. Agreed extended periods of unpaid annual leave to allow short term trips overseas are also possible. It looks like there may be exciting times ahead. In fact, all these options could herald the 'new paradigm in medical mission' that Val Inchley declared two years ago our century so sorely needs.[7] It has been said that God does not need our ability but our availability. New ways of working enable us to make the same choice as Isaiah. 'Here am I, send me'.[8]

***Martin Tansworth** is a Flexible Career Scheme GP*

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Sam David describes the development of EMFI, CMF's Indian sister organisation

A journey of joy

Beginnings

EMFI (Evangelical Medical Fellowship of India) started up in 1971 when several UESI (Union of Evangelical Students of India) members became convinced of the need to form a fellowship for students graduating from medical and dental schools. This movement was known as 'Medical Auxiliary of UESI, till 1974. One of the key triggers was the realisation that Christian medics needed to be a voice against deteriorating ethical standards. Dr Frank Garlick, Professor of Surgery in Vellore, and his wife Val, provided initial leadership.

Growth of a movement

Convinced of its importance, many doctors joined EMFI and offered their services on a voluntary basis. Dr Nghakliana became Travelling Secretary, meeting students and graduates across the country. The founding General Secretary Dr Mathews started up a journal, *The Voice*.

In 1985 Dr Kuruvilla George and his wife Margaret gave up their home and practice in the UK and settled in India, with KG (as he was affectionately known) taking up the mantle of EMFI leadership and becoming the first fulltime General Secretary. Crucially at this time, a fulltime paid associate worker was appointed: Hansraj Jain, a young theological graduate, taking up the challenge.

So came a new phase of growth in EMFI: more staffworkers joined and the ministry expanded. Realising the need to pioneer Christian fellowships among medical students in unreached medical colleges, EMFI began focusing more and more on student work.

Recent times

Today EMFI has 18 full time staff and their spouses, all actively involved in the day-to-day activities and in promoting the fellowship's ministry. We continue to work in partnership with UESI staff to coordinate work, especially in the northeast. We are also members of the International Christian Medical and Dental Association.

EMFI's ministry involves:

- Helping members to realise the call
- Nurturing medical and dental students
- Encouraging fellowship & witness among Christian doctors and dentists
- Promoting mission and Indian medical ministries

Our key strength is working with individuals in college hostels and homes. Staffworkers make regular visits to each medical and dental college. Member graduates get involved in teaching and financial support. Fresh contacts are made through repeated visits; Bible study and prayer groups slowly form. Most groups meet in hostels or close to college. Staffworkers try to be sensitive to individual needs. Many times, the Holy Spirit leads our workers to specific places, where they find young men and women in need of counsel and prayer. Many issues regarding their calling as doctors and dentists or ethical dilemmas are discussed over a cup of tea or meal. Computers and the Internet have enabled us to communicate with students and graduates more easily, and we thank God for EMFI–UK's help with this.

New initiatives

Institute of Medical Mission was conceived and launched last year as we realised the need to equip and mentor students and graduates who have expressed desires to further their calling. Rather than being campus based, a selected faculty goes to different locations to conduct short courses. Four seven-day *Foundation Courses in Missions* have just been completed. 44 doctors/dentists, nurses and allied health staff have undergone this training, and made fresh commitments to follow the Lord in all aspects of their lives. It is our hope that this initiative will spearhead a fresh move towards medical ministries and mission in India.

Vishranti is a project that promotes rest for busy health professionals, encouraging rest and relaxation by facilitating family vacations, and allowing for renewal and reflection. It also focuses on promoting healthy families and links in with life revision and marriage enrichment retreats.

Luke Society encourages networks between general practitioners in private surgeries (known as private practitioners in India) and those working for Government medical services, aiming to influence the nature of medical practice and promote a caring culture.

Final thoughts

EMFI is a wonderful testimony of God's work among doctors and dentists in India. Through years of prayer and faith, today we reach out to students and graduates from over 105 medical and dental colleges all over India. Hundreds of young students, many from other backgrounds, commit their lives in obedience to God's call. It has become a vital component of medical missions in India, with 50 young medical/dental graduates joining missions over the last two years. Pray that God will open doors in other colleges too.

Our prayer is that we will continue to be *The Voice* in the ever-changing world of medicine. Primarily a fellowship, we hope to remain relevant to our members as they respond to God's call. It is a joy and privilege to serve him in the medical and dental fraternity, and to witness something of what God is doing.

***Sam David** is General Secretary of EMFI*

news abroad

Current CMF involvement in work abroad

There are 123 members working abroad fulltime, in 45 different countries, linked with a variety of mission and secular agencies. Twenty of those have started this year. Fifteen completed assignments and returned to the UK. We are aware of twelve members who are preparing to go overseas during 2005/6 and a further 196 members, based in the UK, but actively involved in some form of short-term overseas mission activity on a regular basis.

We would be interested to hear from you if you are involved overseas and think we might not be aware of the fact.

Current needs

Our website at *www.healthserve.org* contains a list of current vacancies that we are aware of, in the opportunities pages. Vacancies far outweigh applicants.

We have had one post Tsunami request for medics who would be willing to spend 3 to 6 weeks in Sri Lanka helping to strengthen a team of longer term medical staff from Colombo (which includes one of our members) who are working in the east of the country where the medical needs are greatest. Funding from the UK has facilitated the setting up of mobile clinics but more staff are needed. Contact details can be found on the HealthServe site.

Other useful websites, listing vacancies in humanitarian agencies, recently included in a *BMJ* article on humanitarian assistance were:

Aidworker – *www.aidworker.com*
Alertnet – *www.alertnet.org*
International Health Exchange – *www.ihe.org.uk*
Merlin – *www.merlin.org.uk*
People in Aid – *www.peopleinaid.org*
RedR – *www.redr.org*
ReliefWeb – *www.reliefweb.int*
The Sphere Project – *www.sphereproject.org*

Plans for short term teams

We are continuing to work on this issue. Two types of team are under consideration. One being that of multidisciplinary, capacity building teams linked to the needs of our members working overseas, responding to their requests for assistance. The other would be in the nature of mission experience trips offering UK members the opportunity to experience what it is like to work overseas and challenging them to get involved. We have developed a good working relationship with BMS and SIM who currently offer similar trips but which only relate to their mission partners overseas.

One of our members in a Muslim country writes, *'We could do with a Gynaecologist to teach me how to do vaginal hysterectomies; a Dentist – simply because we don't have one and an ultrasonographer who could teach two of our nurses some basic obstetric ultrasound and one of our new doctors, general ultrasound techniques.'* The best time to come would be after April 2006. A multidisciplinary team in the making? Any volunteers?

If you would be interested in either sort of team visit, please register your interest with us. Contact: *peter.armon@cmf.org.uk*

Snippets from the newsletters of some of our members working overseas

We might think we have problems but one member writes from Benin:

It's a very odd sort of life our here. Perhaps that's why it attracts such odd people or is it that when they first come out to Africa people are quite ordinary but through the circumstances and pressures, they gradually become most peculiar? Certainly the pressures are enormous. Enormous and unrelenting.

Another from Chad:

The hospital has received some funding to improve its facilities but I was struck by the lack of good medicines, poor lab facilities, broken down X-ray machine etc. There was a measles epidemic while I was there but no immunisations to prevent its spread. Imagine the difficulties of maintaining a cold chain, bringing vaccinations the 12 hours drive on poor roads with temperatures over 40°C.

Another from Tanzania:

Oh the delight of doing a Caesarean Section in a newly renovated theatre with new theatre lights that work!

A call to prayer

Pray for our members overseas as many face the challenges of isolation, limited facilities, new languages to learn and culture to understand, unfamiliar diseases to treat and defining appropriate approaches to their treatment, power cuts, telephones down and curfews in addition to the usual problems of balancing the needs of the family and the demands of work and church activities. But lives are being transformed, broken bodies mended, disease healed, new lives brought safely to birth and the Gospel is being lived out by our members in more than 45 nations. That's something we can praise God for. Please pray out of Psalm 20.

For those who want to get involved or find out more

Our website at *www.healthserve.org* contains many items of useful information for those thinking of working overseas, short or long term. Current needs and vacancies are listed on the *Opportunities Pages*; other short term opportunities can be found on the *HealthServe Pages* under 'sending and receiving agencies' and the *HealthServe Pages* themselves contain lists of useful contact addresses for a whole variety of healthcare mission related issues. Details can also be found of overseas mission conferences and our student elective pages contain a wealth of information and reports.

Peter Armon *is CMF Overseas Support Secretary*

eutychus

'Spirituality' is escapist, shallow and self-indulgent

'The great religions are more than spirituality. They pose the question: how do we translate our private experiences into the public world we share and make? How do we turn our intimations of eternity into a more gracious order of acts, relationships and institutions? How do we escape not from but into reality? How do we move from soul to society? That is why, while spirituality changes our mood, religion changes our life. Yes, there is much positive about our search for spirituality, but there is also something escapist, shallow and self-indulgent. Just as street protest is the attempt to achieve the results of politics without the hard work of politics, so the current cult of spirituality is the attempt to achieve the results of religion without the disciplines, codes and commitments of religion. That is not good news.' (Chief Rabbi Jonathan Sacks [*Times* 2005; 24 August] cited in *SMJ* 2005;45(1):3-4 *www.smj.org.uk/0205/spirit.htm*)

2,000-year-old seed germinates

A date palm grown from a 2,000-year-old seed found during excavations at Masada, Israel is now 12 inches tall. It is believed to be the oldest seed ever germinated. The Judean date palm died out in the Middle Ages but had been valued for its medicinal properties. Researchers at the Louis Borick Natural Medicine Research Centre in Jerusalem hope the plant may help in the development of new medicines. If the sapling survives it will not bear fruit for about 30 years, and only if it is female. (*Independent 2005*; 14 June)

Relief of poverty comes before population control

The president of the Indian Medical Association has called for India to adopt a one-child policy similar to China's. A number of states already use coercive methods to prevent large families, such as the withholding of government jobs, benefits and subsidies if couples have more than three children. Ashish Bose, a demographer, who disagrees with coercive population control said, 'In a democracy when people want employment, drinking water and literacy, one cannot distribute contraceptives and ask them to solve the population first.' (*BioEdge* 2005; 10 May)

Fake acupuncture as good as the real thing

In a study of more than 300 patients, both genuine and sham acupuncture reduced the intensity of headache compared to no treatment at all. But real acupuncture was no better than needles placed at non-acupuncture points on the body. (*JAMA* 2005;293:2118–2125)

Religious hate law revolt fails

The government has survived a backbench revolt over its plans for a new law to ban incitement to religious hatred. Critics, including comic actor Rowan Atkinson, The National Secular Society and the Evangelical Alliance say the measure will limit freedom of expression. But Home Secretary Charles Clarke says the bill protects 'people not faiths'. Clarke, apparently motivated by a desire to win back Muslim votes lost over the Iraq war, had previously written a letter of apology to the mosques of Britain for failing to get the incitement of religious hatred proposals through Parliament before the election. (*IRIB News* 2005; 12 April, *news.bbc.co.uk/1/hi/uk_politics/4114582.stm*)

As easy as ABC?

Uganda's ABC programme (abstinence, being faithful, condoms) has led to dramatic decreases in HIV infection rates for over a decade. No country in the world has seen its HIV incidence fall through condom promotion alone. Changes in primary sexual behaviour are always present when HIV rates decline. There are valid criticisms of the ABC approach but its critics and proponents alike should work together if the Ugandan success is to be maintained and replicated in other countries. (*PMJ* 2005;81:273-275)

New website tells stories of women's abortion regrets

www.tellmyabortionstory.com is a web site that provides a confidential place for those who have experienced abortion to share their stories. The site allows visitors to read stories by women who have experienced abortion, written in their own words, and to share their stories with others.

Bedside Bibles to stay

In response to a wave of protests Leicester hospital bosses decided to reverse a decision to remove Bibles from the bedsides of patients amid concerns over offending non-Christians and spreading MRSA. Leicester-based Gideons International, which distributes the Bibles, had described the proposal as 'outrageous' and Muslim and Hindu leaders had also condemned it as medically non-sensical and motivated by political correctness.
(*news.bbc.co.uk/1/hi/england/leicestershire/4077988.stm*)

Did Jesus die from a blood clot?

Jesus may have died from a blood clot in his lungs according to Israeli doctors. Dr Benjamin Brenner from Rambam Medical Centre bases his theory on New Testament and contemporary religious sources about the crucifixion. He believes Jesus developed a deep vein thrombosis in his legs while nailed to the cross, which then travelled from his legs to his lungs and killed him. Other scientists have dismissed the theory and Bible scholars have said the spirituality behind Jesus' death is more important than his mode of death. (*news.bbc.co.uk/1/hi/health/4075936.stm*)

Lottery money funds abortion

Scotland's Cardinal Keith O'Brien has called for a boycott of the National Lottery over what he described as 'blatant misuse of funds'. The lottery has granted some £3.3 million to pro-abortion organisations such as Brook Advisory Centres and the FPA. Cardinal O'Brien said, 'I am quite staggered at the volume of funds provided to these agencies, which is in stark contrast to the lack of support for organisations offering alternative approaches.' (*The Scotsman* 2005; 14 March]

Cannabis link to road accidents proven

Heavy cannabis users are 10 times more likely to be injured, or to injure others, in car accidents, researchers have found. The scientists from the University of Auckland, New Zealand, say their study is the first proof that there is a link between using cannabis and accidents. Previously, there was only laboratory research and post mortem evidence. (*Addiction* 2005;100(5):605)

Links Manual

A guide to starting up and maintaining health partnerships

- THET (tropical health education trust) 2005
- Download as a PDF file at *www.thet.org*
- £3.50 pb

A recent article in *BMJ Careers* highlighted the launch of NHS Links *(career-focus.bmjjournals.com/cgi/content/full/330/7488/78)*. Set up in collaboration with THET, it aims to establish a network of doctors and health professionals involved in a variety of health links between NHS Trusts and health centres in less developed countries. It aims to encourage and support the spread of such links in NHS hospitals and Primary Care Trusts and raise awareness about global health.

THET produced this excellent handbook to coincide with the launch. It contains the information you need to establish such a link. A foreword by Sir Nigel Crisp, chief executive for the NHS (England), commends and encourages the involvement of NHS staff in such work.

A fundamental principle behind every link, described in the introduction, is '*to respond to the requests, and work towards the goals, of those responsible for healthcare*' in the overseas situation. The writer points out how a link based in a NHS Trust can be far more effective in the longer term than the work of a single individual, but goes on to emphasise that '*long term institutional involvement and commitment are necessary on both sides of the link*'.

The booklet describes the benefits to the UK institution, the individual and the overseas hospital and gives practical advice on how to make a success of a link. It lists action points to follow through and includes thumbnail sketches of those who have already established successful links. There are sample job descriptions for a Link Co-ordinator; examples of presentations to inspire your board and bring them onside; points to consider when preparing to go on an overseas trip and in preparing to receive someone from overseas visiting your hospital, together with tips on fundraising, budgeting, booking flights etc.

> For those who could get excited about the possibility of making a worthwhile contribution to overseas healthcare, while continuing to work in the NHS, this booklet is a must

For those who could get excited about the possibility of making a worthwhile contribution to overseas healthcare, while continuing to work in the NHS, this booklet is a must. It contains a wealth of practical detail with little left to the imagination. Once you have read it, you will have no excuse not to get involved!

***Peter Armon** is CMF Overseas Support Secretary*

What can I Do?

The HIV/AIDS ministry of Gideon Byamugisha

- FB productions, 50 minutes
- Video £16, DVD £20, Leader's guide £2
- Available in the UK through TALC at *www.talcuk.org*

An ordained minister in the Church of Uganda, Canon Gideon Byamugisha discovered in the early nineties that he was HIV positive after his wife suddenly died of an AIDS related illness. Coping with grief and shock, he found a calling to challenge the church and society in its response to AIDS and to offer support to those with HIV. After becoming the first African clergyman to come out openly as HIV positive in the mid nineties, Byamugisha found himself in demand across Africa and the world.

He now works for World Vision and seeks to bring a message to the church that it needs to respond positively to the HIV/AIDS pandemic. This video, produced by the Strategies for Hope Trust and the Friends of Canon Gideon Foundation is an attempt to get that message across to a wider audience. As an introduction to the man and the issues, it is a good resource that could be used in most churches.

Gideon comes over as a genuine, godly man seeking to challenge stigma, get over a clear message about prevention, and to encourage a compassionate response from Christians. But it is no more than an introduction – skimming over prevention issues, not even looking at the access to treatment issue, or at how the western church has largely blanked the issue of AIDS. Gideon is seen talking to audiences in Africa, but not to western congregations (although he has spoken to British churches). The African churches have dealt with HIV far more than those here in the UK, and with good reason – they have had no choice!

The video is perhaps strongest in tackling the issue of stigma, and at showing a compassionate response to HIV positive people within the local church. As a resource this is a good video to use with church youth groups, a home group or any small meeting. It is broken down into fourteen bite sized chapters, and a study guide is available. But it is no more than a starter, and Gideon is not the strongest of communicators. His message about 'ABC plus' prevention is sound, but not clearly expressed and could easily confuse those not familiar with the issue.

> Worth getting hold of if you want to get people thinking about the issues, but there are more useful resources out there

Worth getting hold of if you want to get people thinking about the issues, but there are more useful resources out there if people want to go deeper.

For example, *The Truth About AIDS* by Patrick Dixon, available from ACET International at *www.acet-international.org* (free for use in developing nations).

***Steve Fouch** is CMF Allied Professions Secretary*

obituaries

Therefore, since we are surrounded by such a great cloud of witnesses, let us throw off everything that hinders and the sin that so easily entangles, and let us run with perseverance the race marked out for us.

(Hebrews 12:1)

We report the deaths of the following Christian doctors, give thanks for their lives and offer sympathy to their families:

Winifred Anderson (*q* Glasgow 1929; *d* 26 March 2005) was a missionary doctor in India and Nepal. She arrived in India in 1932 and worked as an obstetrician and gynaecologist in Patna for several years. In the 1950s she took a post in Kathmandu with the United Mission to Nepal. Medical services were being developed and an old royal palace, with its furniture, chandeliers and paintings was made into a hospital. Win had a flat on the top floor with a view of the Himalayas. She continued in obstetrics and gynaecology, delivering some of the babies of the ruling families. After her retirement she did some work in Bangladesh and Pakistan. On a visit to Nepal in the 1980s Win trekked over four passes in one day, with a combined ascent up to 10,000 feet. In retirement she lived in Scotland and continued to be involved in missionary work and her local church. She never married but enjoyed her large extended family. She was invested with the Insignia of the Order of the Hospital of St John of Jerusalem in 1940. Win died at the age of one hundred. (*Taken with permission from obituary written by Margaret Bancewicz*)

Ian Burleigh (*q* Glasgow 1952; *d* 2005) was a retired GP living in Lanarkshire.

Joan Ellinger (*q* Royal Free 1935; *d* 17 April 2005) was a GP at the

Brook Lane Medical Mission in South London. Because of her Christian commitment she felt she ought to be a missionary, but did not want to go into medicine at all, her chief love being history. However, she qualified as a doctor and went to Brook Lane Medical Mission, a plant from the 1904 Bermondsey Medical Mission. Here she considered a call to this huge new housing estate, as overseas mission was closed to her because of needing to look after her widowed mother. She became a full partner in 1939, and stayed until her retirement in 1981. She remained single, and was an old fashioned family doctor in the best sense, with a prodigious memory for patients' details and for their complicated family interconnections. At practice prayers every morning, she would usually begin 'Lord, thank you for another day in which to serve you'. Her whole life was devoted to serving her Lord and her patients. (*Andrew Fergusson*)

Eric Gardner (*q* Cambridge 1938; *d* 3 April 2005) was a consultant anaesthetist in London, at Whipps Cross Hospital from 1948, and at Barnet General Hospital from 1957. He was very involved in the Intensive Treatment Unit and resuscitation. He retired early on health grounds in 1976 and then worked as an adviser to overseas doctors for the Council for Postgraduate Medical Education. A man of deep faith and an active member of his church, he took a keen interest in overseas missions. Predeceased by his wife, he leaves three children, three grandchildren and one great grandchild. (*Taken from Angela McKenzie*)

Francis Grimm (*d* 21 May 2005) was the founder of the Hospital (now Healthcare) Christian Medical Fellowship. His witness and service in the Kingdom of God was extraordinary, especially in the dimensions of its global impact on the healthcare fields.

Alexander Henderson (*q* Kings, London 1947; *d* 17 March 2005) was a consultant anaesthetist at the Luton and Dunstable Hospital for 33 years, after working in London and Cardiff. He pioneered the intractable pain clinic in Bedfordshire. From 1991 to 1998, after retiring, he did valuable work as an anaesthetist in Thailand, India, Kenya, Uganda and Israel. He also worked in Togo on the YWAM ship *Anastasis* and was an elder and active member at his church in Dunstable.

David Short (*q* Cambridge 1942; *d* 4 May 2005) was emeritus professor of clinical medicine in Aberdeen, and former president of CMF. See page 14 in this issue of *Triple Helix* for a fuller account of his life.

David Thomson (*q* Glasgow 1938; *d* 7 February 2005) was a retired GP living in Malvern.

David Tyrrell (*q* Sheffield 1948; *d* 2 May 2005) was president of

CMF from 1977 to 1979. He was a virologist and discovered the enterovirus but was widely known for being head of the Common Cold Research Unit. He worked extensively on the causes and consequences of the common cold. He chaired government committees on variant CJD, AIDS and influenza and was chairman of the chronic fatigue syndrome research foundation. For nearly 20 years he was president of the Friends of the Christian Medical College at Ludhiana. In 1970 he was elected FRS and in 1980 appointed CBE. In his local church at Whiteparish, near Salisbury, he was organist and choirmaster. He is survived by his wife, Moyra, and by two daughters.

This is a new column in *Triple Helix*. We have previously carried brief obituary notes in *CMF News* but here are able to give more details. We try to commission obituaries but are limited by the information we have to hand, which explains the variable length of reports. We welcome 200 word submissions in the above format and particularly value personal reflections.

Janet Goodall muses on the real meaning of worship

Bow down and worship or stand up and sing?

'Words mean what I want them to mean,' says Humpty Dumpty in Lewis Carroll's Alice in Wonderland. He is not alone. Today's teenagers, for example, use 'cool,' random' and 'wicked' in ways puzzling to their elders. Christians, too, can alter a good word's meaning. Our Lord Jesus came amongst us as 'the Word' (John 1:1). By his precise use of the word of God he defeated his tempter (Matthew 4:1-11). We must learn and use God's word as he did to wield well 'the sword of the Spirit' (Ephesians 6:17). The obvious enemy strategy would be to disarm us, but a subtler alternative is to reduce the impact of certain godly words.

Thus, 'ministry' could stand for praying over someone, 'sharing' for a mutual baring of souls and 'worship' for standing up singing, led by the 'worship leader'. English usage can change with time, but accuracy is important when using words already translated from another language. Many medical words of Greek origin, such as anaesthetic and hypodermic, are already in popular parlance but non-professionals might confuse 'hypochondrium' with 'hypochondriac.' Similarly, Christian songs are popularly referred to as 'the worship' because the singers often look worshipful, yet in the original text the words used for worship have virtually no musical connotations. A New Testament Greek concordance, or even a standard dictionary, clarifies this.

Translators use our English 'worship' for several words in the original text. These variously imply homage, obeisance, piety and awe, with reverential acknowledgment of God's claims (Exodus 4:31). As a response to Jesus, worshippers frequently bowed down or fell at his feet (Matthew 2:11, Mark 5:33). The Greek word *latreia* covers both 'worship' and 'service' and is used by Paul in Romans 12:1. He defines as a spiritual act of worship the sacrificial offering of the whole body (NIV), also translatable as our 'reasonable service' (AV).

Biblical words used for praise are different. They convey nuances of lauding someone, of speaking or singing praise. *Psalmos* indicates singing to a harp (hence our 'psalm') and *psallo* to any associated twitching or twanging. The Greek *humnos* (compare 'hymn'), refers to a song of praise to God. Tuneful praise can be translated as 'making music' to the Lord (Judges 5:3; Psalms 27:6, 147:7). It is when wholly focussed on our crucified, risen and enthroned Lord in heaven that we find praise turns to worship (Revelation 5:9-14).

This puts a different slant on the call to 'have a time of worship.' Making music to the Lord can indeed inspire a worshipful response, but only he knows the truth behind the oft-cited comment, 'The worship was wonderful'. Some who are persecuted for their faith continue to sing their Lord's praises even to the death - wonderful worship indeed. Few of the rest of us produce songs of praise during a night call, or when the clinic overruns and our blood sugars drop. True worshippers will worship in spirit come what may (John 4:23-24) and Paul's challenge remains - to offer our lives and lifework as a sacrificial offering to the one who, praise be, offered so much for us.

'Let's have a time of worship? 'Yes, a lifetime! - but we must understand that true worship can become a matter of life and death.

***Janet Goodall** is Emeritus Consultant Paediatrician in Stoke-on-Trent*

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