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for today's Christian doctor

triple helix

prenatal eugenics

Joffe bill, culture wars, HIV/AIDS, human trafficking, work permits, cloning, reflecting christ, portfolio careers, week of nights, news from abroad

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contents

Joffe Bill defeated

Giving thanks for a successful campaign

There is much to give thanks for but the work is far from over

Lord Joffe's *Assisted Dying for the Terminally Ill Bill,*[1] which sought to legalise physician-assisted suicide in England and Wales, was defeated at second reading in the House of Lords on Friday 12 May by a massive majority of 148-100 after an eight hour debate in which over 90 peers spoke.[2] As there were only two months left in the parliamentary session the 'wrecking' amendment to delay it by six months, proposed by Lord Carlile, effectively killed the bill.

We have now seen three incarnations of this bill in as many years. The first ran out of parliamentary time, the second led to a Select Committee and Report,[3] and this, the third, was the first to come to a vote. By rejecting it at a second reading, rather than allowing it to proceed to committee stage, the British Upper House have rejected the underlying principle of the bill (assisted dying) and signalled that there is no need to debate its fine detail. This was an overwhelming defeat for the pro-euthanasia movement, and in particular for Lord Joffe and Deborah Annetts of *Dignity in Dying* (formerly the *Voluntary Euthanasia Society*) who collectively drafted the legislation.

The Joffe bill's defeat was the result of a sustained campaign by a broad coalition of organisations and individuals. It was hugely significant that the Royal College of Physicians (RCP), after taking a neutral position at the time of giving evidence to the Select Committee, changed its position to oppose the bill after taking a survey of members' opinions.[4] The move made front-page news in the *Times* on 10 May after significant coverage of the wider issues in broadsheet and tabloid newspapers over the previous four days.[5] A media storm followed leading up to the Lords' debate with opponents, including several CMF members, being interviewed on all the major television and radio stations, and on regional media. At the same time a large number of peers delayed their departure from Westminster to listen to the debate and register their votes.

These events followed a campaign organised by *Care Not Killing*, an alliance of over 30 human rights groups, professional groups, hospices and faith groups including CMF, which resulted in peers receiving over 150 individual letters each,[6] a petition of 100,000 signatures delivered to 10 Downing Street,[7] and the delivery to peers of leaflets, DVDs, position papers and a 25,000 word critique of the bill written by Professor John Keown, a world authority on euthanasia legislation.[8] Disabled groups, doctors and patients, with good stories to tell about effective palliative care, were widely featured on the media and the battle was won with arguments that highlighted the dangers posed by the legislation for vulnerable people, and the fact that requests for assisted dying are virtually unheard of when good palliative care is made readily accessible. Throughout the proceedings thousands of Christians faithfully prayed.

The RCP has now joined the RCN, RCGP, RCPsych and APM (Association of Palliative Medicine) in opposing assisted dying, leaving the British Medical Association as the last bastion of medical neutrality on the issue, isolated not only form the Royal Colleges, but also from the World Medical Association itself. The BMA holds its annual representative meeting on 26-29 June (after *Triple Helix* goes to press). On the agenda are 24 motions on assisted dying, of which only one supports a neutral position.[9]

Lord Joffe's stated intention to bring the bill back yet again to the House of Lords next session was greeted by howls of derision in the House, and it seems unlikely that he will attempt to do this. However there may be an attempt to introduce it into the House of Commons. As it is a private member's bill rather than a government bill, this could only happen if a sympathetic MP were to win a ballot in November; but with 650 MPs vying for position, and only about five private members' bills being debated per session, this may prove more difficult than it sounds. However it is sobering that the Abortion Act became law after being introduced as a private members bill that the government did not oppose, and which uninformed public opinion supported.

In the meantime there is much to give thanks for, and although a significant battle has largely been won in the House of Lords and in the medical profession, the war is far from over. There is still much work still to be done in changing the opinions of the public and of MPs, and Christian doctors have a pivotal role to play in the process through educating the churches, the profession and society in general about the dangers of assisted dying legislation, and through promoting wider accessibility and better public funding for palliative care.

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

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news reviews

Culture Wars
Defining the battle line

Review by **Peter Saunders**
CMF General Secretary

The 20th Century was defined by economic and class-based divisions between socialists and capitalists. But with the main political parties now increasingly embracing free market capitalism and in the absence of an argument about economic management, culture rather than economics will be the future's defining political divide. The 21st Century will be defined by cultural and social divides, between liberals and conservatives.

American culture wars are already being fought.[1] Liberals embrace abortion, gay marriage, drug legalisation, sexual permissiveness, embryo research, euthanasia, easy divorce, cohabitation, political correctness, positive discrimination, government interference, and higher taxes and spending to pay for welfare; Conservatives most likely go to church and oppose all of the above. The best predictor of whether a white American voted Republican in 2000 was church attendance more than once a week – 79 percent of this group voted Bush.

By contrast, British liberalism reigns largely unchallenged. Small victories are won – the government defeat over the *Racial and Religious Hatred Bill*, and the rejection of the Joffe Bill – but the general policy thrust, both Conservative and Labour, is liberal. Daily, the headlines are dominated by yet another liberal triumph. Cohabiting couples are to have equal rights as the married; churches and mosques are to be forced to rent out their premises to homosexuals; under-age sex is actively encouraged by the media; single parent families are to be admired as much as married families; drug-taking celebs are condoned; Christian teaching is thought freakish and extreme; and the Human Rights Act makes a mockery of the criminal justice system to the point of virtual collapse of law and order.

The British liberal establishment is now so powerful that it is a wonder we won the euthanasia vote. Government departments, institutions, the media, and even medical journals and organisations like the BMA are increasingly influenced by powerful liberals. As a result, Christians are increasingly marginalised, left without a voice, by the new establishment.

Many UK Christians will have reservations about some of the issues supported by our brethren in the US. Christian morality is in some ways a strange mixture of right and left wing politics – mixing traditionally left wing concerns for the poor, disabled, ethnic minority groups and developing world with a more traditionally right wing opposition to abortion, euthanasia and sexual immorality. The common factors we would want to emphasise are a concern for the vulnerable and marginalised, and recognition that those most easily exploited need to be both strengthened and protected.

But following in the footsteps of Christ in these days involves both the willingness to speak out on behalf of the voiceless, and the willingness to suffer and expend energy on their behalf. And to do that effectively, we need to be involved at every level of society, not only at the grassroots, but also in the media and institutions.

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Complementary medicine
The Professors, the Prince and the WHO

Review by **Rachael Pickering**
Associate Editor

The ongoing conflict between orthodox medicine and the proponents of complementary and alternative medicine (CAM) spilled onto the letters pages of the *Times* recently.[1] An open letter from leading doctors, including Professor Ernst and Nobel Prize winner Sir Black, criticised the NHS' seeping acceptance of CAM. It urged those holding influential positions to review local practices and lobby the Department of Health on the matter: '…patients, the public and the NHS are best served by using the available funds for treatments that are based on solid evidence'. They also criticised the Smallwood report, commissioned by the Prince of Wales, which suggested that more NHS-provided CAM might lead to widespread benefits.[2]

This gloves-off approach came just as Prince Charles was speaking at the World Health Organisation, promoting his fervent belief that CAM therapies are the answer to our medical prayers: 'I believe that the proper mix of proven complementary, traditional and modern remedies…can help to create a powerful healing force for our world…orthodox practice can learn from complementary medicine, the West can learn from the East and new from old traditions'.[3] This may be an admirable aim but the standards of proof deemed acceptable by CAM advocates appear far woollier than the rigorous standards demanded of orthodox medical trials.

Prince Charles' alternative medical hobbyhorse is more than 20 years old but he comes from a long line of ancestral CAM enthusiasts, right back to Queen Victoria's grandfather.[4] His view of orthodox doctors as small-minded and petty for refusing to admit CAM into the NHS fold is well known. But despite this, and to his own amazement, the BMA actually elected him president for its 150th anniversary year; he used his tenure well, making both friends in high medical places and digs at doctors' reluctance over CAM in several speeches.[5] And in 1997 he established the Prince's Foundation for Integrated Health to encourage CAM's integration into modern healthcare.[6]

As Christian doctors, we no doubt agree with the spirit of the Prince's vision: 'integrated healthcare – the best of all healthcare for the whole person'.[7] But whether or not CAM can realise this vision is where we will continue to disagree. True whole person medicine needs to be properly evidence-based.

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SAVE versus ABC

The Alphabet Wars of AIDS Prevention

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

In April, Christian Aid declared its support for the new HIV prevention strategy SAVE (Safer practices, Available medications, Voluntary counselling and testing, Empowerment.), as ABC (Abstain from sex until marriage, Be faithful to one sexual partner, and use Condoms) was 'not well suited to the complexities of human life'.[1] Some groups, who support ABC as applied in Uganda, are very unhappy with Christian Aid's announcement;[2] others though feel that ABC is now too pressured by US funding, causing an epidemic rebound due to over-emphasis of A and under-emphasis of C.[3,4]

Christian Aid is not against ABC but sees SAVE as a more comprehensive strategy. Developed by ANERELA+ (African NEtwork of REligious Leaders living with or personally affected by HIV and AIDS), SAVE seeks to provide a nuanced and broad based response to the real issues faced by African communities.[5] UNAIDS regards these strategies as integral to HIV prevention, but is not itself promoting any one acronym.[6]

By devising catchy acronyms to encompass complex realities, we can create falsely opposed positions. ABC is highly effective for a general population. It can be embraced by SAVE's *Safer Practices* arm; but its value is limited for example when working with prostitutes who instead require emphasis on condom use and finding viable alternative employment.[7]

In reality, there are several AIDS epidemics, each requiring a specific strategy. The anger directed by conservative and liberal factions towards the other's methods is obscuring the evidence: we need various locally appropriate and integrated HIV prevention programmes.[8]

God's plan for human sexuality is the ultimate HIV safeguard, yet we are a fallen humanity.[9] Even believers sometimes fail to be sexually pure, let alone those who do not share our faith in Jesus and are without the empowerment of the Holy Spirit to lead regenerated lives. Christians need to address harm minimisation when fighting HIV. Equally, secular groups need to recognise that, without primary sexual behaviour change, condoms are of limited, even detrimental, value.[10] Rather than getting bogged down in childish alphabet wars, the way ahead lies in adopting a more balanced approach, listening to one another and working together with what actually saves lives.

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Human Trafficking

Horrific indifference to human misery and injustice

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

In June and July 2006, Germany played host to the World Cup. Up to three million football fans from across the globe descended on the country. Amongst the leisure services provided by the German authorities were dozens of legalised brothels. Up to 100,000 women, mostly from outside Germany, are thought to have been involved. German state licensed brothels have strict rules on condom use and ensure the women's access to health facilities, but the premiums men will pay for sex without condoms may have resulted in many unlicensed, unregulated brothels as well.[1]

There are several alarming issues: the moral question of promoting sex for financial gain; the public health issues of STDs and HIV; and the matter of human trafficking.

Trafficking is hard to quantify but anecdotal evidence from human rights groups suggests that, as far away as Latin America and Sub-Saharan Africa, girls and young women were being approached with offers of lucrative summer work in Germany – jobs that in most cases end up in unlicensed brothels. All over Eastern Europe, including the new EU accession states, thousands of women and girls were in danger of being trafficked to Germany.[2] But the authorities, including FIFA and the FA, did not express concern.

Human trafficking is a major 21st Century global issue. UNICEF estimates that 1.2 million children are trafficked each year and forced into labour or prostitution.[3] Similar numbers of adults are also victims of this modern slave trade with many of the women ending up in the sex industry. Home Office Research, based solely on reported cases, estimated that up to 1,420 women were trafficked into the UK over just one year.[4]

This is not economic migration but the abduction or deception of people into bonded labour, often in harsh and dangerous conditions. The horrific indifference to this human misery and injustice is deeply disturbing. When linked to the sex trade, the sexual and mental health impacts of this industry are truly horrifying. How many of these girls and young women end up infected with STDs and HIV is anyone's guess, and the potential for HIV spread to other clients, their partners and subsequent children is another cause for grave concern.

Either by supporting the church-based Stop the Traffik campaign or by other means, we need to lobby our government and the European Union to take active measures to tackle this pernicious industry. We should also consider getting behind groups – including a significant number of churches – who are helping victims of trafficking.[5] Scripture warns us that God judges harshly those who force people into slavery, and the commodification of vulnerable human beings into sex objects is a debasement of the image of God in each trafficked person.[6]

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Helen Barratt raises questions about prenatal eugenics

A question of perfection

Speaking to the *Daily Telegraph* recently, Lisa Green from Margate, Kent, described how 35 weeks into her second pregnancy, her obstetrician broke the news that her baby had Down's syndrome, and encouraged Mrs Green and her husband to consider a termination. She went on to say, 'My baby was fully formed and his name was decided. I was appalled. He urged us to think about the termination and think about how having a baby with "mental retardation" would affect our lives.'

Mr and Mrs Green decided to go ahead with the pregnancy and, two weeks later, she gave birth to Harrison who is now two years old and has just started nursery part-time. He is, according to his mother, a 'happy and healthy' child. However, Mrs Green added, 'The frightening thing is that, had we been told by the same doctor about the Down's syndrome earlier in the pregnancy, there is a chance we might have decided to abort. That decision would have been based on incomplete and biased information.' Their obstetrician, Mr Prakash Belgaumkar, reportedly 'listed only the potential negatives about Down's syndrome', and failed to provide the couple with any further information to read 'for a more balanced view'.[1]

The NHS National Down's Syndrome Cytogenic Register (NDSCR) shows that in 2004 abortions of Down's Syndrome children, at about 937, outstripped live births at 657. The register contains detailed data on all cases of Down's syndrome diagnosed cytogenetically in England and Wales from 1989 to 2004.[2] Similar figures published by the Down's Syndrome Association, demonstrate that 62% of Down's Syndrome children are diagnosed in the womb, and 92% of these are aborted.[3] Separate data from the Department of Health reveal that these included 11 'late' abortions for Down's syndrome in 2004, which took place after the usual 24-week limit.[1]

Overall, the incidence of the condition is rising: there were 1,067 Down's syndrome pregnancies in 1989 but by 2004 this had risen to 1,659. This is largely because women are tending to delay having children until later in life when the risk of having a child with the condition is higher; the number of women giving birth in their forties has doubled over the past decade. Yet, despite this, the number of Down's Syndrome babies born each year has actually fallen from 750 in 1989 to the current level of 657.

Although prenatal screening is not currently offered to all pregnant women, the results of routine ultrasound or maternal blood tests can raise suspicion of the condition. However, a firm diagnosis can only be made through tissue diagnosis, either at 10-12 weeks by chorionic villus sampling or by amnioncentesis at 16-20 weeks. However, these investigations are not without risk - approximately one percent of women will miscarry as a result of the test - and there is around a five percent false positive rate. It is also estimated that the cost to the NHS is approximately £15,300 per Down's syndrome pregnancy detected.[1]

A survey carried out by the Down's Syndrome Association, involving 900 families given a positive diagnosis for the condition, suggests that couples are having to embark on antenatal tests without being given time or balanced information to consider the full consequences, as the Green family also claimed. Nuala Scarisbrick, a trustee of the pro-life organization Life, described the offer of late terminations for Down's babies as a case of 'overt eugenics'.[1] She added: 'There are human rights for everybody unless you are disabled in some way, it seems'. Similarly, writing in *The Independent*, Lord Rix, chairman of the learning disability charity Mencap, notes: 'The ghost of the biologist Sir Francis Galton, who founded the eugenics movement in 1885, still stalks the corridors of many a teaching hospital.... Down's syndrome is not a disease, it is not an infection, it cannot be cured but attitudes can be changed.'[4]

Much has already been written elsewhere about the wrongs and rights of abortion, and more recently about the debate surrounding 'late' abortions.[5] However, the specific issue of abortion for fetal abnormality raises other, perhaps even more challenging, questions. There can be no doubt that raising a child with special needs involves substantial costs in many areas, and few of us – if honest – would actually choose to bring a child with disabilities into the world. The prevalent attitude towards Down's syndrome pregnancies also speaks volumes about society's constant pursuit of perfection, and its consequent refusal to accept anything that fails to meet up to our own exacting standards.

However, throughout the Bible we see God's concern for the weak, and as stewards of his creation, we are called to emulate this; 'bearing one another's burdens' lies at the very heart of Christian morality.[6] We must 'defend the cause of the weak'[7] and 'help the weak'.[8] This mandate involves compassionate caring like that demonstrated by the Samaritan man in Jesus' parable, not seeking our own human means to obliterate weakness (and the weak) from the world.[9] Arguably, illness and disability are the consequence of the Fall, but we must not forget our equality before God – regardless of our ability.[10] Indeed the apostle Paul reminds us that while we were *all* still weak, Christ died for us.[11] For Christian doctors, bearing one another's burdens involves not only seeking to provide the best medical care for all members of our society, especially the most vulnerable, but also proactively supporting their families in the longer term.

Helen Barratt *is a Foundation Trainee in Berkshire*

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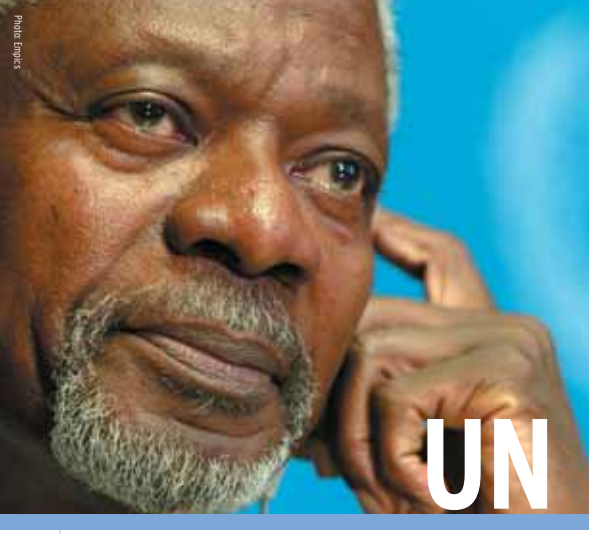
Steve Fouch reports from the recent meeting on HIV/AIDS



UN misses AIDS targets

At the start of June, delegations from across the globe, including over 100 from faith-based groups, descended on New York for a high level meeting at the UN General Assembly (UNGASS). It was five years since the UN's first declaration on HIV and AIDS in 2001. That declaration had been criticised in many ways, but it was a first – the global community had never come together at that level before to consider how it could respond one of greatest threats to health and development in modern times.

The aim this year was to strengthen the declaration and look at how much had been achieved (or not), and at what further actions and commitments the world community needed to make to turn the tide of the global HIV pandemic.

In many ways, the picture looked grim. Most of the 2001 targets have not been met – many by a very long way. For instance, globally only 20 percent of young women, and 33 percent of young men, can correctly identify ways of preventing HIV transmission. The 2001 target was for 90 percent to be able to do this by 2006. Even more scandalously, only nine percent of HIV-positive pregnant women receive antiretroviral (ARV) treatment to prevent their baby contracting HIV; the UNGASS 2001 target was for 80 percent to be in treatment by 2005.

While some progress has been made on treatment, only 20 percent of people who need it have access to it. Support services reach less than ten per cent of orphans and children made vulnerable by HIV. The list goes on.[1]

On the plus side, over 20 nations have achieved their targets, with some even exceeding them. More than half of those needing ARV therapy in Uganda now receive it – the target was for *at least* 50 percent on ARVs by 2006. Other nations are hitting the targets for treatment, prevention of mother to child transmission, care for orphans, and reducing the rate of new infection. But over a hundred countries are not only failing to reach their targets, they are failing significantly.[2]

The final declaration in 2006 was a step forward on 2001 – stronger statements on women's rights, on access to affordable medicines for the world's poor, and a recognition of the role of sexual abstinence and fidelity programmes within a wider prevention strategy. But there were no concrete commitments to funding treatment or prevention, and no commitment to universal access to ARVs. To date, only about 1.5-2 million of the 9-10 million poor people in need of ARV therapy have access to it.

The declaration did not acknowledge that groups such as homosexual men, commercial sex workers and intravenous dugs users are particularly vulnerable to HIV and need specific strategies aimed at their needs.

Furthermore, although acknowledged for the first time, much of language about protecting the rights of girls and women is far weaker than was hoped, allowing some countries to ignore the needs of the group most vulnerable to HIV infection. The reasons for this weakening were manifold – many African and Muslim governments opposed any language on the rights of women and girls and on recognising specific groups that are vulnerable to HIV have specific needs. The US had sought to oppose the WTO Doha agreements allowing poor nations to produce generic copies of patented ARVs – thankfully they were in a minority. Some of the Civil Society groups represented wanted references to abstinence and fidelity programmes removed – thankfully they too failed, as did their attempt to water down a commitment to evidence based approaches to HIV prevention. Others wanted the right to abortion included, again unsuccessfully.

Many governments oppose any language on the rights of women

However, for all the failings of this declaration (and the fact that it is only a declaration means it is likely that many countries will ignore most of it), the inclusion of a significant number of faith-based groups at this meeting has opened up a doorway. We may be responsible for as much as 60 percent of all the care in some of the worst affected nations (possibly more in some), and so we have a unique position as Christians to hold our governments to account.

And the UK government, for all its funding of AIDS overseas second only to the USA in quantity, is failing at home. A junior health minister, visiting the UK Permanent mission to the UN for the high level meeting, admitted to me that the UK government did not see this as anything other than a development issue. The Department of Health's official position is that we are doing enough at home already. This is despite the fact that there is no specific HIV prevention strategy in the UK, that it is bundled in with a failing sexual health strategy, and that the rate of new HIV infections is increasing at an alarming rate – especially (and alarmingly) within the heterosexual population.[3]

CMF will continue to watch and challenge our government and, through networks such as the Christian HIV and AIDS Alliance[4], seek to hold the global community to account and encourage the global church in the response to this pandemic. If the HIV and AIDS pandemic does not come under control, it will be for want of diligence and effort.

Steve Fouch *is CMF Allied Professions Secretary and also Secretary for the Christian HIV and AIDS Alliance (CHAA)*

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Clare Cooper comments on the career disruption facing international medical graduates

Dismayed + discarded

key points

In March the Department of Health announced that international medical graduates (IMGs) now require work permits. This affects up to 15,000 foreign doctors currently working in the NHS or looking for work post-PLAB, as well as those doctors intending to come to the UK in the near future. Any trust wishing to appoint an IMG doctor must now go through an expensive and complex process of proving that the post could not have been filled by any of the other applicants. Although this change in policy will help stem the Developing World medical brain drain, there is the issue of justice for doctors already established here.

The shock announcement that international medical graduates (IMGs) now need a work permit to train or work in the NHS came in March. Years of encouraging doctors to come to the UK were suddenly ended by a statement from Health Minister Lord Warner: doctors will only be recruited to the UK where there is a genuine skills shortage. NHS Trusts will be required to get a work permit for every doctor they wish to employ from outside the European Economic Area (EEA) and will also have to demonstrate that a resident worker could not fill the vacancy.[1] This decision affects not only those who wish to come here to work, but also those who are in the UK now. Despairing doctors who have invested much time, effort and money to further their medical careers in Britain feel badly let down. Many will have to return home at short notice. This sudden change has caused confusion among employers and employees alike.

Background

The NHS has relied on international recruits to maintain adequate staffing levels. As some overseas doctors return to their own countries after training, they have helped fill junior posts without generating too many applicants for consultant posts. Now the system has broken down. SHO posts in Accident and Emergency, for example, have attracted on average 537 applicants over the past 18 months.[2] Some advertisements have resulted in more than 1,000 applications. With next year's medical graduates increasing by 20 percent, high numbers of IMGs passing PLAB (Professional Linguistic Assessment Board) tests, and European Union doctors also seeking work in the UK, action had to be taken.

Previously, overseas doctors and dentists could train in foundation programmes as senior house officers and in specialist registrar grades or their equivalent. For immigration purposes they were considered as being in training, not employment. Now the posts are being regarded as employed positions requiring work permits. The old category of 'postgraduate doctors and dentists' continues but only applies to non-EU nationals who have completed their medical or dental studies in the UK and are allowed two years permit-free training in the foundation programme.

Permission to work

To obtain a work permit an employer must show that a vacancy exists which cannot be filled by a resident worker from the UK or EEA, nor by a UK doctor who is either a refugee or on the Highly Skilled Migrant Programme (HSMP). Doctors with existing leave to remain can stay until that leave expires. Should they be in a post when the leave expires, they will have to apply for a different category of leave to complete the post, probably the work permit category. IMGs in some immigration categories (eg. a dependent of another migrant) may not be able to apply for such a work permit and would have to leave the UK and then make the appropriate application for entry clearance from abroad.

Refugee doctors, along with UK and EEA

graduates, will now have less competition when applying for jobs. However, there are concerns that some medical staffing departments think they are only to consider the European applicants, regardless of others' immigration status. We are now left with a situation where a graduate from a substandard Eastern European medical school (who, for political reasons is exempted PLAB and speaks English only as a third language) is to be preferred over a doctor, fluent in English, who trained in a top Indian medical school (based on the British system) and has passed PLAB. It is not surprising that BAPIO (British Association of Physicians of Indian Origin) has initiated legal action against the Department of Health (DoH).[3]

Getting a work permit

To obtain a permit, the employer must pay a £153 fee and submit application form WP1, the candidate's GMC certificate and references, and evidence that the post could not be filled by a resident worker: a copy of the advert; confirmation of where and when it was advertised; details of how many applied and how many were short listed; and an explanation as to why each resident applicant was not appointed. On top of all this, the doctor also needs to be granted leave to remain in the UK.

Devastating effects

The new Immigration changes will have devastating effects on 12,000 to 15,000 International Medical Graduates (IMGs) who are either already working in the NHS or have passed PLAB exam and are looking for jobs. There has to be a smooth transition period, and the doctors who are already in the UK, prior to the announcement of these new rules, should be given adequate time and opportunity to complete their training and to make proper plans regarding their future. Henceforth, the GMC, DoH, Home Office, BMA and ethnic minority doctors organisations should work together and have proper work force plans, so that IMGs are treated with dignity and respect.[4]
(Dr Umesh Prabhu, The British Association of Physicians of Indian Origin)

Betrayal

There is near universal acceptance that UK graduates should have posts available to them. Nevertheless, the unexpected introduction of these regulations without consulting doctors' representatives has angered many. IMGs already here will find it much harder to get a job, especially a highly regarded position. Overseas doctors feel betrayed. They were encouraged to come to the UK but now compete with more UK graduates, thanks to medical school expansion, resulting in unemployment for both groups. Nonetheless, the current remedy is ill thought out. Overseas doctors have expressed distress over the DoH 's insensitivity. Some dread the humiliation of returning home, poorer and jobless.

One physician recalls a recent unpleasant experience when selecting 70 candidates for medical training posts. Four EEA candidates had scored fewer marks than the best 70, but they were above the 'minimum acceptable'. So, the selectors were obliged to displace four IMGs to make way for the EEA candidates. 'I cannot recall ever feeling as tainted as I did by this final process.'[5] Jobs are not necessarily being given to the best applicants.

Ways forward

The DoH has failed to collect workforce-planning data that would allow for accurate projections of medical vacancies. In addition there is uncertainty as to the effects on vacancy numbers of Modernising Medical Careers and the phasing out of SHO posts. Numbers of applicants and posts may not match in the coming year or so. What can be done?

- The number of doctors taking the PLAB exams could be limited. This question has already been raised with the GMC.
- IMGs already here could be exempt from the new regulations.
- The BMA has called for better workforce planning and an increase in training grade posts, consultants and GPs.[6]
- Clear guidance is needed regarding the wording of advertisements in order to ensure that they are not discriminatory; for example, stating 'non-EEA nationals or candidates who require a work permit need not apply' should not be acceptable.
- There will be a greater role for organisations like PRIME (Partnership in International Medical Education) to offer teaching in home countries.
- The BMA and the British International Doctors Association advocate an annual international application process with doctors applying for training posts from their home country, and only travelling to the UK once a job offer had been made. Recruitment would thereby be on the basis of workforce demand as in the USA and Australia. Once within the UK, IMGs would then compete with other medical graduates fairly. According to the DoH, such a recruitment process should be in place in the UK by August 2007.[7]

Negotiations are underway and the rules may be modified as a result. It is a pity though that consultation did not take place *before* Lord Warner's announcement, as this may have averted some of our colleagues' distress.

Love our neighbours

The DoH's change in policy is not in keeping with biblical morality: 'When an alien lives with you in your land, do not ill-treat him. The alien living with you must be treated as one of your native-born'.[8] Nor does it conform to Jesus' command to 'love your neighbour as yourself'.[9] The Good Samaritan cared for aliens, sacrificially giving them time and practical help, despite cultural divisions. The new regulations will help commendably to stem the Developing World brain drain.[10] However, the effect on those caught in the middle - their UK training incomplete and their future uncertain - is to be condemned.

***Clare Cooper** is CMF Medical Secretary*

Despairing doctors feel badly let down

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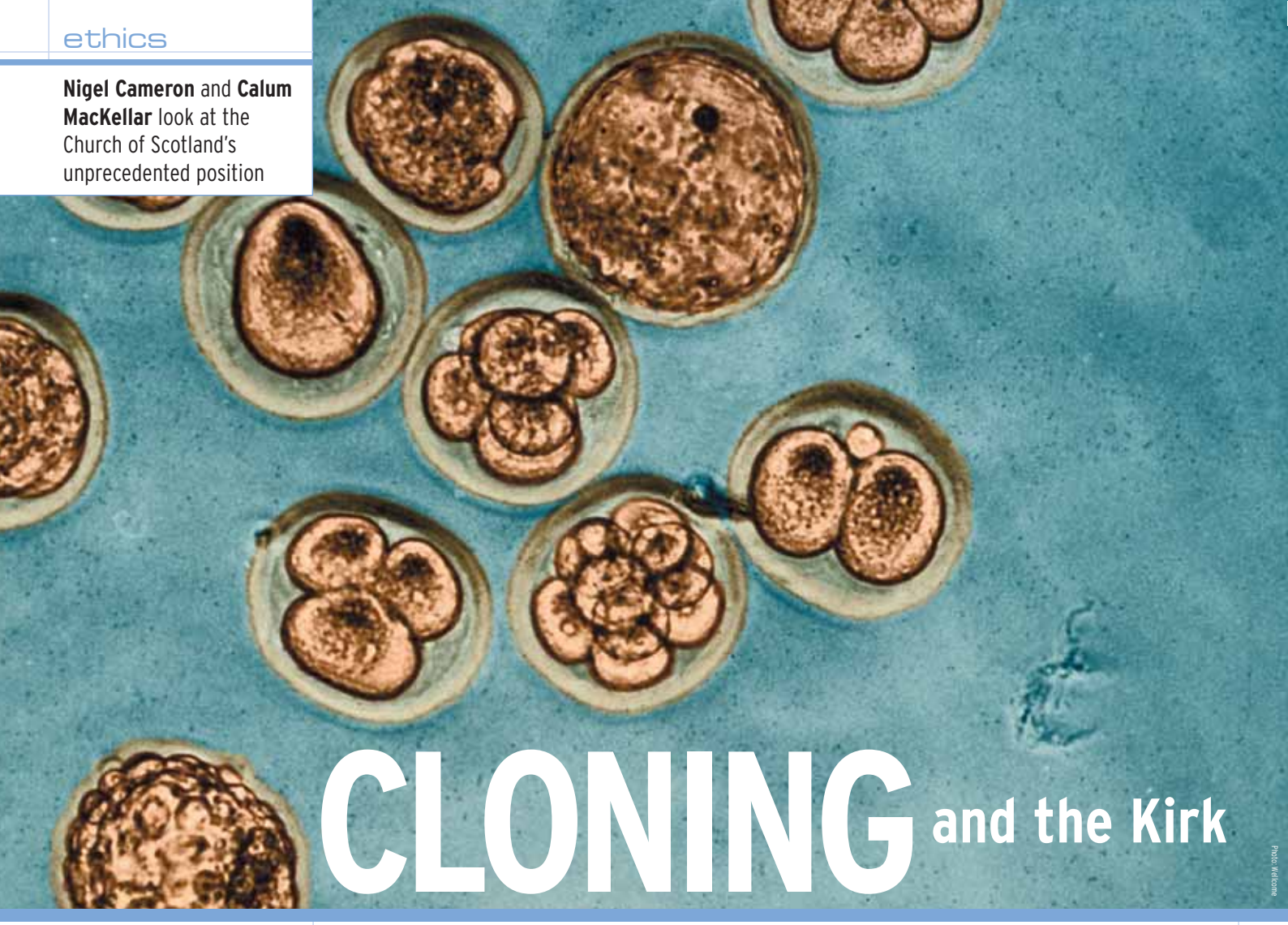
Nigel Cameron and **Calum MacKellar** look at the Church of Scotland's unprecedented position



CLONING and the Kirk

Photo: Wellcome

key points

Buoyed up by the success of Dolly the Scottish Sheep and manipulated by atheistic working party members, the Church of Scotland's ruling body, the Kirk, has made the unprecedented move of approving therapeutic human cloning. In aligning itself with the UK government's ethically rogue position on cloning, the Kirk is now on a moral collision course with almost all other expressions of Christian opinion around the globe, as well as the United Nations. Many Church of Scotland members are deeply distressed by this ruling which has turned their denomination into a rogue church.

The Church of Scotland has made a dubious mark for itself by approving the cloning of human embryos for research, swimming against the moral tide of the likes of the United Nations General Assembly, The Council of Europe, The World Council of Churches, President Bush and the Roman Catholic Church. And although the majority vote of the Kirk during its General Assembly in May 2006 cannot remove the dignity given by God to human embryos, the Church of Scotland is now on a collision course with almost all other expressions of Christian opinion around the globe.

What happened?

How has this happened in what used to be a bastion of biblical principles? There are stories of working parties on which most participants were not even members of the Kirk including known atheists working in the field of embryonic stem cell technology. There are rumours about the role of the Science Religion and Technology Project of the Church of Scotland, chief puppeteer of the Kirk's approach to science and technology and an advocate for the less savoury ambitions of the biotechnology industry. But probably the most significant reason for the majority vote is the strong utilitarian influences that have now established themselves in the Kirk. And these have decided that human embryos can no longer have full moral status because they have become useful to researchers!

Scotland of course has reason to be proud of the efforts that went into cloning Dolly. Our problem in the UK is that back in the 1980s, with the Warnock Report and in contrast with almost every other nation on the planet, the creation of embryos for experimentation was endorsed. And despite the fact that almost no other democratic nation has followed our lead, the UK government has stuck to its unethical and lonely guns and decided that creating cloned human embryos for research was a good thing.

World opinions

Most nations do not allow any cloned embryos to be created. Feeling on this matter is so strong that the world's first global policy statement on bioethics has been approved by another general assembly, that of the United Nations: the UN Declaration on Human Cloning decided by nearly three to one to urge all nations to ban all forms of human cloning.[1] In addition, the European Convention on Human Rights and Biomedicine of the Council of Europe, which is the world's first biopolicy treaty, specifically prohibits the creation of human embryos for research through any means including cloning. At present, out of the 46 countries of the Council of Europe:

- **19 member states** have ratified the convention, making it legally binding in Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Georgia, Greece, Hungary, Iceland, Lithuania,

Moldova, Portugal, Romania, San Marino, Slovakia, Slovenia, Spain and Turkey.

- **13 member states** have signed their intention to ratify the convention as soon as their national parliaments have enacted the necessary legislation: Bosnia and Herzegovina, Finland, France, Italy, Latvia, Luxembourg, The Netherlands, Norway, Poland, Serbia and Montenegro, Switzerland, the Former Yugoslav Republic of Macedonia and Ukraine.
- **One member state** – Sweden – had signed its intention to ratify the convention but has since legalised the creation of human embryos for research, thus making ratification impossible. In doing so, Sweden is the only country to have openly and publicly repudiated its previous ethical stance.
- **Five member states** have not signed the convention because they find it too liberal, giving insufficient protection to human beings, especially human embryos: Austria, Ireland, Germany, Liechtenstein and Malta.
- **Six member states** have not signed the convention because they are either too busy on other matters to consider new legislation on biomedical ethics, too small or have only just joined the Council of Europe: Albania, Andorra, Armenia, Azerbaijan, Monaco and Russia.
- **Two member states** – United Kingdom and Belgium – have publicly indicated that they have no intention, at present, of signing the convention. This is because, amongst other things, it would prohibit the creation of human embryos for research through cloning or other procedures.

Rogue states

So the UK and Belgium are the only states refusing to sign the convention because of their very liberal bioethical stances. And in this regard, they are beginning to be seen by the rest of Europe as ethically rogue states in which any number of moral principles can be disregarded if they become a hindrance to scientific research. In other words, many countries such as Turkey are now in a position to look down upon the UK and question the manner in which the British government drafts its extensive but unethical legislation in the field of biomedicine.

Dangerous precedents

And for the Church of Scotland, which is a moral body, to support the UK government in its unethical isolation, to knowingly reject European Human Rights Legislation and to support the creation of human embryos specifically for destructive research can only but create a very dangerous precedent. It will completely undermine the Church's reputation and Christian witness both at home and internationally.

The Catholic Church, true to its commitment to human life from the beginning, is against cloning for research. No surprise perhaps. What is remarkable is that the World Council of Churches (WCC), at the other end of the spectrum on so many issues, takes the same view. And if the Catholic Church and the WCC are of the same mind, if President Bush agrees with environmentalists and radical feminist leaders, then the Church of Scotland should be very concerned about its unethical stance, which is in opposition to most other countries, lobby groups and established Christian churches around the world.

But the Church of Scotland did not only endorse human cloning. In its General Assembly of May 2006, it also agreed that human embryos left over from IVF could be used for destructive research. But in doing so, it did not mention that there are already more than 110,000 frozen human embryos stored in the UK and already available for research.[2] It failed to indicate that scientists have already destroyed 18,000 human embryos.[3] It ignored the reality that UK researchers would go to prison if they destroyed human embryos in at least eleven European countries including Slovakia, Poland, Germany, Ireland, Norway and Italy. And it completely overlooked the fact that many infertile couples in the UK are seeking to but cannot adopt these embryos.

Sacrifices

Instead, the Church of Scotland preferred to disregard the views of a significant number of its members who believe that these human embryos can be considered as children. The Kirk is now openly endorsing a practice that could be compared to the human sacrifice of children for a perceived potential benefit in the health field. This is not dissimilar to the practice of the Phoenicians some 3000 years ago, as they also sacrificed their children to their gods for some perceived potential benefit in their quality or length of life.[4] And it is difficult to describe the deep sense of distress and shame that these Church of Scotland members now experience towards their denomination.

Rogue church

This is not a debate about the freedom of science, or about abortion, and we certainly cannot allow it to become a debate about boosting the profits of the biotech industry. The importance of a clear moral framework to guide policy as we fast-forward into the momentous challenges of the biotech century is incalculable. Controversial procedures such as cloning have emerged as the flashpoint ethical questions of our generation, a unifying force that draws together in opposition bodies of men and women of principle from across the cultural and political spectrums. It is unfortunate that the Kirk is not one of these bodies. Instead it has betrayed its responsibility and spiritual calling and become an ethically rogue church that encourages the rest of society to slip down the slippery slope to a 'brave new world' where godly principles are dismissed as outdated.

Prof Dr Nigel Cameron *chairs the Centre for Bioethics and Public Policy in London*
Dr Calum MacKellar *is a bioethicist and an Elder in the Church of Scotland*


Photo: Empics

Roslin Institute's Ian Wilmut

Strong utilitarian influences have now established themselves in the Kirk

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Janet Goodall reflects on Ephesians

Reflecting Christ in the workplace

key points

Healthcare professionals are not exempt from stress, burnout and post-traumatic stress disorder. Jesus too suffered fatigue and at times felt overwhelmed, but he received grace and strength to persevere. He knows how we feel when we are tempted to give in, give up or get out. Paul's letter to the Ephesians embodies much of Jesus' teaching about dealing with life's stressors. He reminds us of our calling, our competencies and the character God has in mind for us.

'I've just about had enough. I'm getting out!' How many times have we heard this? How often have we thought it? In Britain, we so often hear of stress, burnout and post-traumatic stress disorder. Healthcare professionals are not the only ones to witness one tragedy too many or simply to suffer from being overstretched. Yet if we lived in a war zone or a part of the world affected by natural or unnatural disasters, we might then consider our British trials to be relatively modest. In his incarnation Jesus, too, suffered fatigue.[1] At times, he felt quite overwhelmed by the horror that lay ahead of him, but received grace and strength to go through with it.[2] He knew the fullest force of temptation because he never yielded, and therefore he now knows exactly how we feel when we are tempted to give in, give up or get out.[3]

When Paul was persuaded to leave Ephesus, he knew that arrest and possible death lay ahead but still he longed to complete his appointed task.[4] Much of what he says in his letter to the young Ephesian church is still relevant and encouraging to those working under pressure today. He reminds us of our calling, our competencies and the character God has in mind for us.

Our calling – Ephesians 1:3-14

Even though he was writing from prison, Paul quickly turns to praise. He lists the many blessings given to those who, through Jesus Christ, have been adopted into his family, *chosen* by God[5] with the thrice-mentioned intention that they should live to his praise and glory.[6] This repetition should make us ask if that is how we come across - not only when wearing our shining going-to-church faces, but also in the workplace. The church is the body of Christ, not just a building. So, whether we are in our consulting rooms, operating suites or committee meetings, *there* is the church. God is bringing *all things* under the headship of Christ so this must include *everything* that happens in our places of work.[7]

Therefore, our ultimate authority is not our own autonomy, primary care trust, health authority, or even the Minister of Health, but Christ himself. Assurance that all new edicts, difficult patients and ethical dilemmas are to be dealt with 'to the praise of his glory' should help us to look trustfully to God for the wisdom and understanding 'lavished' on us for times like these, rather than letting ourselves get anxious, frustrated and exhausted.[8] Paul's own great

enthusiasm would have been fuelled by knowing that the Greek *en theo* means 'possessed by a god'. If our calling is to be possessed by the God of gods, then we too should work with enthusiasm.

Our competencies – Ephesians 4:7-13

We are reminded that we have been *called* by God, so we are not just doing a job but fulfilling our vocation.[9] We are all told to be humble, gentle, patient and loving;[10] but we also need to find our particular God-given competence and use it in the workplace as much as elsewhere. Yet since the Fall, the work of 'subduing the earth' has been hard and burdensome.[11] Many around us still complain bitterly that, rather than subduing their workload, it is subduing them! It is in Christ that we can receive God's redemption and abundant supply of grace, raising us up to enjoy his gifts.[12] Christians should not join the chorus of moaners but instead act as encouragers and burden-sharers.

Just as God elected people in the early church to be apostles, prophets, evangelists, pastors and teachers, so we should find distinctive, perhaps parallel, gifts in each other for use as much in our professional callings as within a formal church setting. Paul defined the marks of an apostle as signs, wonders and miracles;[13] however, he claimed those who had believed through his ministry as the seal of his apostleship.[14] Many Christian doctors experience this same seal, even when not widely known as wonder-workers. Some of our patients have been prompted to put their faith in Christ simply because we have, even unconsciously, acted as channels of his love to them. Our employers might veto open evangelism in the workplace, but in Britain the official line is that spiritual support may be offered when not offensive to the recipient. More people are likely to complain about hasty, uncaring attitudes than about Christian concern for their deepest needs.

By applying biblical principles and being open to the Holy Spirit, some are enabled to 'prophesy' the results of a particular course of action, both in consultations and on committees. Through a divine nudge, an unconscious foretelling, our words might be used to avert an approaching disaster, perhaps within someone's relationship. It can be easier for practitioners of front line - rather than back room - medicine to see themselves as pastors, whereas others know that their special competence is in administration or simply the ability to help others.[15] We should beware of the assumption of some church fellowships that doctors will automatically take a leading role, and thereby arrest growth in ability for others. It could be that our God-given gifts are primarily intended for use in the mission field of our daily workplace, inaccessible to others of God's people whose intended tasks lie elsewhere.

Not all have all gifts, but each is given for the common good.[16] In Ephesians four, Paul explains how our 'works of service' all become complementary as each part does its work within the body of Christ.[17] This does not exclude different roles emerging at different times of life, or being recognised and encouraged by others when an obvious gift lies dormant. Our prayer should be that whatever gifts we have been given - indeed, our whole lives - will be used 'to the praise of his glory'.[18]

Our character – Ephesians 5:1-21

'Be imitators of God.'[19] What an ambition! This only becomes a possibility as we allow God's Spirit to fill our lives, especially producing his first fruit of love.[20] As the Spirit of Jesus gradually works the necessary transformation, the intended image of God emerges. The alternative is to be moulded by the image of the world about us, whose ugly manifestations stem from something else having taken God's place.[21]

Since Paul forewarns us about this in detail, we should take careful note. We must be on our guard against unsavoury gossip, coarse jokes, foolish – and possibly complaining – talk, as well as sexual immorality. Temptations attack when punishing rotas keep us away from Christian friends or family, but being unemployed can leave us equally vulnerable. We are instead to 'find out what pleases the Lord', namely goodness, righteousness and truth, and to let Christ's light shine on any shady areas.[22]

Much of our medical practice deals with people (including some of our colleagues, either in person or within their families) damaged by the lifestyles Paul denounced. Whilst shunning the sins we should sensitively make the most of every opportunity to introduce offenders to our source of light.[23] This will need the Spirit's wisdom, gleaned from prayerfully studying the word of God, often in fellowship with others.[24]

As we turn our minds and hearts to the Lord, sometimes by making music to him, we not only reflect on his glory together but actually start to be reflections of it ourselves, and to be transformed into his likeness.[25] This metamorphosis is the Spirit's intention for all believers.

The passage ends by going back to 'everything' - the 'all things' that we have often found hard to cope with, or even considered walking away from. We have been reminded of our calling, of the great gift of himself that God has given and still gives, along with unique competencies for use in his service. His goal is to develop our characters to become like his. No wonder we are challenged to a new attitude in the workplace: *always* giving thanks to God the Father for *everything*, in the name of our Lord Jesus Christ.[26] Still thinking of getting out? First make sure that you have invited him in.

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

This article is based on a talk by Canon Mark Brown at a recent CMF day conference.

Many complain that their workload is subduing them!

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Rachael Pickering looks at this increasingly popular career pathway

Portfolio careers

key points

Charles Handy, Oxbridge management guru, coined the term portfolio career in the late eighties. It describes a CV made up of several careers rather than one full-time job. Doctors are beginning to branch out into portfolio careers, and several CMF members have very successful ones. Advantages include flexibility, family time, and job satisfaction; disadvantages include unpredictability and financial uncertainties. Everyone's career and talents are unique and there are many different ways of developing a satisfying and manageable portfolio career. The opportunities to serve God through portfolio work are endless.

They are the latest fashion accessories for medical CVs. But what exactly is a portfolio career? Why would you want one? And how can you get one?

Job for life?

Even within the relatively stable working environment of the medical world, there has been a move away from the traditional 'one job for life'. It is no longer rare for GP partners and consultants to move practice or hospital. Going a step further and diversifying, many doctors are acquiring more than one string to their medical bows by carving out portfolio careers for themselves.

The eighteenth century Italian word *portafoglio* describes as a folder used to carry around loose paper and drawings, hence modern day artists' portfolios. Today though, it has come to mean the collection of an individual's talents and skills.[1]

The concept of a portfolio career is attributed to Charles Handy, Oxbridge management guru and social philosopher.[2] In the late eighties, he predicted that workers would start to want more active control of their careers by having lots of small jobs.[3] And indeed, although Handy didn't specifically mention medical careers in his prediction, NHS portfolio doctors are becoming less of a rarity.[4] And within CMF, several members are putting their bulging portfolios to use for the Kingdom of God.

Ministering surgeon

Until recently, Hugh Thomson was a full time consultant upper GI surgeon. Now he works one day a week for the NHS doing endoscopies:

I spend the rest of my time as a pastor at Birmingham City Church. Combining roles is stimulating. Working in the NHS keeps my feet on the ground and gives me opportunities to share my faith. I do miss surgery and (to be perfectly honest) being important! But I have absolutely no regrets in making the change. I do think that my years in full time medical work have equipped me for pastoral ministry in a way that no Bible college could have done.

Hippocratic GP

GP Rhona Knight has found herself increasingly drawn towards the Hippocratic tradition of medical education:

After ten years of juggling GP partnership with the needs of my growing family, I resigned and became a salaried GP whilst seeking God's guidance for my career. In my PDP (Professional Development Plan) I identified a love of teaching and a need to develop a special interest.

I became a GPwSI (GP with Special Interest) after obtaining a Diploma in Practical Dermatology, and have just finished an MA in Medical Education. I now find myself with a portfolio career that includes salaried GP work, undergraduate and postgraduate teaching, and a

growing interest in bioethics and its communication to non-specialist audiences.

Looking back, I was always interested in teaching, but I didn't know that this was what I'd end up doing. I'm much happier; life, though a bit of a juggling act, is so much more flexible.

Paediatric youthworker

Chris Richards combines being a Newcastle consultant paediatrician with disaster medicine and charity work:

In April this year I went part-time in order to work for Lovewise, a charity I started up that goes into schools and youth groups to talk about Christian perspectives on marriage, sex and relationships. I give class presentations, meet with headteachers, and write booklets. My clinical job helps gives me credibility with teachers, which is a big help!

I appreciate being able to serve the Lord in two very different ways. As a paediatrician I care for children and parents, whilst as director of Lovewise I use my creative gifts to change the hearts and lives of children.

Occasionally I go to refugee crises around the world, as I spent three years of my training working in refugee camps in Africa and Asia. My trust usually lets me go, and it usually continues to pay me!

Prime educator

Huw Morgan combines GP appraisal work with an international consultancy role in family medicine development and education:

I spend most of my time volunteering with Partnerships in International Medical Education (PRIME), a Christian charity linked to CMF. This involves many trips to developing countries but there's also admin work to do back home. It is very exciting to have opportunities to present Christian truth as part of good medical practice to Muslim, Hindu and Buddhist healthcare workers, and to establish training programmes with Christian person-centred care at their core.

As a junior I could never have predicted that I would be doing this now. I always had an interest in overseas work but at that time thought only in terms of the traditional missionary doctor role. The world has changed, and teaching and empowering others in Christ's name is very much the necessary 21st Century paradigm. I thoroughly recommend it!

Pros and cons

A portfolio career can get very complicated. Trevor Stammers' portfolio includes being a GP principal and tutor, writing for both religious and academic press, speaking at various events such as CARE, broadcasting, and writing books on his area of expertise, sexual health. On top of all this, he's also studying for an MA in Bioethics:

The biggest problem I face is when my different careers collide: for example, my GP partners have to carry the can when I have to attend an urgent meeting regarding one of my other roles. In addition, two part time jobs can easily grow to become two fulltime jobs. So you have to prune them regularly! A separate problem is that others may doubt your commitment to their particular venture as you are 'only part-time'. Accountability can be non-existent in all or some spheres of your life so you can get isolated, lonely and too remote. Family life, if not prioritised, can easily suffer too.

But, on the other hand, a portfolio career can be enormously invigorating. One job may help to feed another. I find that my stress levels are lower because I have various interesting roles and don't become preoccupied by one particular fulltime stress. And my family is better off with a happy portfolio doctor than with a miserable full time GP!

Random choice or divine calling?

It's tempting to see our medical career paths as being down to good (or bad) luck or random chance. But many senior Christian medics look down the retrospectoscope and see that events which seemed random at the time were actually part of the Lord's sovereign plan for their lives.

As Christians, how can we discern whether God is calling us down particular career pathways? It's so easy to fret over career moves but the apostle Paul advises otherwise: 'Do not be anxious about anything, but in everything, by prayer and petition, with thanksgiving, present your requests to God'.[5] On occasion, it may be appropriate to lay down the odd fleece.[6] Often it's wise to seek general guidance from the Bible, and then push a few doors.[7]

Interested?

Although it's vitally important to get thoroughly trained in your major specialty of interest, it's never too early to start exploring more diverse career options. Most portfolio doctors diversify their careers as seniors but early opportunities do come along to some juniors.

Consider your talents and skills, and your career so far. What do you enjoy most about medicine? Is there anything you can't bear? Have there been any twists in your career plan so far? Do you have training in more than one speciality? Consider also your personality, lifestyle and family. Not everyone can cope with the downsides of portfolio careers.

Sometimes though, simply looking at your CV doesn't help diverse career paths spring to mind. Another way of looking at your career is to map out your life and employment history as a flow chart on a large piece of card. Remember to mark in all the co-existing factors in your life – children and spouse, hobbies and time constraints, strengths and weaknesses, and don't forget your ambitions. Show it to a couple of trusted friends, a non-medic as well as a fellow doctor, and ask where they think your strengths and weaknesses lie.

At the end of the day, most doctors will continue to pursue traditional career pathways. But, no matter how many careers end up in our portfolios, may all our career choices work together for the glory of our Lord.[8]

Dr Rachael Pickering *works in primary care, palliative medicine and medical journalism in London*

My family is better off with a happy portfolio doctor

portfolio benefits

- Combine hobbies with professional talents
- Family benefits
- Flexibility
- Home working opportunities
- Satisfaction
- Self-determination
- Sense of freedom

portfolio problems

- Ego sacrifices
- Financial consequences
- Juggling acts
- Peer criticism
- Uncertainty

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Laurence Crutchlow
gives some top tips

Surviving a week of NIGHTS

Our relationship with God is not just a function of scheduled activity

The prospect of working every night for a week is daunting to say the least! After working nights in several specialties as a GP trainee, I offer these thoughts and coping strategies in the hope of reducing anxiety for anyone starting out on weeks of nights.

Why nights?

The creation of weeks of nights was almost accidental. The New Deal of the late 1990s reduced junior doctors' hours, but left the on-call system intact. Then the imposition of the European Working Time Directive in 2004 made the on-call system unsustainable, since it stipulates eleven hours compulsory rest per 24 hours of work. Whole weeks of nights then evolved as hospital managers tried to reduce the number of working days lost by doctors taking compulsory rest.

Pros and cons

This change has brought some advantages. There are few 24 or 32-hour shifts. Doctors working nights for a sustained period may be able to adapt their body clocks to their shifts. Training may be improved by having a number of weeks with no night working at all, so minimising disruption to ward rounds, theatre lists and clinics.

But there have been some difficulties. Some have found that arranging leave has become difficult. If swapping night shifts is banned (as in many trusts), serious problems may be caused for those who need, say for family reasons, to be on annual leave at specific times. Some firms are adversely affected during the ordinary day, particularly if the registrar is on nights.

Dangers

Murray *et al* suggest that the 91 hour week that can be clocked up when doing seven consecutive nights is dangerous for both patients and doctors.[1] They presented evidence from the USA suggesting that serious medical errors increase by one third when doctors' hours lengthen from 65 to over 80 in a week. In addition, the risk of being involved in a road accident whilst commuting was shown to rise by 16 percent for those working these longer hours.

Personal life

Many of us also have difficulties with our family

lives during night shifts. Working six weeks of nights during my first year of marriage has been difficult, but such problems are difficult to avoid. One successful strategy is to plan specific time together just before and after a block of nights. In addition, my wife has tried, where possible, to make any evenings and nights when she has be to away from home coincide with my weeks of nights.

Maintaining health

The physical impact of night shifts can be reduced with preparation. Re-setting your body clock is difficult. Some shift based rotas, such as those worked by many A&E doctors, may aid body clock adjustment by scheduling a half-night shift, for example six pm to two am, in the run up to nights. However, in most cases, nights are started at the end of a week of ordinary days.

Ensure you are not overtired before your week of nights starts. Don't start the week with no petrol in the car and no food in the house. Accept that you will do little else between shifts than travel, eat and sleep. It may be best to go to bed at midday and get up at 7.30pm, much as if day and night were reversed, but this can be difficult if it is too light or noisy at home.

Make sure you don't dehydrate. Many of us try to survive nights with urine outputs that would have nurses calling for a doctor urgently! I always try to eat during a shift, and find that I get very tired if I don't. However, some find eating makes them sleepy, and it can be difficult to eat healthily at 3am!

I personally find sleeping in quiet patches helpful, but not everyone agrees. There is some evidence that short naps do help: Murray *et al* quote a NASA field study amongst pilots which suggested that a 40 minute nap produced a 34 percent increase in performance and a 54 percent increase in psychological alertness when compared with no nap.[2]

How to work

The manner in which you work makes a big difference. Working efficiently is vital. Take a handover, familiarising yourself with the sickest patients. Get routine jobs sorted out first, so that only emergencies need concern you in the early hours of the morning. Along with your senior, set a plan for any difficult patients at the beginning of the shift; that way they have more chance of rest and you can work more quickly. There is not time to 'wait and see' if you are busy, so ward emergencies are best treated definitively when you first see them. Many investigations can wait until morning, but be prepared to argue your case (graciously) with technicians for the few that cannot.

I have learned some lessons only through bitter experience. My judgment *is* worse during night shifts, particularly between about 3 and 7 am – I've learned to double-check my work.

Try to foster a good relationship with A&E. Often the same A&E SHO is on throughout your week of nights: a friendly attitude can lead to more cooperative A&E calls, so fostering a better working relationship.

I cannot hope to be refreshed if I do not leave on time. A clear handover makes it easier to get away promptly. In a shift system, it is inevitable that we will pass on some work and not complete everything ourselves. We should not feel guilty about this, but in turn we must be prepared to take on handed over work ourselves at the start of our shifts. In some jobs, you will be scheduled to work until 10 am in order to participate in a post-take ward round. However, if those ward rounds have a habit of going on past the end of your shift, you may need to ask to leave on time. I have found most consultants to be reasonable about this but you may have to take up any problems with whoever is responsible for monitoring your hours.

Keeping in touch with God

How can your relationship with God fit into such busy weeks? Church and house group meetings are almost impossible to attend when on nights. Even formal quiet times may be difficult. However, our relationship with God is not just a function of scheduled activity. We are commanded to pray constantly.[3] Gaps during work allow prayer, and these may be more frequent at night. In addition, it is possible to pray whilst working, perhaps when waiting for a bleep to be answered or for the blood gas machine to process your ABG. There is often time to read a pocket Bible or some devotional material such as the *Doctor's Life Support*, which is also available on the CMF website.[4,5]

Looking outwards, I have found more opportunities for meaningful conversations at night, particularly with other staff. Night shifts may therefore be an exercise in practising the presence of God, learning to depend more on his personal relationship with us, as our usual faith props are temporarily unavailable. We need to trust that God's promises are enduring, and that he will not withdraw from us simply because we are tired and can't be at church. He is with us 'to the end of the age'.[6]

Ultimately, obedience to God must take priority. Frequent blocks of nights have an impact not only on our relationship with God but on fellowship with other believers. If we feel called to career choices that will involve many years of night work, then we must evolve sophisticated coping strategies and trust God to help us do this. But, if having tried some of these coping strategies, nights as a seasoned junior are still proving a serious stumbling block, then perhaps God is leading you to serve him in a less acute specialty.

Laurence Crutchlow *is a VTS SHO in Birmingham*

top tips

Before the week starts

- Plan family/friends time before and after the week
- Stock up with provisions

During a shift

- Look after yourself – drink, eat and try a power nap
- Look after your faith – pray in snatches, buy a pocket Bible and get online for daily devotions
- Look after your patients – take a handover, prioritise and be proactive

After each shift

- Leave promptly
- Get to bed
- Don't aim to do anything else

Why not get online and tell us your opinions on the CMF Juniors' forum? Log on at *www.cmf.org.uk/forum*

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Jason Roach looks at our response to the spiritual death of general medical journals

The death of medical journals?

The *British Medical Journal's* appalling coverage of the end of life debate over the past few months has led many to question what is going on at our flagship journal.[1,2] The controversy has arisen because the majority of the journal's coverage on physician assisted suicide took a different view to the majority opinion of the medical profession;[3,4] the BMA recently took a neutral stance and the Royal College of Physicians' membership was clearly against any change in the law.[5,6] However, despite our frustrations, when journalists fail to meet our expectations, we should respond proactively, not just reactively.

It is hardly surprising that the media industry, of which the *BMJ* is a part, is biased, since literature - and I dare to call news reporting that - often reflects the culture in which it is produced. And it is no secret that many parts of our culture are increasingly convinced that autonomy is an overriding ethical principle. This slide away from a deontological worldview should not surprise us, as 'the secret power of lawlessness is already at work'.[7] Moreover medical journals are often staffed by a unique, self-selecting and highly trained group. They are (arguably) among the wise of this world and, as such, Paul's words to the Corinthians should echo in our minds as we read their work: 'Has not God made foolish the wisdom of the world?'[8] In other words, we should expect that some people of influence, whose wisdom should tell them otherwise, will make decidedly foolish decisions. It's a problem that is by no means limited to the *BMJ*.[9]

However, the horizon is not completely bleak. As Colson comments, 'Even postmodernists are beginning to realise the inadequacy of their beliefs as they come face to face with the social chaos the naturalism breeds'.[10] The coverage of other sections of the media regarding the Joffe Bill was remarkably positive, and our message is reaching the front lines both here and elsewhere.[11,12,13,14] Additionally, the *Care Not Killing* campaign and many others like it proved, among other things, that appealing to logical consequence can be effective at proving Colson right in the battleground of ideas.[15]

So there are both positive and negative signs, both victories and losses for the kingdom. And whichever way the tide seems to be turning, our response should neither be to give up in despair and retreat into Christian ghettos, nor to be overoptimistic and expect heavenly change on earth. Instead we should show realistic determination. There is no room for complacency. The quote often employed at this point is that of English philosopher Edmund Burke, 'All that is necessary for the triumph of evil is that good men do nothing.' I would like to outline three pressing reasons why Christians should act:

- ***We should be appalled by what appals God:*** our Lord and saviour wept over the godless city of Jerusalem and said that we are blessed if we do the same.[16,17]
- ***We should desire what God desires:*** God longs for all things to be brought under the rule of Christ, for 'all things were created by him and for him'.[18] He tells us to pray that his kingdom rule would be known both now and in the future.[19]
- ***We should store up for ourselves treasures in heaven:*** God promises that if we will devote our resources to the work of the kingdom, he will repay us abundantly with blessing in eternity.[20]

So here are three powerful reasons why we should be proactive in our response to the negative ethical onslaught of opinion leaders. And we *are* doing this. It was with great joy that I read comments, letters, rapid responses and radio interviews explaining in plain language why medicine should be about caring and *not* killing, showing how God's good, pleasing and perfect will was right and best for the good of all mankind. Let us continue to do this.

The truth is that journals are influenced and run by a very small number of people who, like all of us, have their own agendas aspirations and opinions. They and their readership can be influenced; personally, I hope that my appeal for internal review by the *BMJ* ethics committee might bear some fruit.[21] For the sake of the name of the Lord we love and serve, let's not just complain, but campaign – not just with placards but with pens, perseverance and prayer – so that, by God's grace, we may stem the tide.

Jason Roach *is Editor of BMJ Clinical Evidence*

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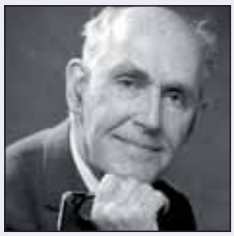
obituaries

Alec Bookless
(*q* Guy's 1935; *d* 22 March 2003)



Alec studied at Cambridge and Guy's, developing a lasting interest in the Church Mission Society. After qualifying he joined a medical practice near Sanderstead, Surrey and married Daphne with whom he had three daughters. During the Second World War Alec served in the medical corps in Europe and was evacuated from Dunkirk in 1940. He was sent to hospitals in Egypt and Sudan, but returned to Britain in 1945 and rejoined his practice. He continued as a member of the Territorial Army, eventually becoming a Lieutenant Colonel in charge of the medical division.

Alec was well known for seeing his patients as people rather than cases, remembering details of their families and interests. His relationship with his patients continued after retirement: he would visit many at home and in hospital.

Alec had many friends and interests. He loved walking in the countryside and taking holidays in Scotland. His Christian faith shone through his attitudes and his character. He is survived by his daughters Margaret and Hilary.

Barbara Hill and David Bookless

John Hammerton
(*q* Glasgow 1938; *d* 6 December 2005)

A GP in Clay Cross from 1940-1980, John campaigned for the advancement of general practice as a specialty and was involved in the Royal College of General Practitioners from its early days. In the early 1970s he started the Chesterfield Vocational Training Scheme and was its first course organiser. He felt very strongly that medical practice meant giving oneself to the community and particularly to the patients one cared for. He served as a local councillor for twelve years, then as a county councillor for three years; he was also a Justice of the Peace. John also served CMF as president from 1973 to 1975. After retirement he served on the Synod of the Church of England. He leaves a wife, Helen, four children, twelve grandchildren and five great-grandchildren.

Bill Hammerton

Former CMF General Secretary Keith Sanders adds: John gave me consistent support and encouragement, being very much aware that the Christian faith should and could be demonstrated, not only in what one did but also in how one practised. John demonstrated a very wide understanding of how the fear and love of God could be seen. He was of a strong gentle spirit, very much to be trusted.

Kevin Kelly
(*q* Guy's 1953; *d* 13 January 2005)

Kevin joined the Royal Navy in 1942. Following the war he trained as a doctor and became a general practitioner, working in Redhill, Surrey for 38 years. His warm, personal style and attention to the welfare of others, as well as his skill as a doctor, were much appreciated. Somebody summed it up by saying that as soon as Kevin turned up they felt reassured. Both he and his late wife Iona were counsellors for many years with the Catholic Marriage Advisory Council. Kevin was also medical director of the annual diocesan pilgrimage to Lourdes. When he retired they went to work at a hospital in St Lucia. In recognition of his work with the church, Kevin was nominated for a Papal Order as a Knight of St Gregory; he also joined the Equestrian Order of the Holy Sepulchre. Kevin took these papal knighthoods as a great honour. He was a man of vitality and generosity, devoted to helping others both through medicine and the church. He connected with people from a huge range of backgrounds in such an easy way that he would immediately make them feel he was a friend. He leaves four children and 14 grandchildren.

Seán Kelly

Paul Robert
(*q* Royal Free 1957; *d* 25 May 2005)

Paul Robert was born in Morges, Switzerland. After completing his basic medical studies in Switzerland, he spent three years at the Royal Free Hospital in London. He married Paulette Matile, a nurse and accomplished musician. Together they went to South Africa in 1957 as medical missionaries. Paul started his work at Elim Hospital in the then Northern Transvaal. Later he took over as superintendent of Masana Hospital. In 1983 he accepted the onerous job of Secretary for Health for the Gazankulu Homeland. With the dissolution of the homelands, he was involved in re-integrating health services into the National Department of Health. Wherever he worked, he and Paulette were actively involved in the church and community affairs. In addition to his administrative capabilities, Paul had a wide range of the clinical skills needed in rural areas. All with whom he came into contact with were struck by his dedication and integrity, and his devotion to his mission to help others. After retirement, the Roberts returned to Switzerland to be near their families. Paul nevertheless continued to be active in many things. All his colleagues, friends and those whose lives he touched extend their deepest condolences to Paulette, their three daughters and their families.

Pierre Jaques, for the South African Medical Journal

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.

eutychus

Going to church may extend life

Weekly religious attendance could add years to your life, according to a medical study carried out in the US. The effects of exercise, religious attendance and anti-cholesterol drugs on life expectancy were examined. All three were found to be beneficial, with religious attendance adding two to three years to your life. The results of the research were published in the March-April issue of the *Journal of the American Board of Family Medicine*. (*BBC News* 2006; 4 April, *news.bbc.co.uk/1/hi/health/4876666.stm*)

Christian Classics Ethereal Library

Hundreds of free Christian classics written through the centuries are available for free download in a variety of formats from *www.ccel.org*. Some extra features include hymn and chant tunes, audiobooks, searchable Bible concordances, dictionaries and foreign language assistance.

Abortion for foetal abnormality

A BBC Four TV programme broadcast on 26 April has asked whether parents of disabled children should risk bearing further children who may be disabled. John Harris, an ethicist at Manchester University, has said that we have 'moral reasons to avoid bringing inherited conditions into existence where we have that choice'. (*BBC Health* 2006; 26 April, *news.bbc.co.uk/1/hi/health/4942954.stm*)

PVS patients awakened by sleeping pill

Zolpidem, a drug commonly used as a sleeping pill, appears to have had a miraculous effect on brain-damaged patients who have been in a permanent vegetative state for years, arousing them to the point where some are able to speak to their families, according to a paper published in the medical journal *NeuroRehabilitation*. The dramatic improvement occurred in three patients within 20 minutes of taking the drug, and wore off after around four hours at which point the patients returned to their permanent vegetative state. (*Guardian* 2006; 23 May, *en.wikipedia.org/wiki/Zolpidem*)

Strange encounters in lifts

Residents of the Zurich block of flats where the euthanasia clinic Dignitas has its suicide rooms have complained to the authorities about the number of corpses being moved around the building. Because coffins will not fit in the communal lift, Dignitas loads bodies into body bags to take them down to hearses in the street. Gloria Sonny, 52, who lives in the block said: 'Almost every day, the bodies of people who have chosen to kill themselves are taken down in the lift'. The controversial clinic has helped more than 450 people, including over 30 Brits, to end their lives since it opened in 1998. (*Daily Record* 2006; 20 May)

'Near death' has biological basis

Near death experiences have a biological explanation rather than a spiritual one, research suggests. The US team said the same parts of the brain are activated when people dream as in near death experiences. The study, in *Neurology*, compared 55 people who had had near death experiences and 55 who had not. Those with near death experiences were more likely to have less clearly separated boundaries between sleeping and waking, the scientists found. (*BBC News* 2006; 11 April, *news.bbc.co.uk/1/hi/health/4898726.stm*)

Ethical stem cell bank

A new umbilical cord blood bank has been opened in Dubai. The Dubai Cord Blood and Research Centre (DCBRC) will store cord blood which is rich in stem cells and which can be used as an ethical alternative to embryonic stem cells. Researchers plan to use the cells to investigate possible cures for genetic diseases prevalent in the country such as thalassaemia and sickle-cell disease. Dr Mahmoud Taleb Al Ali, head of research at DCBRC said: 'The use of cord blood removes any ethical questions that might arise. If it's embryonic stem cells, then that is different'. (*Gulf News* 2006; 7 June, *archive.gulfnews.com/articles/06/06/07/10045220.html*, reported in *SPUC Digest*)

'Perfect' babies at a price

The first 'designer baby' clinic is to be set up in Britain and £6,000 is expected to be charged for each child. The clinic will offer screening for inherited genetic disorders such as muscular dystrophy and cystic fibrosis and embryos who are carrying the genes will be destroyed. Josephine Quintavalle, of Comment on Reproductive Ethics, said, 'Paying £5 million for a state-of-the-art centre in order to eliminate more embryos with disabilities sounds like aggressive eugenics. We need to develop real cures for genetic diseases, not kill the carriers.' (*Telegraph* 2006; 26 March, reported in *SPUC Digest*)

Mothers single by choice?

The *Independent* has run a feature examining a recent trend for single women to set out to have babies on their own. 82,000 women in their thirties with no partner are said to give birth every year, and recent survey found that two thirds of women think it is OK for a woman to deliberately have a child alone, although 66% said that a father figure is necessary for a child's well-being. Helen Kendrew, a fertility nurse, said that, 'In their twenties women tend to put careers first and imagine that husbands and families are going to fall into line at some point... but when they get to their thirties and forties and it hasn't quite worked out like that, it can be a hell of a shock'. (*Independent* 2006; 21 May, reported in *SPUC Digest*)

More elderly abuse

A debate in the House of Commons has drawn attention to reports claiming that up to 500,000 elderly people in the UK are victims of physical, psychological, financial or sexual abuse at any one time. Government ministers were urged to take action regarding widespread malnutrition in care homes. Paul Burstow MP also highlighed the problem of mismanaged medication, claiming that up to 22,233 elderly people may be on sedation without medical grounds. (*UK Parliamentary Debate* 2006, 7 February, reported in *SPUC Digest*)

World 'lacks 4m health workers'

Four million health workers are needed to combat the 'chronic shortage' around the world, a report from the World Health Organization has warned. Fifty-seven countries have a serious shortage of health workers, affecting children's jabs, pregnancy care and access to treatment, it said. Thirty-six of these countries are in sub-Saharan Africa. The WHO's World Health Report 2006 said the shortage affected how diseases such as HIV/Aids could be tackled. (*BBC News* 2006; 7 April, *news.bbc.co.uk/1/hi/health/4877376.stm*)

The Shaming of the Strong

The challenge of an unborn life

Sarah Williams

- Life Journey (Kingsway) 2005
- £6.99 Pb 176 pp
- ISBN 1 84291 1791

To date, there has been a shortage of accessible material on the experience of continuing a pregnancy where the child has been found to have a severe abnormality. Here, at last, is a book where allied medical professionals, pastors and friends can see into the hearts of a family living through the dilemmas, sorrows and joys that this experience brings.

Sarah and Paul Williams' third daughter, Cerian, was diagnosed prenatally as having thanataphoric dysplasia – a condition incompatible with life outside the womb. The book is beautifully written, carefully crafted and, at times, completely heartbreaking. Sarah Williams takes the reader from the scan where the bad news is given, right through to the death, birth, funeral and her return to work. The only autobiographical details given are those we need in order to understand her journey, and so her story is uncluttered and can be read in just a few hours.

For some, the theological and ethical discussions, which are a normal part of Sarah's academic life, may make sections of the book hard going. For some, her relatively comfortable, middle-class life will be hard to relate to. It is out of this context, however, that the title of the book comes: 'Cerian was, by the world's definition, a weak thing, but the beauty and completeness of her personhood had nullified the value system to which I had subscribed for so long'. Hear the tribute Sarah reads at Cerian's funeral: 'You were not precious to me because of the things you did. Your worth was written into your being from the very first moment of your existence'.

Is this a book you could give a couple going through a similar experience? It is certainly not reading for the faint-hearted, but such a couple won't be and are likely to be eager to learn from those who have gone before. It is not a formal resource book – there is no index or reference section or list of helpful agencies – but it will be a valued resource: ways to help other children in the family, ways for family, friends, pastors, colleagues and staff to make the journey easier.

> Beautifully written, carefully crafted and, at times, completely heartbreaking

Ultimately, this is an uplifting book. It tells of our wonderful God, who loves and treasures the damaged, and calls us to do the same. Sarah Williams writes as a Christian but not a legalist. She works through a variety of issues honestly and humanly – not in a way that would be unattractive to non-Christians but in a way that is likely to intrigue. Is it a book to give to your obstetric colleague or your obstetrician? Most definitely! Mine should get his in the post any day now.

***Karen Palmer** is a Staff Grade Psychiatrist in Glasgow*

Sent to Heal!

Emergence and Development of Medical Missions

Christopher H Grundmann

- University Press of America 2005
- £30 Pb £45 Hb 375 pp
- ISBN 0 7618 3320 X

Midway through the nineteenth century, a new force emerged in Western missions to Africa and Asia – the medical missionary. Prior to that time, doctors, nurses and others with training in the healing and caring arts had travelled with missions to the far flung parts of the world, but only as an adjunct to the primary task of 'winning souls for Christ'. But a seismic shift in missiology and praxis occurred as mission societies were set up with the express aim of providing medical services to the world's poor.

Grundmann's scholarly work looks at the sources of this movement – from the nursing and medical monastic orders of the Dark and Middle Ages to the early medical missionary work of the Spanish and Portuguese Jesuits of the sixteenth century, through to the Catholic nursing and missionary orders of the seventeenth and eighteenth centuries. But it was with Peter Parker and the Medical Missionary Society in China in Guangzhou (Canton) that the modern, protestant/evangelical medical missionary movement began. Forced by the Chinese authorities into the small Euro American enclave of Canton, with limited access to the Chinese population, the small number of missionaries found that provision of medical service offered the one opportunity to reach out the local population. Parker became an enthusiastic advocate for this strategy, and soon medical missions began to grow up either as separate societies (for example the Edinburgh Medical Missionary Society and the Medical Missionary Association), or as part of existing missionary societies.

This book looks at the other key figures in the development of nineteenth century medical mission, particularly from the UK and the USA, but also Dutch, German and Danish medical missionaries, at their achievements and wider impacts. And he asks probing questions about medical missions – did they succeed in the missionary task? What was the view of medical mission and medical missionaries held by the wider mission and Christian communities? Not all the answers he comes to are comforting; yet, despite his strong critique, Grundmann is undoubtedly an enthusiastic advocate for medical mission himself.

This is not light reading – the main text and very extensive appendices and references formed the basis of a PhD thesis – so it is not best approached as a motivational book on mission. But for the serious student of medical mission, and for those wishing to grapple with the roots of the twentieth/twenty-first century wave of healthcare mission, this book forms an extremely valuable source of detailed background information. It reveals how many of the strategies, questions and struggles being faced today by those using medical skills in the mission field are echoed in the experiences of the past.

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

news from abroad

Thinking of working abroad? Peter Armon explains exactly how CMF could help you...

I'm just writing to let you know that I'm off to the ends of the earth next week for a couple of years...

So often, this is the first we hear of someone's intent to work overseas. Leaving it that late means that you may miss out on the resources CMF has to offer – both before and after you arrive at your intended destination. If you are thinking of working overseas, in whatever capacity – secular or with a mission agency, short or longer term – we would like to hear from you sooner rather than later.

What can CMF offer you?

- We may be able to link you with **resources** or persons, either in the UK or at your intended destination, who can offer you invaluable advice and help, both before you go and after you arrive. They may even be able to meet you off the plane!
- If you will be working with a mission agency or in a voluntary capacity, we can offer you **reduced or free membership** during your time overseas, according to your circumstances. If, however, you are salaried and able to pay the full subscription, then we would value your continuing contribution.
- Our overseas website hosts the **Healthcare Mission Resources Directory**, *www.healthserve.org/pages* It offers extensive yellow pages of useful information and addresses. There are sections on support agencies, personal resources, sending & receiving organisations, and many other useful contact addresses.
- Our **Handbook on Medical Mission** is available online at *www.healthserve.org/pubs/*. It offers advice on preparing to work overseas and is also available in a downloadable PDF file. Alternatively, it can be requested in hard copy from the CMF office.
- You can continue to receive **CMF publications**, *Triple Helix*, *CMF News & CMF Files*. If security is a problem, they can be sent in an unmarked plain envelope or, if you'd prefer, to a UK contact address.
- We offer **free subscription** to the journals *Tropical Doctor*, *Medicine* and *Surgery*, if they would be of value to you. The latter two journals enable you to build up an excellent resource of teaching materials. *Surgery* is a recommended Royal College of Surgeons training resource. *Medicine* can be ordered in CD format. *Tropical Doctor* will be sent to you directly from the Royal Society of Medicine, but *Medicine* and *Surgery* will come quarterly via the CMF office.
- We will keep in touch with you via a **bi-annual Overseas Newsletter**. This contains useful information on courses, pointers to useful websites, and updates on matters related to revalidation, registration & re-entry issues. Please note though: it is important that each individual remains on the GMC mailing list while working overseas.
- CMF organises an annual two week **Developing Health Course** which is held at Oak Hill College in North London each July. Aimed at both those who are working overseas and those who are intending to do so, the course offers an update in knowledge and skills relevant for those working in the less developed world, within a Christian context. It also provides an opportunity to share experiences with like minded people from different healthcare professions, some with many years of experience overseas and others just setting off, together with a number of overseas nationals. The speakers, the majority of whom have worked abroad, are all experts in their field and are always available to talk over matters of concern. The course is recognised by the Royal College of Physicians (carrying 50+ CME points) and by the NMC. Unique in its approach, it is always very much appreciated by those who attend. Visit *www.healthserve.org/developing_health/* for details.
- A **Developing Health CD Rom** (based on the course) is also available. It contains the speakers' notes and presentations as well as a huge amount of useful information, protocols, guidelines, Powerpoint presentations, practical booklets and other materials. Suitable both for personal learning and teaching purposes, these CDs are free to all who might benefit from using them.
- CMF has a vast number of members with experience of working abroad, in all sorts of capacities and situations. It should be possible to link you with a member who would be willing to act as your **mentor**.
- Through our membership of the International Christian Medical & Dental Association (ICMDA), a worldwide network of some 65 Christian medical associations, it should be possible to link you with **national Christian medical colleagues** working in the country you will be going to.
- We advertise overseas posts at *www.healthserve.org/overseas_opportunites/*. We may well be able to help you find locum relief to cover your leave. Adverts placed on the site are linked to an email alert system that notifies more than 300 healthcare professionals of your need.
- We will **pray for you**. Within the office, we produce a prayer bulletin that is updated monthly. If you include us on your mailing list, we can pray for you more even more effectively. For your security, the bulletin is not circulated beyond the office, but we can assure you that you will be prayed for, by name, regularly each month.

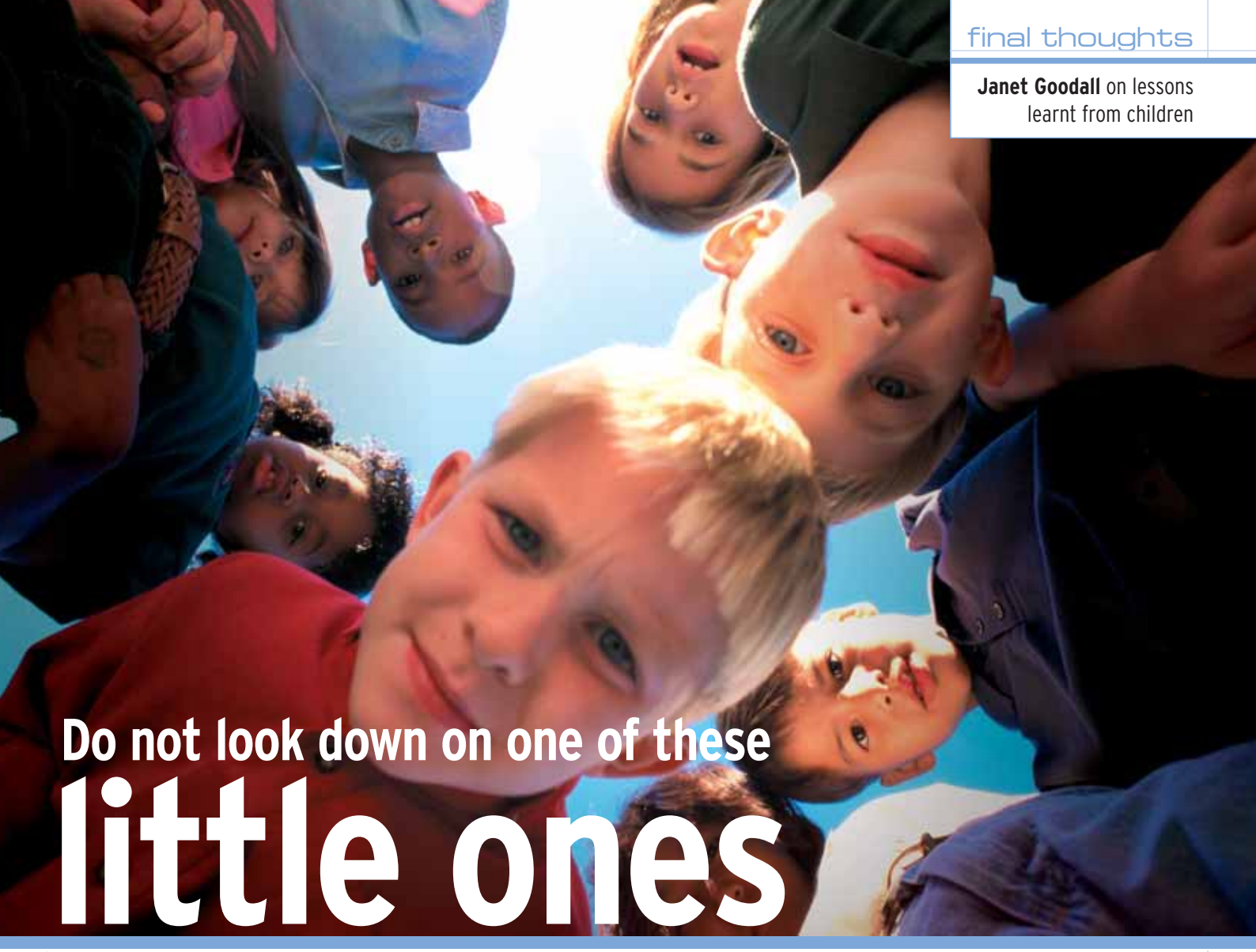
These are all very good reasons for getting in touch sooner rather than later! Please contact me at *peter.armon@cmf.org.uk* for a quicker and more informed reply. If there are any other ways in which you think we might be able to help you, then please don't hesitate to ask. We are here to serve and support you, and to enable you to more effectively function in your work overseas.

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

Some of the overseas vacancies currently advertised on our overseas website *www.healthserve.org/overseas_opportunites*

- Rumginae Rural Hospital in Papua New Guinea needs a doctor.
- World Vision in East Timor urgently needs doctors.
- SIM UK in northern Thailand needs doctors.
- Mukinge Hospital in Zambia is in urgent need of a general surgeon.
- Tonga in the South Pacific: a GP is needed.
- Medair in DR Congo are looking for a health co-ordinator (salaried post).
- Oasis Hospital in UAE has a number of medical vacancies.
- Kabul in Afghanistan: an anaesthetist, GPs, a paediatrician and a pathologist are needed.

Janet Goodall on lessons learnt from children



Do not look down on one of these little ones

Yesterday I attended a fund-raising coffee morning for a church overseas. One of the well-heeled ladies present had with her two young grandsons, who, despite all the lovely edibles, readily agreed that they found grown-up parties boring. They clearly longed to opt out. This morning, at a church breakfast convened to pray for all the children at risk in our world, we considered another small boy who had been drawn into an adult circle. 'Jesus...called a little child and had him stand among them.' (Matthew 18:1-11)

I have often wondered about that little boy. Did he, too, long to be somewhere else? Was he shy or smiley, was he a street child, or perhaps the beloved son or grandson of someone there? We can surmise that Jesus made him feel special, perhaps a little more subdued than usual, but sure of Jesus' care for him. In fact, we are simply told that he was little, that he responded to Jesus' call, and he did what was asked of him. If he was under ten years old, which seems likely, he would not have understood the parable that Jesus was drawing out from his humility, but all the same he was used to teach those present (and those to come) a very important lesson.

The famous pioneer missionary to inland China, Hudson Taylor, once wrote, 'God chose me because I was weak enough. God does not do his greatest work by large committees. He trains someone to be quiet enough, and little enough, and then he uses him'. Jesus' awful warning was that if we fail to emulate child-like humility, consider ourselves too important to do what he says, and fail to put total trust in him whether or not we understand his purposes, then we cannot enter his kingdom.

He gave a dire warning, too, to those who entice children to do wrong - better to drown than to do that. We might think of such people as nasty unsavoury characters, but might we not, however unwittingly, be wielding a harmful influence ourselves? We in the developed world prefer to blame poverty on unemployment here and overpopulation elsewhere, but the technically advanced and affluent lifestyle of many westerners has a global impact. Broken homes on the one hand and hunger and disease on the other hit the children hardest. If they survive at all, they are likely to suffer long-term effects, some enticed into bad ways as a direct result of emotional or material poverty. They have angels in heaven but need helpers on earth.

So what can we do? Unlike the little boy standing before Jesus, we get the message, but the child teaches us to hear his call and obey whatever he asks of us. Only then can we be used to fulfil his great purposes of justice and mercy for our damaged world, both through renewed humility of lifestyle and ready obedience in service.

Paul, reputedly of small physical stature himself, reflected: 'God chose the foolish things of the world to shame the wise; God chose the weak things of the world to shame the strong. He chose the lowly things of this world and the despised things - and the things that are not - to nullify the things that are, so that no-one may boast before him'. (1 Corinthians 1:27-29)

Whoever welcomes any such small people in the name of our Lord Jesus has, he said, the great privilege of welcoming him. Surely none of us wants to opt out of that.

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

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