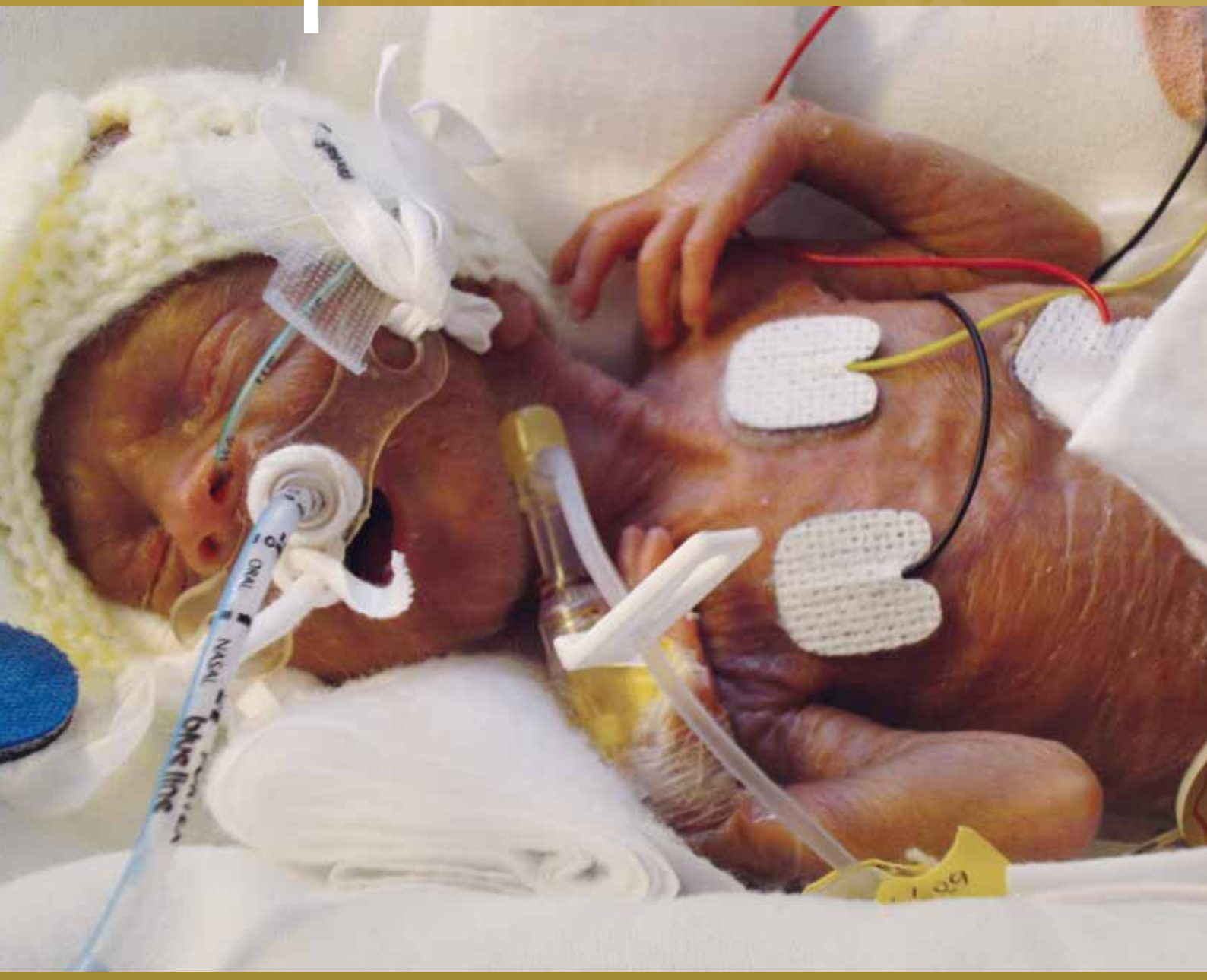
Summer 2011

for today's Christian doctor

triple helix



the price of life

medical mission, stillbirths, cross-cultural challenge, learning from our suffering, I never thought, a curious cure, the importance of prayer, reviews

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contents

Faith matters in healthcare encounters

Principles and boundaries

Dr Richard Scott

The case of a Christian GP reprimanded by the General Medical Council for talking about his faith to a patient [1,2] has revived interest in the appropriateness of faith-based discussion during a medical consultation.

Dr Richard Scott was accused of 'harassment' and told by the medical regulator that he risked bringing the profession into disrepute by discussing his religious beliefs. He has however refused to accept a formal warning on his record, and is arguing that he acted within official GMC guidelines.

Dr Scott, a doctor for 28 years, works at the Bethesda Medical Centre in Margate, Kent. Its six partners are all Christians and state on the official NHS Choices website that they are likely to discuss spiritual matters with patients during consultations. The conversation with the patient in question only turned to faith issues after they had fully explored the medical options and only after Dr Scott asked if he could talk about his Christian beliefs and was given the go-ahead.

After receiving the patient's complaint, the GMC, without investigating the matter further, sent Dr Scott a letter warning him over his conduct and told him that the way he expressed his religious beliefs had 'distressed' the patient and did 'not meet with the standards required of a doctor'.

Niall Dickson, chief executive of the GMC, was reported by the *Daily Telegraph* as saying: 'Our guidance, which all doctors must follow, is clear. Doctors should not normally discuss their personal beliefs with patients unless those beliefs are directly relevant to the patient's care. They also must not impose their beliefs on patients, or cause distress by the inappropriate or insensitive expression of religious, political or other beliefs or views.'

However, in a later debate on Radio 4's PM programme, in which I also took part, Dickson was able to give a fuller context to his comments and actually confirmed the appropriateness of sensitive faith discussions with patients [3]: 'There may be circumstances where a patient is at a point where they do want to discuss faith and it may be appropriate for the doctor to reflect on their own faith during that discussion.'

When asked how frequently exploitation of a vulnerable patient occurred in practice he said that it was very uncommon and had happened only on a couple of occasions: 'The vast majority of doctors with faith or without faith know how to talk to patients and know where the patient is at. Even if you haven't got faith you should, if a patient wants to talk about faith, be able to respond positively.'

I was able to speak about the large amount of evidence there is for the beneficial effects of faith on physical and mental health [4] and referred to 1,200 research studies and 400 reviews in peer-reviewed medical journals on the subject of which 81% showed a positive correlation.

I emphasised, as the GMC guidance states [5], that although faith discussions would not normally be part of the consultation, there were occasions when they were appropriate. The World Health Organisation's definition of health includes physical, mental, social and spiritual dimensions and part of practising whole-person medicine means addressing all issues that have a bearing on a person's health. I emphasised that faith discussions should be embarked upon with sensitivity, permission and respect.

The GMC guidance itself recognises that 'all doctors have personal beliefs which affect their day-to-day practice' and that these principles apply to all doctors whatever their political, religious or moral beliefs. It emphasises that 'personal beliefs and values, and cultural and religious practices are central to the lives of doctors and patients' (p4); that 'patients' personal beliefs may be fundamental to their sense of well-being and could help them to cope with pain or other negative aspects of illness or treatment.' (p5) and that 'discussing personal beliefs may, when approached sensitively, help you to work in partnership with patients to address their particular treatment needs.' (p9)

I was later encouraged to see that both the RCGP's recently launched 'End of Life Charter' [6] and the NICE draft consultation document on end of life care [7] make reference to the importance of spiritual care and support, with the latter mentioning religious support specifically. And I was further encouraged to see Professor Mike Richards, national clinical director for cancer and end-of-life care, saying that that patients at the end of their lives should be offered spiritual support from GPs if they wanted it. RCGP clinical champion for end-of-life care Professor Keri Thomas, went even further by backing Dr Scott's stance, and saying that spiritual care was 'essential' for end-of-life care. [8]

Let's pray that the GMC handles Dr Scott's case wisely and let's all be encouraged to practise medicine that addresses the needs of the whole person, to take opportunities to address spiritual issues impacting on health, and to share our own faith if it is appropriate to do so. To this end I warmly recommend Graham McCall's new book *At A Given Moment - Faith Matters In Healthcare Encounters*. [9]

***Peter Saunders** is CMF Chief Executive*

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news reviews

Missing midwives report

A global shortfall which also threatens the UK

Review by **Steve Fouch**
CMF Head of Allied Professions Ministries

According to a recent report,[1] there is a global shortage of midwives that is having a significant negative impact on maternal and child health, setting back progress towards Millennium Development Goals 4 and 5.[2] In most parts of the developing world, as few as 6% of women have access to a midwife or skilled birth attendant, let alone an obstetrician or hospital care. This lack of access to primary, secondary, antenatal and postnatal care costs about a million lives a year – mostly in infant deaths, although 350,000 mothers still lose their lives during pregnancy, childbirth and the immediate postnatal period.

As CMF highlighted in our submission to DFID's consultation on maternal health strategy,[3] one of the key needs is the training, professional development and funding to employ health professionals, build good multidisciplinary teams and focus on the intergration of community and secondary care services so that the delays in getting women with complicated labour to acute medical services are overcome. Single, 'magic bullet' solutions will not work here, but ensuring there are enough trained midwives is a key plank in any successful strategy.

Ironically, we face a shortfall of skilled midwives here in the UK – leading to over stretched labour wards, stressed and unmotivated staff, and a question mark about the impact this will have on our own maternal and neonatal health record.[4] As we seek to address the maternal health needs of the world's poor, we also need to think about how we are providing for the care of mothers and children in our own nation.

Care for the vulnerable is a central duty for God's people – this is seen throughout scripture – and without a doubt, mothers and children are an increasingly vulnerable group who need our care, support and advocacy.[5]

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The BBC documentary 'Choosing to die'

Wasteful, dangerous and further evidence of a campaigning stance

Review by **Peter Saunders**
CMF Chief Executive

The BBC's decision to screen a man's dying moments at the Dignitas suicide facility in a documentary fronted by Terry Pratchett have come in for heavy criticism. Over 900 complaints were received by the BBC and a group of five peers wrote to *The Times* complaining of BBC bias.[1]

A five-minute sequence in the BBC2 programme 'Choosing to die', screened on 13 June, showed fantasy novelist Pratchett witnessing a British man in his early 70s who had motor neurone disease, taking his own life at the controversial Swiss location. A second man with multiple sclerosis, who was interviewed but whose actual death was not filmed, apparently took 90 minutes to die.[2] It was strikingly obvious to viewers that neither of the two men was imminently dying, and the second almost certainly had a life expectancy of decades. Neither was typical either of the 60,000 MS and 5,000 MND patients in this country, the vast majority of whom want support in living, and not assisted suicide.

By putting their extensive public resources behind this campaign and by giving Terry Pratchett, who is both a patron of DID and key funder of the controversial Falconer Commission on Assisted Dying,[3] a platform to propagate his views, the BBC flouted its own guidelines on both suicide portrayal and impartiality.[4]

The BBC's own editorial guidelines on portrayal of suicide[5] are very clear and call for 'great sensitivity'... 'Factual reporting and fictional portrayal of suicide, attempted suicide and self-harm have the potential to make such actions appear possible, and even appropriate, to the vulnerable.'

The WHO guidance on the media coverage of suicide[6] is equally unambiguous: 'Don't publish photographs or suicide notes. Don't report specific details of the method used. Don't give simplistic reasons. Don't glorify or sensationalise suicide.' The phenomenon of suicide contagion (otherwise termed copycat suicide, suicide cluster or the 'Werther effect') is well known and the BBC programme ticked all the boxes of what broadcasters should not do.

The corporation has now produced five documentaries or docudramas[7] since 2008 portraying assisted suicide in a positive light. There have by contrast been no balancing documentaries showing the benefits of palliative care, promoting investment in social support for vulnerable people or highlighting the great dangers of legalisation which have convinced parliaments in Australia, France, Canada, Scotland and the US[8] to resist any change in the law in the last twelve months alone.

This latest move by the BBC was a gross misuse of licence-payers' money and further evidence of a campaigning stance.

CMF spokespeople took part in over 40 media interviews about the programme in the days preceding and following it. Whether the public backlash will bring about any change in behaviour from our national broadcaster is presently unclear. But regardless, Christian doctors have a continuing responsibility to speak out in order to safeguard the vulnerable and to ensure that all have access to good palliative care.

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Welsh morning-after pill scheme

Neither ethical nor evidence-based

Review by **Peter Saunders**
CMF Chief Executive

Since April this year[1] the 'morning-after pill' has been available free from pharmacies across Wales, while still costing about £25 in the rest of the UK. Over 700 high street pharmacies can now provide it, even to girls as young as 13, without consent from a parent or guardian. But research into a pilot project in Bridgend has now questioned whether it is 'an appropriate use of NHS resources'.

According to BBC Wales 'Week In Week Out' programme, the paper, written by a specialty registrar working for NHS Trust Public Health Wales, said: 'Despite the increased uptake of EHC [morning-after pill] in Bridgend… the trend in conceptions for Bridgend was not significantly different to the rest of Wales.'[2]

Apart from ethical concerns we might have about the mechanism of action, bypassing parents and removing prescription from the safety of the doctor-patient relationship, this was a strategy based on no evidence at all.

A paper published in the *Journal of Health Economics*[3] last December showed that morning-after pills don't cut teen pregnancy and actually increase the risk of sexually transmitted disease.[4]

Sourafel Girma and David Paton of Nottingham University compared areas of England where the scheme was introduced with others that declined to provide the morning-after pill free from chemists and found that rates of pregnancy among girls under 16 remained the same, but that rates of sexually transmitted infections actually increased by 12%.

It seems that any effect on decreasing pregnancy rates had been cancelled out by rising levels of promiscuity, a phenomenon known as 'risk compensation'. I noted at the time[5] that these findings were the latest nails in the coffin of the Labour government's teenage pregnancy strategy. This latest move is sadly yet another unfortunate, ill-thought out knee-jerk government response to Britain's spiraling epidemic of unplanned pregnancy, abortion and sexually transmitted disease amongst teenagers. Providing free morning-after pills through pharmacies, when fully rolled out, will cost up to £300,000 a year, money that will be found from existing NHS budgets.

The best way to counter the epidemic of unplanned pregnancy and sexually transmitted disease is to promote real behaviour change through such programmes as Love for Life[6] (Northern Ireland), Love2last[7] (Sheffield) or Lovewise[8] (Newcastle). These are initiatives in which CMF members are already involved. The government should be encouraging them.

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Southern Cross collapse

Capitalism crushes care and compassion?

Review by **Steve Fouch**
CMF Head of Allied Professions Ministries

As Southern Cross, the country's biggest independent provider of care homes for the elderly collapsed, the 31,000 residents of its homes, their families and carers face a hugely uncertain future.[1]

All this because of a mixture of bad management and market speculation.[2] But unlike the banks, which received billions in aid and low cost loans to bail them out, there was no bailout for Southern Cross. It seems our banks are too big to fail. But a company that provides accommodation and care to tens of thousands of our elders is not significant enough to be considered for such support.

This story inevitably raises the question of where our priorities lie as a society. The links between banks and care homes are closer than they at first seem, because the major lenders to Southern Cross are the two banks nationalised in the great bailout – Lloyds TSB and RBS. So if Southern Cross goes bankrupt, it will have a wider impact on the economy and in particular the publicly owned banks.

To be sure, no-one will be turned out on the streets, and there will be care home places found or maintained for all those affected, but the uncertainty must be a cause of great distress for thousands of elderly people. And the impact on the long-term health and well-being of elderly residents moved to new accommodation has, in my experience, often been pretty bad. I wonder if this constitutes a form of abuse?

The Care Quality Commission's recent report castigating 12 NHS trusts for poor nutritional care of the elderly[3] shows that private and public institutions are equally fallible. Against that background the new patient charter for the care of people who are nearing the end of their life will go some way to reminding us of our need to protect the vulnerable.

Jesus once said that where our treasure is, there also will be our heart.[4] Care and compassion are not mainstays of the financial system, but these qualities are in danger of disappearing from the public sector. As we care for a growing elderly population with a dwindling tax base, the pressure to find more 'cost effective' alternatives to caring for the elderly long term will grow – among them assisted suicide and euthanasia. Do we not, instead, need to rediscover an ethic of care and compassion at the heart of our culture, and remember that we will be tomorrow's frail elderly, disabled or dying? What we sow today, we will reap tomorrow.

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After a controversial BBC documentary, **John Wyatt** defends the resuscitation of extremely pre-term babies

Photo: Bliss / Nicola Kurtz

23 WEEK BABIES – THE PRICE OF LIFE

key points

Responding to a recent BBC documentary the author makes a clear and well argued defence for the treatment of extremely pre-term neonates. He explains that resuscitation rules based on gestational age alone are inadequate as they fail to take account of the likelihood of each individual baby's survival.

The assertion that preterm survivors would be highly likely to experience significant disability was badly overstated. Furthermore an attitude that undermines the value of a disabled survivor's life is highly insulting and survivors generally rate their quality of life at a similar level to those who are born at term without medical problems.

Each extremely pre-term baby deserves the chance to be considered for treatment. In cases where there is a good chance of survival it should be standard practice to start provisional intensive care especially in a rich nation such as the UK.

The recent BBC documentary **23 week babies - the price of life** represented six months of filming on the neonatal intensive care unit at Birmingham Women's Hospital. Brilliantly filmed and produced, the programme powerfully illustrated the conflicting emotions of parents confronted with a baby struggling for life at 23 weeks. Four words came to mind: pain, hope, love, despair. As a mother cuddled the tiny form of her bruised and dying baby she whispered, 'Little princess - you are so beautiful…'

But although the programme showed the heart-breaking reality of neonatal death - 'when hello means goodbye...', the underlying theme was expressed in stark form by Adam Wishart, the presenter, 'Is it worth trying to keep these babies alive?' The opinion of many of the professionals interviewed was clearly 'No'.

The clinical decision about whether to commence resuscitation in a baby born at 23 weeks' gestation is complex and multifaceted. These are not easy decisions and they are too important to be discussed by professionals alone. It is right that all of us should discuss and debate the implications. But in addition to the obvious and difficult moral and personal dimensions there are a number of technical and clinical factors, which were not raised in the programme.

Inaccuracy in gestational age

The programme gave the impression that gestational age can be measured with complete accuracy. The only situation in which this is possible is in the rare case of an IVF pregnancy when fertilisation occurs in the laboratory. In all other pregnancies the gestational age is obtained by a combination of the menstrual dates and antenatal ultrasound scanning. Even with early ultrasound scanning, gestational age may be out by four to seven days. If there is no early ultrasound it is possible for the gestational age to be out by plus or minus ten to fourteen days or even more. If the baby who is thought to be 23 weeks of gestation is in reality 25 weeks of gestation this makes a big difference to the chances of survival. Hence in each case of delivery at a stated age of 23 weeks, clinicians need to assess the likelihood that the gestational age is in error when making a decision whether to resuscitate. It is a well-recognised principle of medicine that if there is genuine uncertainty about whether life-saving treatment is appropriate or not, it is better to initiate treatment rather than fail to commence treatment.

Outcome studies have shown that other clinical variables besides gestational age are crucially important in determining the likelihood of survival and the risks of disability. These include birth weight (the higher the better), gender (girls do better than boys), multiple pregnancies (singletons do better than twins and triplets), and whether antenatal steroids were given prior to delivery (antenatal steroids improve survival and reduce brain injury).

Based on data from a large number of neonatal intensive care units in the USA, a web-based calculator[1] has been developed which allows the chances of survival to be estimated, based on an individual baby's gestational age, weight, gender, birth order and steroid treatment.

Based on the USA data, a 23 week gestation singleton female baby of 600 gms weight with antenatal steroids has a 40% chance of survival and a 17% chance of survival without moderate or severe disability. In other words if she survives she has over 40% chance of surviving without disability. In contrast a 24 week gestation twin baby of 500 grams weight without steroids has a 17% chance of survival and only a 4% chance of survival without moderate or severe disability.

So making blanket resuscitation rules based on gestational age alone is scientifically and medically indefensible. It is a basic principle of medicine that we should individualise treatment to the specific patient we are caring for. In this regard neonatology should be no different from any other branch of medicine.

Outcome figures vary between different neonatal units

A statistic repeated in the programme was that nine out of 100 babies born at 23 weeks will survive and only one will reach adulthood without disability. It is not at all clear where this figure came from but it is highly contestable. The EPICure study looked at all extremely premature babies born in the whole of UK and Ireland in 1995.[2] It gave overall survival rates of 11% of all live births at 23 weeks. However other published studies have shown much higher survival rates for babies at 23 weeks of gestation. A study based at University College London Hospitals, found an overall survival rate of 46% as a proportion of all live births at 23 weeks for the period 1996 to 2000[3] and other published studies have reported survival rates of 66% from USA[4] and 41% in Australia.[5]

Most extremely preterm survivors rate their own quality of life highly

The BBC programme gave the strong implication that the majority of extremely preterm survivors were significantly handicapped. In the EPICure study, at 11 years of age 52% of children born at 22 and 23 weeks had mild or no disability.[6] This seems very different from the impression given by the BBC programme. It is one of the paradoxes of neonatology that the long-term outcome after extreme prematurity is better than the outcome following severe birth asphyxia or congenital brain abnormalities. It is very unusual for ex-preterm survivors to be so severely disabled that they are unable to interact with others and engage actively in life.

Studies of health related quality of life in adolescents and adults have shown that ex-preterm survivors give similar self-ratings to those who were born at term without medical problems.[7] In my experience disabled ex-preterm survivors regard any paternalistic suggestion that their life was not worth saving as outrageous and offensive.

UK and European law is quite clear that every baby born alive has the full human rights of a citizen, including 'the right to life'. This is also confirmed in the UN Declaration on the Rights of the Child. From the moment of birth health professionals have a legal duty of care to act in each baby's best interests. In other words the primary responsibility we have is to do the best we can for each individual baby. In each case we should try to balance the burdens and risks of intensive care against the likely benefits for a particular child. The law makes birth the transition point at which full human rights are acquired, irrespective of gestation, and to act in a way which is not in a baby's best interests would be a serious breach of those rights. We cannot treat these babies as disposable – they are as much citizens as we are.

Conclusion – Is it worth trying to keep these babies alive?

Each baby deserves the best possible care. Yet the decision as to whether to commence resuscitation or not is complex. In some cases it is clearly right that doctors say 'enough is enough'. Just because a treatment is available does not mean that it should be used. But if there is a realistic chance that a particular baby can survive without overwhelming and catastrophic injury, then surely as a rich country we owe it to each child to give them a chance of life. In this situation it is best to start 'provisional intensive care'. We start intensive treatment in order to give each baby the very best chance of survival but we recognise that if it is clear that the baby cannot survive, or if there are catastrophic complications, then we may withdraw intensive support.

These decisions are painful and difficult. But there is no reason for doom and gloom about premature babies. We should celebrate the successes that have been achieved, value the lives of those who have survived against all the odds, whether disabled or not, and look forward to future advances in the care of these vulnerable citizens.

John Wyatt *is Emeritus Professor of Neonatal Paediatrics at UCLH. The opinions expressed are his own and do not reflect those of any body or organisation.*

A longer version of this article is available on the CMF blog. See bit.ly/iqwqJW

Photos kindly provided by Bliss, the special care baby charity, who provides vital support and care to premature and sick babies and parents across the UK. www.bliss.org.uk

Photos: Bliss / Nicola Kurtz

From the moment of birth health professionals have a legal duty of care to act in each baby's best interests. In other words the primary responsibility we have is to do the best we can for each individual baby

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The 2011 Rendle Short Lecture was given by **Ted Lankester**

MEDICAL MISSION:
changing the world together

key points

The 2011 Rendle Short Lecture explored the complex arena of medical mission highlighting the diversity of approaches and encouraging a flexible faith-based response to the opportunities.

Faith-based organisations are now widely recognised as having a key role to play in the provision of healthcare in the developing world.

Seeking God's leading, and being prepared to respond in faith to new ideas, may be the catalyst for new movements to reach the lost with the love of Christ.

You don't have to go to Timbuktu to be a medical missionary. God expects each of us to be his ambassadors wherever we are called. 'Exceedingly good cakes' is a well-known strap line from the famous Mr Kipling and it's a simple brand we all understand. But what sort of brand is medical mission? It is complex, diverse and at times bewildering. This lecture gives a few snapshots which, I hope, will show that medical mission is at a very exciting stage, allowing healthcare workers to be involved in a great variety of ways.

Both and: proclamation and demonstration

Should we be proclaiming the gospel or should we be demonstrating the gospel? God is obviously interested in both. As we study the New Testament we see that God has an interest in our human needs such as our state of health today, our hardships and challenges, as well as our eternal salvation. The Bible links the two together, but the links are made in different combinations and in a wide variety of mix and match.

Many of us think we have seen or done medical mission in a way that suits our personality and theology, or is most effective and ethical. For me it is what is often called integral mission; we share the gospel and we are also passionate about justice, poverty, healthcare and psychosocial needs. We don't do the latter just to provide an opportunity to preach, we do it because this is part of God's call and compassion. I sometimes wonder and worry about people who say they are holding a clinic in order to preach about God. But the fact is God sometimes uses that approach and I have seen it work.

One model I like especially is based on this definition; Evangelism is an answer to questions raised by New Testament living. When I worked in the Himalayas in community health programmes amongst Hindu communities, one of our village health workers noticed that 'Our God' seemed to answer prayers. Her problem was that the goats she and her family owned always ran off at night and they spent half the next day rounding them up. 'I have prayed about my problems for months and they have not been answered. Please ask your God.' Later she came back and said that since our team had prayed, her goats had all been well behaved. She became the first Christian in that community.

We should not be so tied into our science that our wider circle of belief excludes miracles. Instead we should welcome the wonder that God sometimes works beyond scalpels and antibiotics. Sadly some Christian doctors are as disbelieving in miracles as Dawkins is in the existence of God.

Health needs that shock us

For those of us who live in comparatively safe and well-governed countries such as the UK, we can so easily forget the huge needs in the wider world. These statistics should shock us into action:

- **Key Need 1** – More than one billion people live in extreme poverty; almost nine million children die each year from preventable diseases[1]; 350,000 women per year do not survive

pregnancy or childbirth,[2] and 58 million out of 136 million women giving birth yearly receive no medical assistance; nearly 33.3 million people are living with HIV/AIDS.[3]

- **Key Need 2** – Appalling access to health care. Two billion people are not able to obtain essential medicines; 1.3 billion people lack access to basic health care. That is nearly one person in five and these are the people who need it the most.[4]
- **Key Need 3** – Huge inequalities. In Nairobi the under five mortality is below 15 per 1000 in high-income areas, and in a slum in the same city 254. In Glasgow the life expectancy varies by 27 years from one part of the city to another.[5]
- **Key Need 4** – Shortage of trained health workers. The world is short by 4.2 million.[6] That means that even if we start new nursing and medical schools we will probably never catch up. So we need to think of alternative ways of reaching those with no access to health care.

Of course we must not forget that great progress has been made, but it was similar scandalous statistics that lay behind a summary in *The Lancet* a few years back, and which many of us have seen at first hand.

After a century of the most spectacular health advances in human history, some of the world's poorest countries face rising death rates, and falling life expectancy. Gains are being lost because of feeble health systems. On the front line we see overworked and overstressed health workers too few in numbers, losing the fight with many collapsing under the strain.[7]

The Great Commission: Today's context

The Great Commission is given to every church in the world. This includes large churches in the global north and small emerging congregations in the poorest countries. Hundreds of thousands of churches are commissioned to go into 'all the world'. But if each of these churches started sending out missionaries it would lead to complete chaos, or perhaps wonderful chaos. Mission is increasingly everyone to everyone, any church to any country. Of course not every church will send out healthcare workers, but thousands will. Consider China, where there are estimated to be 70 million Christians, many with a mission focus. How will that change the world when visas become easy to obtain and the Chinese church has the resources to send people abroad, as its government is already doing? South Korea is already the world's largest mission sending church. Will it soon be China? Where will the UK come in the league? A long way down I expect; so forget the old paradigm of the west to the rest.

Open doors

We often talk about open doors, and in our globalised world they are very numerous. But they sometimes snap shut. Fortunately God is the doorkeeper, so the opening and closing of particular doors is not random, it is all part of God's purpose and plan: In Revelation we read 'See I have placed before you an open door'.[8] It is incredibly reassuring that the next verse goes on to say 'And I know that you have little strength'.[9]

These open doors are leading to something large-scale and exciting which is happening before our eyes. In 2006 the World Health Organisation realised they needed to commission research into how much faith-based groups were providing in the way of health services. The research showed that at least 40% and in some countries as high as 70% of health care in sub-Saharan Africa is provided by faith-based organisations, or by religious health assets as the current jargon describes them.[10]

Suddenly there was a realisation in the secular world, currently dominated by unrepresentative liberal humanism, that faith-based organisations (FBOs) had something very vital to offer and the church was central to it. An article in the DFID magazine *Developments* claimed that 'religion is good for development' quoting a poll by Gallup from 2008 that a sample of sub-Saharan Africans were asked who they would most like to work with in terms of relief and development; 82% responded 'religious institutions'. In response Dr Ed Kessler of the Woolf Institute commented 'Knowledge of and sensitivity to faith issues are vital in the world of humanitarian aid in the world today'.[11]

Because the role of FBOs has now entered the main steam, the reality of what churches and Christians are doing in the world is now a legitimate topic for discussion in any academic group. This is very liberating and gives us an open door, providing we discuss the issues in an open, unbiased and informed way.

Opportunities: Going through those open doors

There are an increasingly large, diverse and often complex range of opportunities in front of us, but we need more than a collection of doors and openings to walk through, we need to recapture the idea of a movement. The 19th century medical mission movement had a huge impact. I have just reread the autobiography of my great uncle Arthur Lankester who was one of many pioneers who founded a chain of mission hospitals in the northwest frontier region of Pakistan; most of which are still doing a vital job today.

Another movement that captured the imagination of many people including myself was Health for all by the Year 2000 and now we have the Millennium Development Goals galvanizing us into action. But we need to rekindle the idea and put into practice a global health care movement led by those who know God, possess the compassion of Christ and are prepared to work towards the most exciting goal of all 'Your Kingdom Come your will be done on earth as it is in heaven'.[12]

Ted Lankester

Photo: © Martin ASHA

After a century of the most spectacular health advances in human history, some of the world's poorest countries face rising death rates, and failing life expectancy

Where does medical mission happen?

Medical mission no longer just happens in institutions. It occurs in homes, neighbourhoods and communities. Often as Christian doctors we think that healthcare is something that mainly happens in hospitals and of course it is found there, but it must start and be grounded in the community. We must always think community because that is where ill health is found and generated and we seek to understand the determinants of ill health within a particular community. It is largely at community level that we can turn off the tap of ill health.

The second place we need to focus, is on church-based institutions. I am saddened when I hear people say that mission hospitals have had their day. While some are struggling, in many resource-poor countries it is self-evident they are badly needed. And although some are closing down, other church-linked hospitals and health institutions are opening up.

Some readers will have worked in hospitals where there are not enough doctors, supplies have run out, there is never enough time to do everything, and when near-exhaustion becomes the norm. This may still be the case but through new governance models we must move away from that as the default image and practice.

There remain many and diverse ways doctors can serve long or short term in church-linked institutions. One model is to remain based in our country of origin as 'non-resident medical missionaries' from where we build a relationship with an overseas institution, visit, support, encourage and train, based on the genuine needs of the hospital as discussed and agreed by those working there full-time. If done well this can be very effective medically and spiritually. Conversely going abroad short-term for an exposure visit or as a medical tourist can, unless sensitively set up, be disruptive and valueless.

The third area for us to focus on is the local church. One of Tearfund's astonishing objectives is to link and partner with 100,000 churches by the year 2016. What a great objective! Tearfund's partners and many others working on the frontline realise that the local church (or temple or mosque) is the key community organisation, present in almost every village or town in the world. Nothing could be more attractive as a Kingdom model than a church in Africa, Asia, Latin America or deprived areas in the global north, being able to care for the neediest in the community through competent, compassionate healthcare offered to all, offered without discrimination on the basis of need not creed.

The fourth arena is the big wide world. In better-resourced countries there are hundreds of highly motivated medical students and junior doctors emerging who look at the world and wonder how they can have a maximum impact. There are opportunities in all the ways discussed above. But there are a great variety of other ways too when we start thinking 'outside the box'; community mental health, integrated urban health programmes, battlefield surgery, Mercy Ships, palliative home-based care, addiction units, the health care of commercial sex workers, writing radio soaps and TV programmes with an exciting storyline and a vital health component. Walking the corridors of power to help initiate and develop new health policies, becoming involved in the media to explain and motivate others to take up the cause. Let's not play safe.

But how easily this vision gets lost when that alluring relationship, well-paid hospital job or vital mortgage displace our idealism. This is often backed up by genuine and apparently wise advice from parents and friends: 'Get the boy home. He is wasting his time out there', was the single worst piece of careers advice I have ever received, and that was from an eminent doctor. How different to Hebrews 11 which is a portrait gallery of some of the real world-changers.

Getting out of the boat

We sometimes think it was weird of Peter to get out of his fishing boat in mid-sea, walk towards Jesus and then start to sink. But Jesus asked him to do it. We must be prepared to get out of our boat (perhaps our standard career path?) if God asks us to, and start taking risks. Most mainstream ideas today started as the often misunderstood and radical vision of those who first brought them into being.

Many secular groups are doing outstanding and inspirational work which we should welcome and engage with as fellow humanitarians. But I am concerned they are often setting today's agenda to the exclusion of those of us who claim to know and love God and are told that as such we have the Mind of Christ. Why are we not helping to set the agenda more when it comes to global health and medical mission? Why are we not, as UN language describes it, more involved in respectful engagement in these debates and policies? In the Old Testament the men of Issachar were commended because they understood the signs of the times. [13]

Postscript

Finally I want to mention a principle I see in action more and more. When God is planning to do something new, bold or significant he often drops the same idea into the minds of many different people. Be responsive to a 'God-drop' that he may be wishing to give you. Ask, 'Lord are you wanting to drop a new idea into my heart and spirit beyond what I am doing at the moment? 'Very often we will find as we receive that 'drop', many other people will have had similar ideas. This may not only transform your own life, but be one of the mechanisms of how a new movement to transform the world with the love of Christ will be gaining momentum in the coming years.

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It is largely at community level that we can turn off the tap of ill health

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We have neglected stillbirths for too long says **Philippa Taylor**

STILLBIRTHS: TRAGEDY & CONTROVERSY

New figures from *The Lancet* reveal the tragedy of the scale of stillbirths, estimated at around 3 million worldwide, every year; more than 8,200 stillborn babies a day. This vast number eclipses deaths from AIDS/HIV and many other diseases that get far more money. Perhaps unsurprisingly, 98% of these are in low- and middle-income countries,[1] which compounds the tragedy as most of these stillbirths would not occur if basic and comprehensive emergency obstetric care were as available as in high-income countries.

The controversy of these figures lies not just in the scale (though that is of course an important issue of inequity and resource provision) but also in the fact that many of these deaths are being ignored. They are being ignored, *The Lancet* claims, because of the politics of abortion.[2]

The Lancet series on stillbirths highlights how this global public health problem fails to feature in any major global or national health targets and commitments:

'The mother's own aspiration of a liveborn baby is not recognised on the world's health agenda. Millions of deaths are not counted; stillbirths are not in the Global Burden of Disease, nor in disability-adjusted life-years lost, and they are not part of the UN Millennium Development Goals… Most stillborn babies are disposed of without any recognition or ritual, such as naming, funeral rites, or the mother holding or dressing the baby.'[3]

So why is stillbirth 'one of the most shamefully neglected areas of public health'?[4]

One of the reasons it remains 'in the shadows', as *The Lancet* editor, Richard Horton, states, is because of pro-abortion sentiments. Although, he says, the definition recommended by the WHO: 'a baby born with no signs of life at or after 28 weeks' gestation' is sensible, since few babies born before this age are likely to survive in low-income countries, some, however, do survive after as few as 22 weeks in high-income countries. Therefore: 'Not to count as a stillbirth the death of a baby born at between 22 and 28 weeks' gestation, or earlier, would be to deny many parents the gravitas their grief demanded. When one considers that in many countries abortion is allowed up to and sometimes beyond 24 weeks, one can begin to understand authorities' reluctance to pursue the point. In reality, however, the two issues are completely separate. Every woman has the right to a safe abortion, should that be necessary, but she also has the right to have the death of her baby counted in the process by which countries monitor and improve the indicators of health.'[5]

Clearly Horton supports the availability of abortion and sees no dilemma in this, however he is prepared to stand up to the pro-abortion lobby when the evidence demands it. It is not the first time that Horton has taken on this lobby. Some may recall that *The Lancet* challenged WHO data and methodology[6] last year on maternal death statistics[7], which were being used to promote abortion worldwide. He was attacked for it, but was vindicated when the WHO estimates were quietly re-written and lowered, in line with *The Lancet* evidence.

Horton will undoubtedly face challenges with this series on stillbirths. One linked article suggests that a primary solution should be to improve women's rights and access to reproductive and sexual health services ie more family planning and abortion on demand. However *The Lancet* rightly calls for prevention and treatment of infection and improved obstetric care, along with recognition and targeting of the problem, not for more abortion: 'We call for inclusion of stillbirth as a recognised outcome in all relevant international health reports and initiatives. We ask every country to develop and implement a plan to improve maternal and neonatal health that includes a reduction in stillbirths, and to count stillbirths in their vital statistics and other health outcome surveillance systems.'[8]

Society is full of contradictions in attitudes to early human life, as Horton clearly reflects. The status and value of unborn and even newborn babies has long been a controversial issue. If fetuses are considered disposable it is unsurprising to find a similar attitude toward stillbirths, hence the failure to include them in the statistics. But biblical teaching is very different. Christians know that each and every one is loved and personally known by God as a unique and precious individual, not just a number to be ignored.

Moreover, the death of a newborn, or unborn, baby is a devastating trauma for parents. Hence the Christian call to respect and care for the weak, and to bear one another's burdens, is desperately needed by a society that, in ignoring these deaths, effectively disregards the impact on parents, grandparents, siblings and other family members.

We should be careful not to think that just because a woman lives in an environment where stillbirths are common, this somehow mitigates against the personal loss and trauma each death generates. Not only will they feel the loss of a pregnancy as much as women from higher-income countries, but they can also bear an additional, if unwarranted, sense of responsibility or shame and, at times, blame from their husbands.[9]

The Lancet has given this issue some high profile coverage. The challenge it leaves is not only to do everything possible to lower mortality rates but also to ensure support and counselling are available for those who are overlooked by the statistics. Every stillbirth is a tragedy; how sad that recognition of this tragedy has become mired in controversial abortion politics. Let's hope that national plans to improve neonatal health will also include goals to recognise and reduce stillbirths and provide the support required for bereaved parents.

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A member working in West Africa recalls what led her to spend a year at Bible college in Kenya

Cross-cultural CHALLENGE

key points

A case history of a girl in West Africa thought by her family to be affected by evil spirits caused a CMF member to study the Bible further on these matters.

She chose to do so in an African Bible college and 'learnt as much over lunch each day, chatting with her Kenyan and Nigerian housemates, as she did in the classroom'. African understandings were reinforced by a research project.

After a consideration of biblical teaching on sickness, health and healthcare, the author concludes that Christian doctors and nurses must include spiritual factors more comprehensively in holistic healthcare.

A young woman was brought to the health centre unconscious after her family had found her collapsed on her way to work. She failed to respond even when a lumbar puncture was undertaken without anaesthetic. All results from the tests which were available were normal.

As she was transferred from trolley to bed, there was a suggestion of some voluntary movement, raising the possibility of a functional cause. When the test results were explained to her family, they reported that they were not surprised. They thought that she had 'seen a ghost in the field'. By the next morning, she had recovered consciousness. No abnormalities could be found and she was discharged to her family's care.

Where 'Western medicine' falls short

Situations like this were not unusual in the health centre. Working in a Muslim country, where African traditional religion continues to have a strong influence, meant that patients often explained their sicknesses in spiritual terms. Yet it seemed that they did not expect the Christian doctors and nurses to be able to address these problems – and the truth was that our focus was primarily on the physical and biological abnormalities that our western training had taught us to assess and treat. Prayer was a significant part of our lives, but we rarely prayed with the patients.

After spending a year in this setting, I returned to the UK to complete specialist training with a sense that we had missed something. The local people were afraid and bound by the spirits they saw all around them. We missionaries were much less aware of these spirits than they were, and were reluctant to discuss them with our patients. Instead, the local people sought the help of the *marabouts* (Islamic teachers and healers) who claimed to be able to control or pacify these spirits.

I knew that the Bible had plenty to say about the involvement of spirits in causing sickness, mainly in the gospels where Jesus casts out many demons, with the result that their former hosts are healed.[1] But I had never seen or heard this applied to medical practice. I wanted to understand better the anxieties and beliefs of my African patients at the same time as studying scripture, so that I might be able to return and help set them free from their fears.

African Bible college for an African context

So after completing my postgraduate training in the UK, I went to the Nairobi Evangelical Graduate School of Theology in Kenya. This college provides masters and doctoral courses in theology, missiology, biblical studies and Christian education – primarily for African students, but I hoped that by living with and learning alongside them I would be able to grow in my understanding of their worldview.

The missiology course included modules on anthropology and theology and my teachers had research interests overlapping my concerns – one had studied the beliefs held by the Swahili people about the *Djinn* (Muslim word for spirits) and the other had investigated local understandings of sickness and death in northern Tanzania.[2] It was a fantastic experience and I learnt as much over lunch each day, chatting with my Kenyan and Nigerian housemates, as I did in the classroom.

Research in West Africa

In my final year, I carried out a research project as part of the programme. I spent a few weeks back in West Africa interviewing friends and contacts about their health beliefs, and found that they all gave God primacy in determining whether they would be sick and whether treatment would work. Although it was recognised that a sickness might have a natural cause, even then God must have permitted it. They actually thought most sicknesses were the result of the evil intentions of another being – either a person or a malevolent spirit, and believed that the *marabouts* were able both to cause and to treat sicknesses.

Their treatments are intended to placate the spirits and to attract blessings from God, and involve herbal washes and rubs, praying and reading the Qur'an, wearing *jujus* (charms), giving alms and making sacrifices. The *marabouts* use divination techniques to reveal both the cause of the sickness and what treatment they should give.

The Bible on sickness, health and healthcare

In one of my theology modules, I also had the opportunity to review what the Bible says about sickness, health and healthcare. I knew that there had been no death or sickness in the Garden of Eden and that this will also be the case in the new creation.[3] However, I was quite surprised by some of my other findings:

- Death arrives early in the Bible and this is followed by infertility, apparently sent by God[4]
- Sickness is not described until Exodus, when it is first seen in the plagues[5]
- God warns his people that sickness will increase if they do not obey him[6]
- The link between sin and sickness persists throughout the Bible – God often sends sickness as a judgment on his people. However, Jesus denies that this link is direct enough for us to claim that any one sickness is a punishment for a particular sin[7]

The Bible also attributes sickness to two other causes. Satan's role is seen in the prologue to the book of Job,[8] when he questions Job's righteousness and seeks God's permission to make him sick; and in the gospels, where, as we have seen, sickness is linked to demon possession. But sickness is also linked to God's glory. In the end, this is the underlying reason for Job's sickness, so that he might know God; Jesus gives this as the explanation for one man's blindness; and this is also why Paul finally accepts his 'thorn in the flesh'.[9]

The truth is that when I am sick, I think primarily of biological aetiology and possible medical treatments. I will, rarely, wonder if God will use this to teach me something, but I never consider whether my sin has anything to do with it, nor do I worry about evil spirits. Yet, for as long as I continue to divide the physical from the spiritual in this way, I fail to have a holistic view of sickness, and in the context in which I work, I am failing to address the needs and fears of my patients.

The challenge to provide holistic care

The story of the young woman illustrates this well. Having completed my research, I now know that she is considered to have a sickness caused by a *Djinn* (a Muslim spirit) who has fallen in love with her. He will attack any potential husband and may kill any children she conceives. He will make her collapse whenever he feels he is losing control of her. Her family will spend a lot of money trying to appease this spirit. However, they will not be hopeful of success, as this sickness is notoriously difficult to treat.[10]

This surely should be the real challenge for medical mission in the 21st century. The people around my health centre have been hard to reach with the gospel. They appreciate the healthcare we provide, but these days many other NGOs are also able to provide good healthcare. As Christian doctors and nurses, we have much more to offer them – not just medical care, but also freedom from the power of evil and the spirits they see around them, and freedom to know and worship God through the victory won by Jesus Christ. This freedom is an integral part of salvation – alongside the acceptance of the truth of the gospel message and a developing relationship with Jesus and his followers.[11] Furthermore, descriptions of the conversion experiences of Muslim-background believers show that most have some experience of the power of God to intervene into their lives, as well as having a Christian friend – whose lifestyle gradually won their sympathy and interest and who presented them with the truths of the gospel message.[12]

I have just returned to work at the health centre where this event occurred. How would I respond now? I still don't have many answers. Jesus' warning about what may happen to a man who has a demon cast out, but who does not fill his life by following him,[13] means that I cannot simply pray for my patient to be freed from evil powers and then walk away. However, I see this as an opportunity to begin to walk a long road with this family, and with local believers who have a greater understanding of the spiritual context than I do. So I would seek to understand what the patient and their family believe about the cause of their illness; I would pray that God would reveal himself in this situation; and I would offer to meet them again to talk further about Jesus, who he is and what he can do to bring them freedom. More generally, I intend to continue to strive to understand and respond to these issues, applying the Bible to the whole of my life – including my medical practice.

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Hugh Thomson
on Isaiah 38-39

Learning from our SUFFERING

key points

Abbreviating a Bible reading given at the 2011 CMF National Graduates' Conference the author explores the human condition since the Fall likening life to a temporary reprieve before justice is finally done.

We should consider suffering to be a tool God can use to accomplish his purposes in the lives of his people rather than something which is to be avoided at all cost.

The death and resurrection of Jesus Christ should remind us of the permanent pardon he has secured for all who put their faith in him.

When I gave up working as a consultant surgeon to be pastor of a church, my family members were appalled: 'What a waste!' they said, 'Think of all the lives you were saving as a surgeon!' But I had to tell them that I never saved a single life. All our patients die eventually. All I was trying to do was postpone death for a little while; to give a brief reprieve from the inevitable end for all human beings.

In the beginning God said to Adam: 'You must not eat the fruit of the tree of the knowledge of good and evil for when you eat of it you will surely die.'[1] Of course they *did* eat, but in God's mercy their death was delayed. The same is true for us: we're disobedient sinners waiting for God's judgement on the last day of history and in the meantime God has reprieved us.

Struggling with suffering

Chapters 38 & 39 of Isaiah record a reprieve for King Hezekiah and for the nation of Israel. When Hezekiah falls ill God commands: 'Put your house in order, because you are going to die; you will not recover.'[2] Hezekiah is absolutely gutted: 'Hezekiah turned his face to the wall… and wept bitterly'.[3] 'Remember, LORD, how I have walked before you faithfully and with wholehearted devotion and have done what is good in your eyes'.[4] How could you do this to me God? I don't deserve this.

God answers with a reprieve for the king: 'I have heard your prayer and seen your tears; I will add 15 years to your life'[5] and God gives him a sign: 'I will make the shadow cast by the sun go back the ten steps it has gone down on the stairway of Ahaz.'[6] This sign is all about God's control over time. The stairway of Ahaz in Jerusalem acted as a sundial: you could tell the time by how far the shadow had got. And when the shadow retreated, that meant God had turned back time. It's a picture of what God is doing for Hezekiah, putting the clock back 15 years for him.

All our patients die eventually. All I was trying to do was postpone death for a little while; to give a brief reprieve from the inevitable end for all human beings

Verses 10-14 tell us how Hezekiah felt when he was told he was going to die and we recognise in his response the stages that many people go through when they're struggling to come to terms with a terminal disease. Firstly there's shock: 'Must I go through the gates of death?'[7] Then anger: 'How could God do this to me?' 'My life is just like a shepherd's tent being pulled down; like a cloth stripped off the loom.'[8] He accuses God: '*You* have made an end of me.' Then there's grief: 'I cried like a swift or thrush, I moaned like a mourning dove.' And finally a cry for help: 'Lord, come to my aid!'[9]

Hezekiah is mourning over his life cut short. Being king suddenly counts for very little when you're facing death. Illness is a great leveller: once you're in a hospital gown, having an anaesthetic, or having an enema, you're pretensions quickly disappear.

How sad that many people come face to face with death and never see things in a right perspective. I can think of patients in a hospital ward in the last days of their lives - and what were they doing? Reading their Bibles? Thinking about the life to come? Not most of them: they were reading *Hello* magazine, or following their stocks and shares, or watching soaps on the ward television. Right up to the very end they were still playing with their toys in life's kindergarten.

In vv.15-20 we find Hezekiah praising God for prolonging his life, and here's the insight he gained: 'Surely it was for my *benefit* that I suffered such anguish.' [10]

God didn't just strike Hezekiah down arbitrarily. No God has purposes in this all along. Isn't that often our experience? We go through an illness or bereavement, or struggle with some clinical disaster in our practice - and it's difficult to understand at the time. But later we look back and see what God was doing, and say with Paul '*In all things God works for the good of those who love him, who have been called according to his purpose*.' [11]

As doctors, our job is to fight disease, delay death and bring comfort. But we mustn't lose sight of the fact that God uses illnesses and has purposes in suffering. We mustn't forget that there are more important things than bodily health. In the Western world we tend to assume that suffering is always bad and something to be avoided at all costs. But people in some other cultures take a different view. What has Hezekiah learned? 'In your love you kept me from the pit of destruction.' How? 'You put all my sins behind your back.' What Hezekiah realised was that God was overlooking his sins and delaying the judgment of death at least for a time.

Relief and reprieve

But it's only a reprieve; just a stay of execution. The king of Babylon sends letters and a gift to Hezekiah. [12] Well how flattering! Hezekiah gives the ambassadors a tour and shows them all the riches of his kingdom [13] but receiving gifts from the Babylonians was equivalent to entering into an alliance with them and trusting in Babylon rather than exclusively in God.

Isaiah is disturbed [14] and God shows him that the outcome will be defeat by Babylon and exile. [15] Hezekiah's response is shocking: 'The word of the LORD you have spoken is good,' Why *good*? 'For he thought, "there will be peace and security in my lifetime."' [16] No concern for the future of God's people; no concern for the glory of God's name; just self-interest.

Well Hezekiah got what he wanted: 'peace and security in his lifetime'. But the reprieve for God's people was temporary and God's judgment in the form of the Babylonians was on its way. Death is coming for Hezekiah and exile is coming for the people of Israel, because God is just and punishes all sin and rebellion… and that involves all of us.

So, thirdly, we see a reprieve for the whole world. Back in Eden, when Adam and Eve disobeyed God, they were thrown out of Eden under a death sentence. But Adam lived 930 years more with the death sentence hanging over him. Adam and Eve finally died, and so has every man and woman since then. We are all under a death sentence and we're all reprieved for this life, as we wait for Jesus to return as judge.

Permanent pardon

700 years after Hezekiah, Jesus came into this world. Hezekiah represented all God's people in his day as their King and Jesus represents all God's people everywhere as our King. But despite the fact that Jesus was the only human being who never sinned, there was no reprieve for Jesus.

For all who belong to Jesus the final judgment arrived 2,000 years ago. All the sins of all God's people everywhere were heaped up together at Calvary on that one day, and blamed on that one man, and there dealt with once and for all. Because of Jesus' suffering we know our sufferings will one day come to an end. Thank God there was no reprieve for Jesus! Jesus has achieved for us a place in glory where illness and suffering and old age will have passed away and we shall have resurrection bodies.

A minister who holds services once a month for disabled people told me about one particular Sunday when they were singing the song 'There is a Redeemer' [17] and he saw a girl in a wheelchair beaming from ear to ear as she sang, with tears pouring down her cheeks. Afterwards he went and asked her why she was so moved and she answered: 'It's the last verse: 'When I *stand* in glory.' I'm not going to be in a wheelchair in heaven!'

That's what Jesus has achieved for us. When Jesus died he gained for us not just a reprieve, but a permanent pardon. We're going to die but we have eternal life.

Now when we struggle with suffering we need to learn to believe that God has purposes even when we can't see what they are – just as God was working in Hezekiah's life and his illness. That's what gives us hope.

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All of Hugh's conference talks are now available on the cmf website at www.cmf.org.uk/media

When Jesus died he gained for us not just a reprieve, but a permanent pardon. We're going to die but we have eternal life

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2. Isaiah 38:2
3. v.3a
4. v.3b
5. v.5
6. v.7
7. v.10
8. v.12
9. v.14
10. v.17
11. Romans 8:28
12. Isaiah 39:1
13. v.2
14. v.3
15. v.6-7
16. v.8
17. *There is a Redeemer* Keith and Melody Green © Universal Music Publishing Group

Margaret E Hodson
reflects on the path which led her into a career in academic medicine

I never thought...

key points

Looking back over the key decision points in her life the author shows how God clearly guided her into an unexpected field.

Overcoming the obstacles of ill health and a culture of discrimination against women wasn't easy but God enabled and blessed each step of the journey.

The author reminds us to continue looking for God's guidance, trusting him for the future and giving thanks for the past.

When I was at medical school, I fully expected God to call me to overseas mission. Yet that call never came. I had wanted to specialise in respiratory medicine since I decided to become a doctor, but it had never occurred to me that I would be called to an academic career. However, as I look back, I am very grateful for the way that God has so clearly guided me.

Childhood

At the age of two I developed asthma, which I have had ever since. Treatment at the time was poor and consequently I missed a lot of school. I enjoyed lessons, but was often too breathless to play games and spent a lot of time busy with my books.

I grew up in a Christian home and attended Sunday school, and I am also grateful for the influence of several Christian teachers. At the local village school a lovely Christian lady taught us how to love and serve the Lord, together with reading, writing, and arithmetic. At secondary school, we had two Christian teachers, one of whom took me to a Billy Graham rally at the local Baptist church, where I rededicated my life to Jesus.

I began to wonder and pray about what I would do with my life. When I was about 14, it became increasingly clear to me that God wanted me to study medicine. Nobody from my school had ever gone to medical school before. At the time, the entry requirements included O-level Latin and A-level Zoology. My school had no classes in either subject. However, the headmaster arranged special tuition for me, so I got the qualifications I needed.

Medical school

At that time there was a quota system so only a few girls could study medicine each year and initially I was not allocated a place. I prayed hard and wrote to the Dean of every medical school in the UK asking that they consider me if anyone dropped out. After five or six weeks, Leeds offered me a place. However, shortly after I arrived, they discovered that the girl who had failed her exam, leading to the spare place, had in fact been given the wrong examination paper. They had to reinstate her, but fortunately they decided to keep me as well!

At medical school one of the GPs at the university health centre taught me to treat my asthma. Consequently, I missed very little time from classes. I worked hard, and valued the support of the Christian Union and local church. A CMF group also invited the students round for meals and helpful talks at least once a month.

I prayed a lot about what I should do when I qualified. However, in the summer when I should have taken my finals, I became very ill with viral pneumonia and asthma. I spent many weeks in hospital and the staff wondered if I would ever be able to work because my lungs were so bad.

However, six months later I was able to go back to Leeds to take my final exams, which I passed with honours and distinctions.

Life as a junior doctor

During my house jobs, the consultants made it clear to me that it was not a suitable for a lady, to want to become a consultant physician. Various people tried to talk me into taking a laboratory job or doing anaesthetics, which they thought would be less demanding. Indeed, on one occasion I was seriously considering accepting an anaesthetic post, but the Spirit gave me no peace for 48 hours. I realised it was not part of God's plan and turned it down: one week later I was offered a general medical registrar post at the local teaching hospital.

Still keen to pursue to a career in respiratory medicine, I felt led to apply for a post at the Royal Brompton Hospital in London, a specialist centre for the treatment of heart and lung diseases. I was told by my consultants, that I would be unlikely to get the job as I had no medical relatives, I was a woman, and I had not been trained in London. They must have given me a good reference, however, as I was appointed.

Royal Brompton Hospital

On my arrival I was allocated to work on the cystic fibrosis (CF) firm. I did not know that adults with CF even existed. I soon realised the tremendous challenges involved in caring for these young people, many of whom were preparing for death with peace and dignity. During these years, I worked with the Free Church chaplain to set up informal Sunday services in the hospital, making them suitable for young adults and others with life-threatening illnesses, but very little knowledge of the Christian faith.

I felt called to continue working with CF patients, but I was told that it was not easy for a woman to get a consultant post at the Royal Brompton and I would need to have more qualifications than my male colleagues! So I set about getting an MSc in immunology, a new science at that time, as well as my MD and anaesthetic exams.

I was subsequently appointed as a senior lecturer with honorary consultant status to the adult cystic fibrosis unit. I was certainly not very interested in academic medicine at the time and patient care remained my main interest, but I had to take this route. At that time, the University was more prepared to appoint women than the hospital, and an academic appointment automatically led to honorary status with the hospital.

I was given laboratory space and I raised money for a research team to work with me, and it soon became clear to me that this too was part of God's plan. Over the years, I have gone on to have the privilege of working on some of the big developments in CF care, including new methods of physiotherapy, inhaled antibiotics, Pulmozyme and transplantation. I have also been able to develop new methods of care delivery, such as nurse specialists and home care services, many of which are now standard around the world. In 2002, I was awarded the first Rossi Medal by an international committee for the greatest contribution to improving treatment for patients with cystic fibrosis in the past 25 years. This however was a reflection of the work of a dedicated team, not of me as an individual.

One of the hardest things about being a clinical academic is money. My research group has never received any funding from the university, so I have had to find every penny myself. God has, however, been very faithful and whenever we have needed money, we have managed to raise it.

During these exciting years God gave me a wonderful gift without which much would not have been possible. In my first year as a senior lecturer, a new secretary was appointed to the department. She was a Christian and wanted to work with a Christian consultant. I have been privileged to work with her for over 30 years. She made it her life's work to help me improve care for cystic fibrosis patients and maintaining Christian witness within our hospital.

The future

I do not intend to retire until I reach heaven. However, the work I do will change as the years go by and I am confident God will find something useful for me to do. I hope to serve more in the church as gradually I reduce my clinical work. I have been a lay minister for many years and recently was made a lay chaplain to the hospital. I am still an asthmatic, but during the last 35 years I cannot remember a day off work because of my chest.

I am very grateful that God has so clearly guided me in all the big decisions of my life and I now know why my call was not to work overseas. I have been privileged to serve in academic medicine and I have been given many exciting challenges. Although the discrimination against women has now gone, I would say to any young doctor called to academic medicine, this is hard work but a very exciting journey. It never occurred to me that I would be called to an academic career – I never even thought it would be possible. But with God's call and blessing it was.

***Margaret E Hodson**, MD MSc FRCP DA Dip Med Ed*
Professor of Respiratory Medicine, NHLI/Imperial College Honorary Consultant Physician, Director of Medical Education, Royal Brompton Hospital, London

Margaret E Hodson

I am very grateful that God has so clearly guided me in all the big decisions of my life

Andrew Miller comments on Jesus' bedside manner

A CURIOUS CURE?

Leaving that place, Jesus withdrew to the region of Tyre and Sidon. He entered a house and did not want anyone to know it; yet he could not keep his presence secret. In fact, as soon as she heard about him a Canaanite woman from that vicinity came to him, crying out, "Lord, Son of David, have mercy on me! My daughter is suffering terribly from demon-possession."

Jesus did not answer a word. So his disciples came to him and urged him, "Send her away, for she keeps crying out after us." He answered, "I was sent only to the lost sheep of Israel."

The woman came and knelt before him. "Lord, help me!" she said. He replied, "It is not right to take the children's bread and toss it to their dogs."

"Yes, Lord," she said, "but even the dogs eat the crumbs that fall from their masters' table."

Then Jesus answered, "Woman, you have great faith! Your request is granted." And her daughter was healed from that very hour.

Matthew 15:21-28; Mark 7:24-30

The setting of this encounter is Lebanon, which was under the joint control of Rome and Syria; Jesus was able to stay with some Jews who lived there. He had gone away from Israel for a break but even so word got around, and this woman managed to push her way in.

Preachers use this story to talk about the 'great faith' of this woman. However, most hurriedly skate over Jesus' extraordinary and apparently inexplicable behaviour, which at first (and even second) sight comes across as being dismissive, dishonest and insulting - uniquely so of the 23 recorded healings. So why did he treat this woman in such an out-of-character way?

Was he annoyed about having had his holiday disturbed? Was he grumpy after a bad night's sleep? Had some local kebabs disagreed with him? Before seeking a better explanation, let us acknowledge the difficulties:

Firstly, Jesus initially completely ignored her. But this contrasts starkly with the welcome he offered the Samaritan woman even though this too was socially taboo.[1]

Secondly, he misled her by suggesting that Gentiles were not in his game plan. But this contrasts with what he already knew[2] and had proclaimed in his home synagogue – where he actually specified Sidon and Syria[3] – and it also contrasts with his ready welcome to the Gentile centurion.[4]

Thirdly, he effectively called her 'a dog', a common term that Jews used for Gentiles. But this contrasts with the attention, honour and compassion (remarkably anti-cultural) that Jesus displayed to women on every other occasion.

How do we explain this? It is important to realise that Jesus quickly saw that this woman was desperate and had no intention of taking 'No' for an answer. He certainly would not have behaved this way towards a shy and deferential woman who might have run away at the first sign of being unwelcome.

It is often forgotten that this incident did not involve only Jesus and the woman - *the disciples were there too*. They had previously shown their prejudices against women[5] and the disabled,[6] and now their hostile views of Gentiles were clearly shown when they tried to get rid of this foreigner; their attitudes reflected their Jewish upbringing, culture and theology. By behaving as he did, Jesus clearly and forcefully reflected back to them their own ungodly prejudices, exposing the way that they would have behaved (and as the woman must have anticipated). When Jesus does speak words of healing there is no reluctance but rather a celebration of her having sought him out. Indeed we can imagine that, having quickly assessed her personality, Jesus looked at her and spoke with her in a quizzical way, to encourage her to continue with her pleas; and it is very possible that he was laughing along with her by the end.

In our consultations it is very easy for our approach to be immediately coloured by prejudice. This might be related to race, class, employment status, appearance; it might include alcoholics, refugees, drug addicts, smokers, homosexuals, the obese, unmarried mothers and so on. We need to search our hearts and minds to recognise and acknowledge our own biases, lest we (like the disciples) treat the patient as less than human.

Andrew Miller *is a retired general physician who divides his time between medico-legal work, medical education at a Christian hospital in Egypt, and being a Street Pastor*

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1. John 4:7, 27
2. Isaiah 42:6
3. Luke 4:16-27
4. Mark 8:5-13
5. John 4:27
6. John 9:2

Andrew Flatt on the necessity of prayer

THE IMPORTANCE OF PRAYER

Prayer must be the heartbeat of our Christian lives. Yet a lack of uninterrupted time coupled with secular work environments conspires to limit opportunity. Guilt felt at not being able to pray can be insidious and heavy. I hope the following Scriptures and reflections are of use to those struggling.

When I read the Psalms or the book of Job, I'm reminded of a lesson we must re-learn throughout our Christian lives. This is that God can 'take' whatever we throw at him – whether anger, doubt, grief, apathy or despair. Our starting point in prayer must be echoing St Paul's confidence to go boldly before the throne of grace.[1] Of course, as with any interpersonal relationship, details of how, when and where we communicate will vary according to character.

To come before God, ideally we need a mindset of both joy and surrender. I find it helpful to write down on a plain page everything that I am thankful for. This can and should include anything that comes to mind – from making it to a meeting on time, the taste of tea, the smell of cut grass or a correct management decision. Our daily readings, in reminding us of God's works, should be a point of joy. Likewise a prayer journal can be a source of joy as we realise previous prayers have been answered. Joy is described by Lewis as 'the serious business of Heaven'.[2] Joy is second only after love in St Paul's fruit of the Spirit characteristics,[3] yet joy is often underrated. Our joy in Christ is great, and we must draw on it. Psalm 1 describes the situation of the righteous – as 'trees planted near a stream, which always have leaves, produce fruit in season and succeed in everything that they do'. There are so many ways of encountering the joyous nature of God across different art-forms. I've been grateful recently for a photo of a favourite stained-glass window, and an ipod full of ancient and modern hymns! Small reminders we set for ourselves can be surprisingly helpful. I know a friend who keeps his debit card behind a Bible quotation card; every time he pays for anything by card he has to read the verse. Another uses scriptural phrases as computer passwords (He1srisen!).

To reach a mindset of surrender is as important. 'Blessed are the poor in Spirit' – only through acknowledging our spiritual poverty can we be blessed by communion with God. Just as writing a quick list of things we are thankful for can be useful for realising joy, so writing a list worries can be of benefit; again, including a whole spectrum – whether large issues or ones seemingly trivial. I believe strongly that if an issue matters to us, it matters to God, even if it is a distraction that should be recognised as such. Reading through our list of worries/distractions, we can then surrender each one to God. In my experience, high on the list is neglect of prayer itself(!); as with any issue we can submit it to God, trusting in his strength to help us.

To come before God, ideally we need a mindset of both joy and surrender

There is no escaping the reality that finding time for prayer is difficult. Of course, we may pray at any time in our thoughts, but it is important to grow an alertness as to who/what needs to be prayed for. One train of thought is as follows: each person on earth is in need of prayer; therfore, for each person we come across, our question to ourselves should be, 'What is it that I should pray for them?' Salvation for non-believers, and developent of believers' love should be a high priority, but we must not neglect physical needs; clinical safety, multidisciplinary team workings and colleagues' health are worthy matters to pray about.

There was a story written where an old explorer found a great and powerful treasure of an ancient age, though none knew what became of it. The explorer went on to instruct his daughter to take care of a rescued orphan. The treasure eluded many who searched. Ultimately, the 'treaure' was in fact the orphan himself, a survivor of a powerful race. Likewise, the person of Christ is the aim, substance and outcome of prayer. Augustine of Hippo wrote: 'You have made us for yourself, O Lord, and our hearts are restless until they rest in you.' Christ is our joy, our strength and our song; we must be determined to meet him regularly.

Andrew Flatt *is an ST3 in Microbiology*

If there is a topic you would like to see in future editions of Juniors' Forum or if you would like to contribute to future articles then please contact Katherine Brown, Juniors' Forum editor, on katwin@doctors.org.uk

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1. Hebrews 4:16
2. CS Lewis, *Letters to Malcolm*
3. Galatians 5:22
4. Matthew 5:3

You're Teaching My Child What?

Miriam Grossman

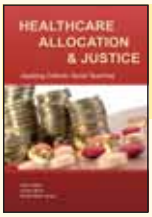
- Regnery 2009
- £16.99 Hb 243pp
- ISBN: 978 1 59698 554 4

With children as young as seven being taught in class that touching their clitoris or penis gives them a nice feeling without warning that such touching can be inappropriate (or even constitute sexual abuse depending on who is doing the touching), it's not only Christian parents who are becoming concerned about what is going on in the classroom under the guise of sex education.

This book, by a US orthodox Jewish psychiatrist, is just the thing for concerned parents to read and pass to friends or their child's teacher and also get into their local libraries. It clearly exposes, without using any religious language, the dangers of early sexualisation of young children through explicit sex education.

The book gives parents the facts they will need to be able to convince teachers and governors that the effects of sex education in the US are far from positive. It will reach people that more overtly Christian books on this theme will not, and I highly recommend it for all CMF members who have or work with or care for children.

***Trevor Stammers** is Programme Director in Medical Ethics and Law St Mary's University College, London*



Healthcare Allocation & Justice

Applying Catholic Social Teaching

Paul Gately, Ashley Beck and David Albert Jones

- CTS (Catholic Truth Society), 2011
- £3.95 Pb 62pp
- ISBN: 978 1 86082 717 4

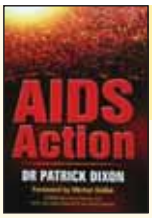
Around the world, demand for healthcare is growing and it is increasingly recognised that we cannot simply increase the proportion of national wealth spent on services. Difficult decisions are thus inevitable, and the aim of this pamphlet is to show how Catholic social teaching can be brought to bear on the question of allocation.

Divided into three sections, the authors first explore healthcare allocation in the context of the United Kingdom. They then set out intellectual resources for addressing the problem, before applying these to the issue.

Drawing from Catholic social teaching, the body of social principles and moral teaching articulated by the church since the late nineteenth century, the key principles of relevance include the dignity of human persons and subsidiarity or 'neighbourliness'. Giving preference to the poor and reducing inequality receive mention, although much of the book's focus in this area is on care for the elderly, rather than tackling socioeconomic inequalities - a key aim for the NHS in recent years.

Healthcare allocation in many ways reflects our priorities as a society and is thus something the church should be engaging with. This pamphlet provides an alternative perspective for those wanting to think around the issue in more depth.

***Helen Barratt** is a Specialty Registrar in Public Health*



AIDS Action

Patrick Dixon

- ACET International Alliance & Operation Mobilisation 2010
- Pb 218pp
- ISBN: 978 0 95475 493 8

Church Communities Confronting HIV & AIDS

Gideon Byamugisha et al

- SPCK 2010
- £12.99 Pb 110pp
- ISBN: 978 0 28106 239 3

These two books aim to challenge, encourage and enable readers to respond practically to the challenge of HIV and AIDS in their own communities and globally. The books take similar overall themes - what is HIV? How can churches and individual Christians respond to the needs for prevention, care and compassion? Dixon's book is more didactic with main themes summarised in bullet points; Gideon's is no less rigorous, but pauses regularly for the reader to respond to the challenges raised in each chapter with personal prayer and reflection. Both raise challenges, not least in the areas of theological approaches to harm reduction, the use of condoms, and how sex and sexuality can be addressed in churches. Two scripturally based approaches to something that is still a key issue for the church.

***Steve Fouch** is CMF Head of Allied Professions Ministries*

On My Way To Heaven

Facing Death With Christ

Mark Ashton

- 10publishing 2010
- £1.75 Pb 26pp
- ISBN: 978 1 90617 308 1

Having only sneaked into the 2006 National Student Conference by virtue of my wife still being at medical school, I was greatly encouraged by Mark Ashton's talks on Matthew – well at least by the two I managed to hear before leaving early to start a week of nights!

Only a couple of years later, Mark was diagnosed with metastatic cancer. This short but profound work was written in the final few months of his life, prior to his death in April 2010.

His confidence that the gospel is true pervades this book; but he's also honest about the struggles, both physical and practical. The changes in his priorities as life nears its end are sobering, and led me to reconsider what is really important. The resurrection features heavily, not only to encourage, but also to remind us to proclaim it powerfully in our words and actions.

I not only gained encouragement in my faith as I read, but also remembered that the perspective of dying patients for whom I care may be very different from what I might expect. Though mainly aimed at Christians who are terminally ill, and those who don't yet believe, I think that any doctor caring for dying patients will learn from this book, whatever their beliefs.

***Laurence Crutchlow** is CMF Associate Head of Student Ministries*

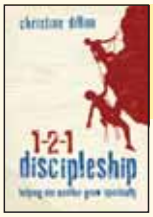
A Pathologist Looks At Healing
Natural, Miraculous, Spiritual
David Powell

- Powell Charity Trust, 2010
- £7.50 Pb 140pp
- ISBN: 978 0 95623 361 5
- (Available from: 7 Maes Bryglass, Peniel, Carmarthen SA32 7HF)

David Powell qualified in medicine in 1952. He was awarded the MD (Commend.) Ed.1959, FRCPath 1974 and FRCP 1981. I say this to make the point that David is not a new boy to medicine. He has been around a long time and has given very careful consideration to the matters of natural, spiritual and miraculous healing. This is one of the few books that I have read twice where the second reading was more enjoyable and enlightening than the first. I read it initially in a hurry, but the author has written a thoughtful and reflective book which greatly repays the same disposition in the reader.

From his experience as a Consultant Pathologist, he takes us through questions about 'normality', the ambiguities of prognosis, the nature of disease, the process of ageing and the business of dying. This sets the scene for an exploration of biblical, historical and contemporary healings. The book is well illustrated with quotations from his own wide reading – secular and medical, historical and contemporary. This is the most considered book I have read on this important subject, and written pastorally by a senior CMF member – in both age and experience - I warmly commend it.

***Peter May** is a retired GP in Southampton*



1-2-1 Discipleship
Helping One Another Grow Spiritually
Christine Dillon

- OMF Christian Focus 2009
- £5.99 Pb 158pp
- ISBN: 978 1 84550 425 0

In *1-2-1 Discipleship*, Dillon aims to explain what discipleship is and gives practical guidelines for discipling others.

The book contains numerous references to scripture and examples from Dillon's own experience. I was surprised to read a section on learning preferences that I had also come across during a General Professional Training (medical) meeting. It helpfully sets out broad general principles rather than propose any exclusive way.

The book is easy to read and designed with short chapters. There are reflection questions at the end of each chapter that allow the reader opportunity to pause and consider how the material can be applied.

1-2-1 Discipleship outlines how believers can help one another grow to be more like Jesus. Dillon hopes to pass on some of the things she has learnt to help others get started in discipling. I found the book practical, relevant and would recommend it for those hoping to encourage others to be more like Jesus.

Healthcare professionals are busy already, but the nature of personal discipleship is flexible, making it easier to fit into busy schedules. Meeting one to one with another believer can be mutually encouraging and fulfilling and this book will help you to get started.

***Adrian Cheung** is a Paediatric Registrar from Sydney*

Better Never To Have Been
The Harm of Coming Into Existence
David Benatar

- Oxford University Press, New York, 2006
- £39 Hb 256pp
- ISBN: 978 0 19929 642 2

This isn't a new book, but it is generating increasing discussion in university departments and elsewhere: hence this review.

The author's argument is that the only way to prevent suffering is for people not to exist, so the extinction of the human race is beneficial. There is no balance to be struck. The absence of pain is good, even if nobody enjoys that good. Absence of pleasure is not bad because if nobody exists then nobody is deprived.

Within its own terms the argument is correct, which matters, because if it gains traction then Parliament, which currently recognises abortion as the lesser of two evils, and is exploring that stance with respect to euthanasia, might move to 'pro-death' as the principled default position.

The proper response is that a person is not simply an individual, but instead belongs within a web of relationships, so a person's birth and life can be good for others.

If you enjoy an ethical challenge, then read this book.

***Malcolm Torry** is Team Rector of the Parish of East Greenwich, and is married to a GP*

Never Let Me Go [DVD]
Directed by Mark Romanek
Screenplay by Alex Garland

- 20th Century Fox Home Entertainment 2011
- Classification: 12
- Starring: Keira Knightley, Carey Mulligan

Based on Kazuo Ishiguro's Booker nominated 2005 novel, this film features Keira Knightly, Carey Mulligan and Andrew Garfield as Ruth, Kathy and Tommy, thee young people who spend their childhood at a seemingly idyllic English boarding school. However as they grow into young adults, they find that they have to come to terms with a brutal reality - that they are actually clones who have been prepared, both physically and through social conditioning, to be living organ donors.

The film captures the existential angst of young people coming to terms with the awful reality that their sole purpose is simply to give life to others.

The most chilling aspect of the film is the way in which they accept the inevitability of their fate apparently making no attempt to escape even as their inevitable 'completions' approach. They have been far too skilfully manipulated already to have any chance of breaking free.

As with any work that portrays a highly Utilitarian view of the value of human life we can see clearly the problems; concepts of 'duress' and 'undue influence' are dismissed out of an overarching belief that the good of society is of greater worth than an individual's life.

***Steve Fouch** is CMF Head of Allied Professions Ministries*

eutychus

The hidden costs of alcohol abuse

A recent survey shows that 14% of Britons admit to having injured themselves while drunk; 11% have seen a friend or relative's relationship end because of alcohol abuse; and 9% have taken time off work after heavy drinking. Young people are disproportionately likely to suffer harm. Some 27% of 18 to 24-year-olds and 31% of 25 to 34-year-olds admit injuring themselves while drunk, while 12% and 15% respectively of the same age groups have taken time off work due to drink.
(*The Guardian*, 1 February, 2011. *bit.ly/eXZurk*)

Pension crisis set to get worse

Government figures reveal that 11 million people alive today (17.6% of the population) will live beyond their 100th birthdays. But analysts predict that without radical reform of the pension system many retirees will face a penniless third age. Joanne Segars, chief executive of the National Association of Pension Funds, said: 'It's fantastic there are millions of centenarians in the pipeline but this will also raise the pressure on the UK's already-strained pension system. An ageing population is one of the toughest challenges our society faces.'
(*The Daily Express* 19 April, 2011. *bit.ly/kE3xSP*)

Social care budgets for the elderly cut

Social care budgets for the elderly in England will be cut this year despite government promises to invest more in social care. Age UK research involving 110 councils, suggests that budgets for social care for the elderly would be cut by 8.4%, equivalent to £610m. Councillor David Rogers, of the Local Government Association (LGA), pointed out that while extra money had been promised by ministers for social care, it was being cancelled out by the wider cuts to local government funding.
(*BBC* 27 June, 2011. *bbc.in/jT2a7k*)

Substituted judgment

At an recent Yale event Professor Daniel Sulmasy stated that authenticity not autonomy should guide end of life decision making. Authenticity, he said, includes knowing a patient's fundamental moral commitments; whom the patient loves, what the patient stands for, and how the patient has acted in the world. Clinicians should make medical decisions on the basis of what they know about the patient as a unique person.
(*Yale News* 13 April, 2011. *bit.ly/fG9Qpl*)

Harvesting organs

Using organs from euthanised patients has become an established procedure in Belgium, after it was legalised in 2002. A team at a hospital in Leuven announced that it had successfully transplanted lungs from four euthanised patients between 2007 and 2009. Given that half of all euthanasia cases in Belgium are involuntary, it must be only a matter of time before the organs are taken from patients who are euthanised without their consent. (*Press release, Pabst Science Publishers* 6 June, 2011. *bit.ly/mrQk4y*)

Three parent IVF

Three parent in vitro fertilisation (IVF) has been developed at Newcastle University. The technique involves swapping DNA from a fertilised human egg into an egg from a donor. By intervening in the fertilisation process to remove malfunctioning mitochondrial DNA the resulting embryo inherits nuclear DNA from both its parents, but mitochondrial DNA from a second 'mother'. The Department of Health has asked the Human Fertilisation and Embryology Authority 'to assess the effectiveness and safety' of the technique, which is currently banned under British law.
(*Reuters*, 11 March, 2011. *reut.rs/hpPnxH*)

Putin's solution

The Russian President, has promised to spend £33 billion to boost the country's flagging population by up to a third over the next four years. As part of a series of measures aimed at making Russia less vulnerable to 'external threats' he has pledged to boost the country's birth rate by between 25 and 30 per cent by 2015.
(*The Telegraph* 20 April, 2011. *tgr.ph/g2Mxg7*)

Hungary threatened for promoting adoption

The Hungarian Government has been threatened with financial penalties for using EU money to fund the campaign promoting adoption over abortion. The advertisement reads:
'I understand it if you aren't ready for me. But think twice, and put me up for adoption. Let me live!'. EU Justice Commissioner Viviane Reding said that the use of EU money was not in line with EU values and funding rules.
(*Europolitics*, 10 June 2011. *bit.ly/iMIluB*)

Girls who are boys

A report by the *Hindustan Times* into the use of genitoplasty on female infants claims that hundreds of girls are being turned into boys each year in the city of Indore, Madhya Pradesh. The procedure which can cost up to £2,000 is driven by parents' deep rooted cultural preferences for boys. In response to the report the Prime Minister's Office has ordered an investigation into the claims and the government of Madhya Pradesh is exploring the possibility of legal proceedings against the practitioners involved.
(*Hindustan Times*, 26 June 2011. *bit.ly/lHtcpg*)

Demand for cosmetic treatments rises

Latest estimates are that approximately 100,000 people from the UK will travel abroad for medical treatment this year including 40,000 for dental treatment and 15,000 for cosmetic surgery. The number of 'medical tourists' from the UK is growing by 20% year on year. Writing in the *International Medical Travel Journal* Ian Yougman suggests that the effect of increased waiting times, limited numbers of NHS dentists and a recent £6 million award against a UK cosmetic surgeon make it likely those numbers will rise further in 2012.
(*International Medical Travel Journal*, 24 June 2011. *bit.ly/kYo7bW*)

Pablo Fernandez reminds us the future is in God's hands

CONFLICT ABOUNDS

Conflict abounds; that was Habakkuk's appraisal of the situation in his day. Many Christian doctors today would identify with Habakkuk's feelings. As they survey the political discussion on the future of the NHS, they ponder on what kind of health service they will be working in when the dust finally settles. What will be the implications for patient care, especially the elderly, those suffering from terminal illness and other disadvantaged groups? Most are already suffering the consequences of the erosion of resources available for their care following previous governments''reforms'.

On a not completely unrelated front, many will be concerned by the deterioration of the moral framework that has seen this country jump to the forefront of liberal policies and attitudes to abortion and human embryo experimentation, as well as the unrelenting pressure for legalisation of euthanasia and assisted suicide. The formidable resources and aggression of the secularising campaign will remind some of the description of the Babylonian forces, 'that ruthless and impetuous people, who sweep across the whole earth… they are a law to themselves and promote their own honour'. [1]

As we face such challenging and confusing times, the future can seem bleak but so it was for the prophet when he took his concern directly to God. It is worth noting God's perspective as he answers: 'the revelation awaits an appointed time... Though it linger, wait for it; it will certainly come and will not delay'. [2] This categorical assurance is followed by a clear, objective appraisal of the enemy forces, [3] exposing the moral bankruptcy and self-defeating consequences of their beliefs and behaviours. The opponent may seem powerful, self-assured and even pretend ownership of the high ground, whether that might be political, scientific or humanistic. God is not impressed by what he sees there and his judgement is devastating: 'You will be filled with shame instead of glory. Now it is your turn! Drink and be exposed!' [4]

We can sometimes lose perspective and be tempted to think that God is not that interested in our society and that our efforts should concentrate on simply maintaining our own integrity towards him. This leaves us feeling somewhat isolated and powerless to influence or even expose what is going wrong around us. But the resulting ghetto mentality is challenged by Habakkuk who looks beyond circumstances to see the greater force at his side, allowing him to pray: 'LORD, I have heard of your fame; I stand in awe of your deeds, O LORD. Renew them in our day, in our time make them known; in wrath remember mercy.' [5] His review of the historical record shows him, and us, that God's purposes are always accomplished. This allows him to conclude that however bad or uncertain things may look, [6] God's enemies will always be defeated and he will vindicate his people in accomplishing the work he has called them to. 'The Sovereign LORD is my strength; he makes my feet like the feet of a deer, he enables me to go on the heights.' [7]

***Pablo Fernandez** is CMF Head of Graduate Ministries*

references

1. Habakkuk 1:6-7
2. Habakkuk 2:3
3. Habakkuk 2:4-10
4. Habakkuk 2:16
5. Habakkuk 3:2
6. Habakkuk 3:17-18
7. Habakkuk 3:19

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