Triple Helix

Christian dimensions in healthcare

Fifty not out...
Sex on the psychiatric ward
My mission

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editorial:

from the cradle to the grave

5th July marks 50 years of the National Health Service, comprehensive healthcare free at the point of need and associated with comprehensive welfare provision. The title of this editorial is Beveridge's 1942 slogan summing up these ambitious aims.

Before 5th July 1948 hospital doctors 'were worried: about the nationalisation of voluntary hospitals; the loss of influence by the teaching hospitals; a fair distribution of consultant skills; and private practice'. GPs 'feared that the new service would convert them to salaried employees and compromise their clinical independence'.[1]

Perhaps the retrospectoscope suggests some self interest as well as concern for patients? John Marsh's lighthearted reminiscences in this edition reveal how one Christian medical student saw things at the time, but Christian health professionals' main concerns then were not losing clinical or financial freedom, but losing the freedom to work as Christians. They need not have worried. A large medical mission in south London sounded a note of relief early in 1949:

'Since writing our last Annual Report, the National Health Scheme has been launched. We are full of gratitude to the Lord who has been merciful to us in our doubts and anxieties, guiding us in many decisions and allowing the work to emerge as free as it was before the Scheme, contrary to all our fears. We had to face the prospect of great changes, which seemed likely to follow the inception of such an immense piece of social legislation; we dreaded being engulfed and losing our freedom, and in our minds we fought many battles which in the end never occurred . . '

' . . at the clinics, as far as the patients are concerned, the service we are able to give them is the same, with this improvement, that they do not have to pay!'[2]

We now take for granted healthcare free at the point of delivery, and the NHS starts its second half century popular with the people and the professions, but facing many challenges. Grateful that the state largely meets physical needs, Christian health professionals seek to address spiritual needs too.

Elsewhere in this edition, Richard Cook looks at another 50th anniversary piece of legislation, the Children Act of 1948 and its 1989 successor, and chaplain Steve Clark marks 50 years of Burrswood's ministry to the whole person.

'From the cradle to the grave.' Can the secular state afford to keep that going? Can it afford not to? And can Christian health professionals continue to care for the needs of the whole person, not just during that interval but before the cradle and beyond the grave?

Andrew Fergusson

References

1. Macpherson G. '1948: a turbulent gestation for the NHS.' *British Medical Journal*, 3 January 1998; 316: 6
2. Quoted in: Fergusson A. 'He Sent Them Out.' Bermondsey and Brook Lane Medical Mission, London. 1988. p63-64

a lifetime in the NHS

John Marsh recalls some differences made by the National Health Service

Memory can be fatally flawed. Some years ago the BBC asked for memories of those who went to the Festival of Britain when it first opened. I knew I took my girlfriend on the second day, but she kept her diary and as husband and wife we later compared events. Our memories were somewhat different.

So my memories of the start of the National Health Service may be open to historical correction. What is certain is that I was in my final year as a medical student at St Thomas's in London. Feelings were high and partisan. When someone painted 'BOOT OUT BEVAN' in large capitals on the river wall facing the House of Commons, the Secretary of the Medical School disclaimed all responsibility on the grounds that it was not on hospital property, but when an old St Thomas's man sent him a cheque for a celebratory dinner, it somehow found its way to the Doctors' Mess at St Thomas's House.

Certain distinguished doctors could no doubt tell more. It was generally believed that three teams of three painted one word each. The rope team who lowered the painters over the river wall were strong men from the rugby club. It was done so quickly that they were even able to go back and touch it up before ringing the press, and there was time for it to be photographed before tarpaulins were thrown over it by workmen.

Some institutions fared better than others. St Thomas's preserved its endowments by putting them all in the name of the medical school. On the other hand Leicester Royal, which had just collected several million to build a new department, saw it all disappear into the Treasury on nationalisation.

Some notable figures apparently never took their NHS salary, presumably to preserve their independence. Many years later, though, I invited Mr Harold Edwards, for whom I had worked at King's College Hospital, to lecture at a college where I taught in Warwickshire. He said the NHS was the best thing that ever happened to him. Before the War he worked at King's for a small honorarium. He did his private consulting and then in the evening started to earn his living as GPs rang in with requests for emergency surgery.

He would work out a list and drive around south London to do an appendicectomy at Reigate or a strangulated hernia at Redhill. He only saw the patient just before surgery and never again. It was all in the hands of the local doctor who probably gave the anaesthetic. When the NHS came he was able to spend his days at King's researching, teaching, and operating in a much more productive and professionally acceptable way.

Aneurin Bevan, Minister of Health 1948

At the beginning Nye Bevan deliberately let the teaching hospitals keep their own private wings in order to ensure that consultants were on tap for all the other patients. As a houseman I used to spend a lot of time ringing around nursing homes to find consultants, so I thought Bevan had the right idea. Bringing this to an end many years later, it seemed to me, was a reversion to what had been an unsatisfactory system.

By the time I qualified in 1949 the NHS was under way and I was among the first to get a salary rather than work for nothing for the privilege. My princely starting salary of £250 a year with board and lodging meant my boss took the view that since housemen were paid, he would not give them the customary shillings from the guinea fees earned for looking after his private patients. As my boss had a large practice I envied some of my friends who got the odd guinea for clerking and assisting.

Board and lodging meant a shared bedroom. I shared with a friend with whom I contested jobs right up to consultant. Our children are still friends. Our official time off was every other weekend. Mine started at three o'clock on a Saturday after the morning list was over. The NHS brought in new governors, but the hospital secretary, the matron, and the treasurer remained a formidable trio. And of course women arrived. The first female registrar was not Thomas's trained. They had not yet come through the system. She was an excellent appointment as a registrar anaesthetist and fought battles for female toilets and the like for the many who followed.

Having spent all my working life in the NHS I look back with gratitude that I was able to give my whole life to one hospital group with an opportunity to teach in a provincial hospital, and that I was able to assess my waiting list priorities entirely on the grounds of clinical necessity.

John Marsh is a retired general surgeon from Leamington Spa

time out

Drew Gibson offers a radical option for professionals under pressure

To describe health professionals as 'busy people' is rather like describing Pavarotti as 'a nice singer'. Doctors, in particular, necessarily embrace a life of physical and emotional pressure which most other people simply cannot appreciate. This is particularly true in the first few years. How many times have you heard your Christian colleagues say that their early years were a time of working flat out, when their devotional life and Christian health came under severe pressure? Can I make a radical suggestion for these difficult times? Why not take six months out?

Could it be possible to jump off the moving walkway and pause to look around for a while before jumping on again? Spending three or four years running from job to job and pillar to post is physically tiring and emotionally and spiritually draining. A short course at a Bible college may be a heaven-sent opportunity to sleep (at night, not during lectures), pray, study the Bible, talk out problems with a sympathetic listener and reflect on where you might be heading.

In my work teaching at Belfast Bible College I often notice that those who benefit most from our courses have seen something of life. They reflect on their experiences, theologise about what they have been doing and develop fresh approaches to familiar problems. It is also an opportunity to recharge their spiritual batteries and relax in a supportive spiritual atmosphere. So what could health professionals in particular gain from a term at Bible college?

Five benefits from Bible college

1. You may never have had the time or energy to do any consistent, relaxed theological thinking about the ethical issues in your area - maybe abortion, human fertilisation or birth control. You may have started to fall into spirals of compromise or callousness. Time away from the pressures of urgent decision making and time spent reading and writing about what you have already experienced at the sharp end offer an opportunity to develop a foundation for future actions which is both biblical and practical.
2. You may take courses in counselling to help deal with emotionally fragile patients. You may take courses in Christian mission to explore opportunities for service overseas or to understand work in the NHS as an expression of Christian mission.
3. You will spend time studying the Bible for its own sake and applying your substantial intellect to the Scriptures in new and exciting ways. Too many professionals with fine, agile minds have an approach to the Bible which is woefully simplistic and are spiritually childish as a consequence.
4. You will create space for quietness, prayer and meditation. Time to let the mind wander, time to talk to God, and time to listen to God. Perhaps you will develop patterns of devotional living which will stand you in good stead for the rest of your life.
5. You will discover a community of worship. Many students find richness in new patterns of worship. Your circumstances may have dictated that attendance at Sunday worship has been infrequent. Perhaps the church you attend has not exactly been bursting with spiritual life. A term at Bible college may inject new life and new approaches.

Drawbacks

Of course there are drawbacks to this 'career break'. The most obvious is financial; six months of lost earnings is not to be ignored. Some judicious saving beforehand, willingness to forgo some luxuries during study, and even a year or two paying off a small loan afterwards would be far from impossible. College fees are by no means prohibitive. At £875, the fees for a three month course at the college where I teach are less than the cost of most family holidays, less than one tenth of the cost of an average family car, and a small percentage of the cost of the next house you will buy.

For many people, financial difficulties are not the greatest problem. In many specialties competition for jobs is fierce. Applicants must give the impression that the job they are seeking has been their ambition from the womb. A CV showing six months at Bible college may be seen as a sign of low commitment. It depends how you present the time you have spent. Some specialties view stepping out positively. Innovative and lateral thinking, risk taking, self motivated study and self improvement are all desirable qualities to bring to your specialty. Skills gained at Bible college, like counselling or a well-founded critique of contemporary social patterns, can only add strength and depth to a healthcare team.

A radical re-orientation?

A term in Bible college may trigger a radical re-orientation of your career values. Unthinkable as it may seem to the upwardly mobile SHO, rising to the top of the cardiothoracic surgery ladder may not be the ultimate goal in life after all. Perhaps God has other plans.

If God calls us to step off the ladder, surely he is perfectly capable of providing for us if he calls us to step back on to the ladder again? He will either restore to us what we have set aside for a while or he will move us in a new direction by opening new opportunities. Time out might be just the way to rekindle your personal spiritual life and to start breathing life back into the healthcare system in the UK and beyond.

Drew Gibson teaches at Belfast Bible College and is married to a doctor

Tom, Jim & Harry ... and the law

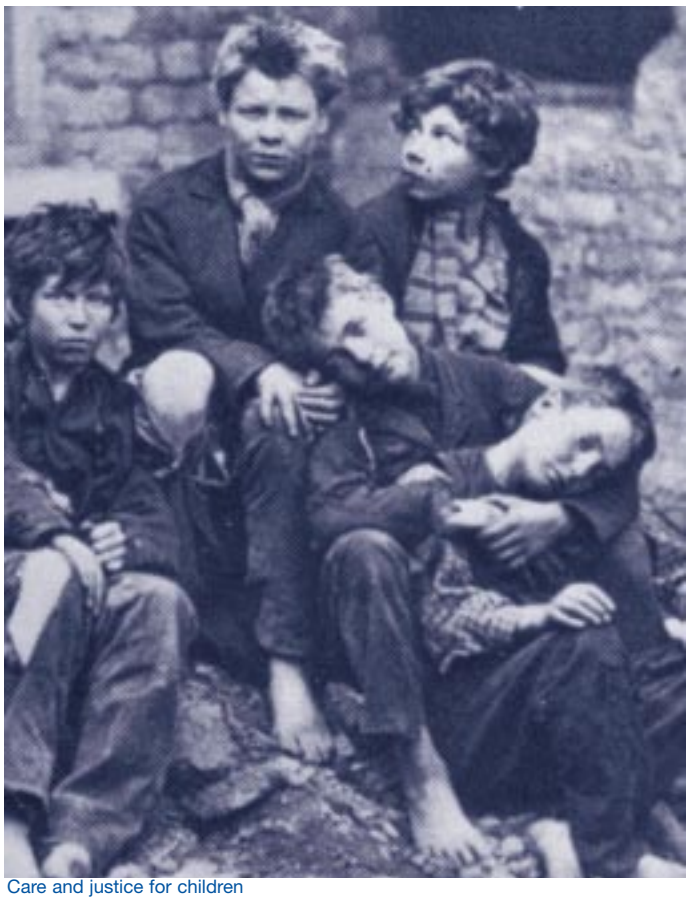
How should the law look after children? asks Richard Cook

Ten year old Jim Jarvis lurked by the fireside on a particularly bleak and cold night. He hoped he would not be noticed by the Christian medical student who ran the 'ragged school' near The London Hospital, but Thomas Barnardo saw him. 'It's time to go home.' 'Ain't got no home.'

Over supper together Barnardo listened to his story. Jim knew of no father and after his mother's death had been put in the workhouse. He absconded, and found sleeping out of doors, had been arrested and briefly imprisoned. After that he lived on his wits and avoided authority. He told Barnardo of many others sleeping on the streets, boys who also had neither parents nor home, who had run away from appalling treatment, or had been turned out to fend for themselves. Late that night, Barnardo was led through some of the grimmest East End backstreets, sure he was on a wild goose chase, until Jim found for him some dozen boys who despite the cold were asleep on a roof behind a parapet, hidden from the eyes of the law[1].

There was little an impecunious medical student could do, except find Jim a foster home and publicise the problem. 'In season and out of season, he impressed upon his every Christian acquaintance the disgrace of these conditions.'[2] Publicity became one of Barnardo's strong points and a vital means of support and help for what was to be his life's work - the first of his many homes for destitute children was opened in 1870.

Photo: Barnardo's



Care and justice for children

It is thought there were 30,000 destitute children roaming the streets of London at that time[3] and they came to Barnardo in huge numbers. Policemen brought them to his door so they would have 'visible means of support' and therefore not be vagrants; parents brought them when too sick to care for them; Barnardo himself found them. He took them from the streets by day, he sought them in their 'lays' at night, he snatched them from 'houses of ill-repute' at any hour. This was dangerous, for the law upheld the rights of parents and considered it impertinent 'to question the moral competence of a parent'[4]. Barnardo might distinguish between kidnapping and 'philanthropic abduction', but the Law did not!

Five year old sold to organ grinders

Harry Gossage's illiterate mother had sold him to a couple of organ grinders[1], who later abandoned him. He was rescued from the workhouse by a local parson and sent to Dr Barnardo's in Stepney. Routine enquiries located Harry's mother who put her mark on a consent form for his admission. She was sent a more detailed agreement that listed, amongst other things, the possibility of emigration. After some delay, Mrs Gossage sought help in reading and filling in this form, this time from a Roman Catholic priest. The result was a letter written in her name demanding that Harry be transferred to an RC institution. Too late! By the time the letter was read Harry was already on his way to Canada. More embarrassingly, he was with an adoptive father who had insisted that their precise destination should not be known. Harry was untraceable.

A writ of *habeas corpus* was applied for on the mother's behalf, and the case wound its way slowly up through the courts, each ruling for the mother being appealed against by Barnardo, until it reached the House of Lords. The judgments were critical of Barnardo and his organisation, but it was agreed he stood on the moral high ground. Public attention had been focused on the way that the Law as it stood 'protected the rights of vicious and brutal parents to make their children brutal and vicious'[5,6].

A Standing Committee of the House of Lords looked at the workings of the Poor Laws particularly in relation to the plight of destitute children, the ones we call today 'at risk'. *The Custody of Children Act 1891* resulted. It was so in line with what Barnardo was fighting for that his opponents mockingly referred to it as the 'Barnardo Relief Bill'.

Although the child's welfare was stated to be paramount under this Act, parents were still regarded as having the right of custody of the child, and the courts' powers only really came into play when parents made application for the return of a 'lost' child, when they had to prove their fitness. Intriguingly

modern is the clause that gives the courts 'power to consult the wishes of the child in considering what order ought to be made'. Also, the parents had the right 'to require that the child be brought up in a particular religion', countering the sectarianism that had caused so much of the previous litigation.

'Poor Law' lasted 350 years

All this was only just over a century ago. At the time, the Elizabethan *Poor Law Relief Act* of 1601 still largely governed society's behaviour towards the destitute, including children. It was a period of unprecedented social upheaval, of increasing wealth but ever more poverty, of disease and high mortality but a rapid learning of 'public health', of callous indifference to others' needs but also of sacrificial caring service. Barnardo was one among many[7] who fought for a more just and caring approach, especially to children.

The last 150 years have seen revisions of the law, but earlier ones were relatively minor adjustments. Indeed the pejorative title was kept in the *Poor Law Act 1930* which set down the responsibilities of local councils in minimalist terms: 'To set to work or put as apprentices all children whose parents are not . . able to keep them'[8].

Fifty years ago, the strains and turmoil of war which stole half the childhood of many children around the world brought into sharp focus society's shortcomings in relation to its children. As the National Health Service was being devised and launched, children were recognised as important enough to merit an Act of their own. A radical and comprehensive attempt was made to 'make provision for the care and welfare . . of boys and girls when they are without parents or have been lost or abandoned . . or when their parents are unable to take care of them'[8]. *The Children Act 1948* was born.

Responsibilities for child care and welfare were brought together under the Local Authority, and were spelled out in rather warmer tones than in previous acts - 'to further the child's best interests and to afford him the opportunity for the proper development of his character and abilities . . '[8].

Are children any safer now?

But what are a child's 'best interests'? And who is to judge? Society's views and standards have changed, and as in Barnardo's day[7] voices other than those of Christians have been heard.

The Children Act 1989 has made the child's rights paramount, stressing and defining parental responsibilities[9]. As its clauses were being debated (all too briefly it seems[10]), the Lord Chancellor stated that 'the overwhelming purpose of parenthood is the responsibility for caring for and raising the child to be a properly developed adult both physically and morally'[11].

Christians and all of goodwill have no difficulty in agreeing with these words, but how the 1989 Act is being applied has caused serious misgivings. Its stress on 'rights' undoubtedly came from the hedonistic and libertine attitudes of many of those instrumental in proposing its measures, and matches the postmodernist ideas of our age[12]. 'Rights' language always

Photo: Barnardo's

Home for destitute children, Stepney Causeway

stresses individuality at the cost of community, and autonomy at the cost of subjection to any independent moral standard[13].

It is here that application of the Act falls short of ideal. The difficult issue of when a child is competent to take responsibility for his or her own actions is unresolved. We live in a fallen world, and our children need protection sometimes from themselves, sometimes from the state, and sometimes from their parents. A perfect 'Children Act' is still awaited.

Richard Cook is a retired paediatric surgeon in Liverpool. This article is based on part of his 1998 CMF Barnardo Lecture

References

l. Batt J H. Dr Barnardo: The Foster-Father of Nobody's Children. Partridge, London. 1903
2. Bready J W. England: Before and After Wesley. Hodder and Stoughton, London. 1939
3. Wagner G. Barnardo. Weidenfeld and Nicholson, London. 1979. p311
4. Wagner G. op cit p223
5. Anderson R. Morality by Act of Parliament. In 'Contemporary Review' Jan 1891 (quoted by Wagner op cit p206)
6. Wymer N. Father of Nobody's Children. Hutchinson, London. 1954
7. Morrison A C L, Wells M M, Eton E, Banwell L G (Editors). The Children Act, 1948. Butterworth, London. 1948
8. Heason K. Evangelicals in Action: An appraisal of social work in the Victorian era. Geoffrey Bles, London. 1962
9. An Introduction to the Children Act 1989. HMSO, London. 1991
10. White R, Carr P, Lowe N. A Guide to the Children Act 1989. Butterworth, London. 1990
1l. Lord Mackay, House of Lords Debate 6th Jan 1988. Hansard, Vol 502, Col 490
12. Burrows L. The Fight for the Family. Family Education Trust, Oxford. 1997
13. Rivers J. Beyond rights: the morality of rights-language. Cambridge Papers, Vol 6, No 3. 1997

John 13 taken literally

Eutychus loves reading obituaries and one in the *BMJ* gives an account of the practice of Dr Eunice Bryant, former medical superintendent of the Christian Medical Mission, Bristol: 'She was a much loved, conscientious doctor, who also attended the down and out and homeless men in the city's Salvation Army hostel, on occasions even washing their feet'. (Source: *British Medical Journal*, 4 April 1998; 316: 1096)

First legal PAS in USA

Following the enactment in November 1997 of Oregon's 1994 Death with Dignity Act, an 85 year old woman with metastatic breast cancer became the first known case in the USA of legal physician assisted suicide. The woman, who has not been named, swallowed prescribed barbiturates with brandy and died, in her own home, 30 minutes later. (Source: *British Medical Journal*, 4 April 1998; 316: 1037)

Cyberspace and reality

Streetwise journalist Janet Street-Porter does not share CyberDoc's enthusiasm for the Internet. Writing in Compuserve's customer magazine she says: 'To solve the problems facing the planet we will have to learn to live side by side: to have dialogue face to face and to learn to give and take. Learning from a screen is a way of assimilating information, not a way of engendering debate . . To my mind computers offer one-dimensional, drab experiences, unthreatening and facile. Give me reality any day.' (Source: *Go . . Online*, April/May 1998, p21)

Transfusion confusion

One Internet debate at least proves her wrong. A breakaway group of Jehovah's Witnesses has anonymously set up the 'Official Site of the Associated Jehovah's Witnesses for Reform on Blood'. In seven languages they strongly criticise the Governing Body's views on blood transfusion, which is banned for members on threat of excommunication and eternal extinction. The debate is raging on more sites, and a legal 'class action' against The Watchtower may follow. (Source: *Evangelicals Now*, March 1998 p1-2 and subsequent months)

Drugs and crime

Home Office research reported in April showed that more than 60% of criminal suspects who agreed to be tested for illegal drugs proved positive. Testing was performed in five areas in England and Wales, and in Trafford, Manchester the figure was 78%. Overall, 20% tested were positive for heroin, 10% for cocaine and 46% for cannabis. (Source: Ian Burrell, *The Independent*, 22 April 1998)

As old as . . Moses?

In a slightly tongue in cheek *BMJ* correspondence about whether there is any such thing as ageing, retired consultant pathologist David Powell, who declares as a conflict of interest 'I am aged', quotes Deuteronomy 34: 7 about Moses who 'was an hundred and twenty years old when he died: his eye was not dim, nor his natural force abated'. (Source: *British Medical Journal*, 16 May 1998; 316: 1531)

Two parent households healthier for children

In a comparative observational study of morbidity and healthcare utilisation of children in households with one adult, the authors conclude: 'The study confirms the importance of single parent families as an indicator of deprivation. Children in such families should be targeted for immunisation and accident prevention.' (Source: *British Medical Journal*, 23 May 1998; 316: 1572-6)

1,000 extra doctors a year?

It appears the government will agree to expand medical school places by 1,000 a year because of a projected shortage of doctors in the UK in the new millennium. The potential impact on the NHS budget is enormous as doctors control most NHS resources. Such an expansion in medical student numbers would require one or more new medical schools. A challenge to CMF student outreach . . (Source: Jeremy Laurance, *The Independent*, 6 June 1998)

Who owns biological information?

The headlines of two adjacent stories filling a page of the *BMJ News* hint at worries about privatisation: 'Europe approves patenting of biotechnological inventions' is one and the other is 'Private company to sequence human genome'. Eutychus has no shares of any kind and has no plans to change that policy. (Source: *British Medical Journal*, 23 May 1998; 316: 1558)

Red light on red light zones

On 29th May, Sweden's parliament outlawed the purchase of sexual services as the most controversial element of a Bill widening protection of women against sexual abuse. It does not outlaw prostitutes but the purchase of their services and the maximum penalty is six months in prison. (Source: AP Stockholm, reported in *The Independent*, 30 May 1998)

Valium in the 70s, Prozac in the 80s, Viagra in the 90s?

Viagra (sildenafil citrate) is a phosphodiesterase inhibitor recently launched in the USA by Pfizer for treating male erectile dysfunction, but in addition to being the fastest ever seller there on legal prescription, there are reports of a huge black market around the world. It has clearly become a recreational sex drug and has led to deaths in men with heart disease taking organic nitrates. Although not licensed yet in the UK, Eutychus has had a junk fax detailing how to get Viagra in London. (Source: Jeremy Laurance, *The Independent*, 27 May 1998)

Quarter of a million child soldiers

R Barnem of Swedish Save the Children claims there are at least 250,000 child soldiers in the world. 'They are small, inconspicuous, expendable, and easily indoctrinated and terrorised into performing extreme acts. They can manage lightweight assault weapons, such as the AK47 . . ' (Source: personal communication reported in *British Medical Journal*, 23 May 1998; 316: 1550)

Among All Nations

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Christian healthcare worldwide

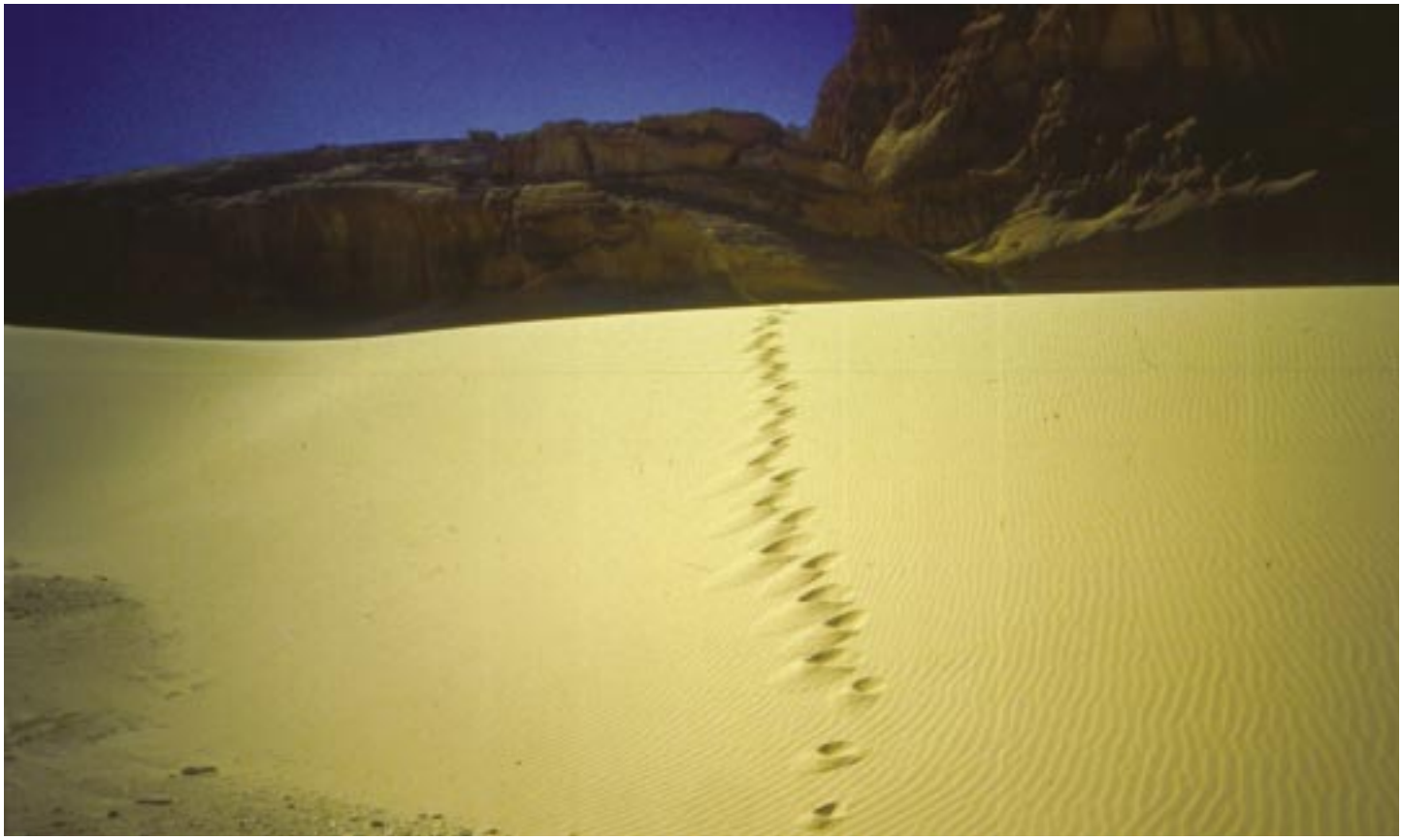


Photo: Jackie Cox/CMS

Walking with God

Moses led his people out of slavery, across a desert, back to the land where their ancestors had lived. But first he stood on the edge of the desert at the bottom of a mountain and heard God speak to him.

He might have been told to climb the mountain to see the route they would take, but at the start of his life's work he saw at the bottom of this mountain a bush, burning without being destroyed. He went to investigate and God told him to listen.

Before Moses could plan strategically he had to converse with God intimately. His life was a mixture of greatness and of weakness, of success and of failure, a life in which God intervened repeatedly to put him back on course. Many times he was frustrated and angry because the big picture did not seem to be developing the way he thought it should. Moses needed to learn to obey God in each small picture.

He ended his life on another mountain with a panoramic view of the land his people were about to enter. In the following pages we might see the big picture of the world explained in terms of poverty or sex or power, but these are the background to our walk with God.

We need to start and stay with the small picture while never ignoring the big one. We need to stand alone on the edge of the desert with God and ask him what he would have us do, and then we need his help to do just that.

Among All Nations is produced in partnership with the **Medical Missionary Association** and **Christians in Health Care** as the international section of *Triple Helix*. They also produce the magazine *Saving Health*, which has more articles on healthcare with mission, and a more comprehensive list of multidisciplinary service opportunities. Details on p15.

money, sex and power

-

surely not me, Lord?

Obstetrician and gynaecologist David Clegg recalls some cameos of work in southern Africa and asks: How much are we in the West to blame?

She lay in a bed soiled by loose stool and vomit, a once beautiful young African girl now emaciated, her abdomen distended by pus, though she was afebrile because of her diminished response to infection. She cannot have understood why this was happening to her and may even have attributed the misfortune to God's will for herself or for her people. Her one hope on growing up would have been to have had a baby of her own but now she was dying childless and friendless.

Her sister in the next bed had children but was now a widow dying of AIDS. Her children would be orphaned and some themselves would die of the same disease. Meanwhile they would live with an overburdened grandmother or be turned out onto the streets.

I was called to see one such small child in the paediatric ward, with large vulval warts. The suffering on that ward was indescribable. How could young nurses be expected to cope and care for those children under those conditions?

The nurses themselves lacked care. At night their Home was visited by rich men (sugar daddies) who assumed that nurses would be 'safe' because they knew how to look after themselves.

On the adult ward I took an elderly lady to a side room for a gynaecological examination - one could not expect to add to the nursing burden by asking for a chaperone. As we entered the side room we found the four or five couches occupied by bodies waiting to be taken to the mortuary.

Who is responsible?

Who is responsible for this suffering and how can it be avoided? There is some local responsibility but much of the cause must be attributed to the wealthy sector of the world - that is, to you and to me. The complex web of chaos and conspiracy by which these causes work would take much time and knowledge to unravel but can be summed up under the headings of 'money, sex and power'.

Poverty operates in many ways both nationally and individually, but the money game was imposed by those in the West who set the rules and have since invited others to join the club. A form of sexual 'freedom' has been authorised by the West. The methods we have used to limit the sad consequences of this abuse of freedom depend on organisation, education and money, but we have the monopoly for all these. The G8 nations are still able to maintain the *status quo* in power but as I look at that young girl I boil with anger.

Her damages in litigation if only she could claim them should be charged to the account of the West and multiplied millions of times for others in her situation. Yet I bring my family back 'home' for the benefit of their education, to a people living on the wrong side of their television sets, in a virtual reality that protects viewers from feeling responsible for the real world.

If we go back to the beginning of the human story on earth we see man given the care of God's creation. Man failed. If we look at Abraham we see the beginning of a people who were meant to be a blessing to all the nations of the earth. They failed.

Christians became the New Testament people of God but the New Testament never replaced God's original intention for man and woman to care for his creation. We have failed. Our world in crisis is the last opportunity to accept the challenge God has given us to show that he cares. If it takes poverty, chastity and obedience, so be it.

David Clegg is now the Overseas Support Secretary of the Christian Medical Fellowship and the General Secretary of the Medical Missionary Association

The nightmare we hoped would never happen

We all have bad work days. Alison Wilkinson describes one in Kenya

The call comes just as I have plodded home after a long and tiring day in the operating theatre. All hands are needed in the hospital to help deal with a road accident. Two biscuits later I stuff the pockets of my white coat with equipment I may need - and when I reach the outpatient department I discover that this is not 'just' an accident. This is the nightmare which we hoped would never happen.

At the local accident blackspot, at the foot of a steep valley, a speeding crowded bus has failed to take the bend over the bridge, and plunged into the Nithi River 60 feet below. Passers-by have scrambled down the slope to bring the injured to the road, and passing vehicles are now bringing them to the hospital in steady numbers.

In the reception area Dr Gordon, our surgeon, rapidly assesses each arrival and gives instructions as to where they should be taken - the seriously injured need immediate attention, the less serious can wait to be attended to later, and there are those so seriously injured that nothing can be done. All our doctors are here, and all available nurses and student nurses, whether on or off duty, work smoothly together as airways are protected, IV lines inserted, injuries determined, management decided.

As I check where there is space for me to work, I find one man among the 'too seriously injured' who is sitting up and talking. His only problem is swelling in the neck and as this may or may not be serious he is transferred to the ward for observation. Next to him is a child of ten years who is restless from a severe head injury - and the pain of a badly fractured leg which will need to be cleaned tonight. The next man is already dead. Another man is brought in with acute abdominal tenderness - he almost certainly has internal bleeding and must be operated on tonight. The man sitting outside has only a small knee laceration, and some bruising. Later he may realise how fortunate he has been. The girl has broken both arms and one leg, but her facial laceration is small.

Elsewhere, others are also working. Dr Amos battles vainly to save the life of a man with severe chest injuries whose wedding he had attended ten days previously. He then has to go and break the news to the young widow, one of our nurses. In the resuscitation room Dr Mike is assessing a large man who complains loudly of pain in his chest - he does not feel the pain from his leg fracture, and must have a spinal injury, but it is his skull fracture which proves fatal.

At last it seems that all the injured have been assessed, and the initial management mapped out. I find a man wandering among the patient trolleys, looking for his relative who was on the bus. I check on his behalf but find no-one of that name - and we both know that means he must be among those who have not survived. Our parish minister is around. He came to offer help and to be among the distressed, but found his nephew among the injured. Fortunately he is not seriously hurt.

In the ward, nursing staff are coping admirably with the many admissions. I look into theatre where Dr Gordon and his team have several more operations to do. It is now well after midnight, and there is little more I can do to help, so I head for home, knowing that others have a full night's work ahead of them. Tomorrow the less urgent injuries will be more carefully assessed, X-rayed, operated on, plastered, put in traction.

Next morning, the whole community is stunned. Fifty-six people dead, 44 injured, some seriously. Many are local people. In the hospital we are all tired, physically and emotionally. The press arrive, then senior police officers and the Provincial Commissioner. The telephone never stops ringing with enquiries. And there is still much more medical work to be done.

Over the next few days there are many messages of appreciation for the care given. And, from our own minister, Rev Julius Nyaga:

'On behalf of all Christians in this parish and region, I thank you all for the effort and good spirit that I witnessed, the love to save lives . . I could not tell the nurse from the driver because of the teamwork . . Be sure that your work is rewarded by the Father'.

Alison Wilkinson is a missionary doctor at the PCEA Hospital in Chogoria, Kenya

My mission - to ur

Medical student Rebecca Underwood went 'On-Track' with Interserve to try and get her own life on track

There's a one-eyed yellow idol to the north of Kathmandu,
There's a little marble cross below the town;
There's a broken-hearted woman tends the grave of Mad Carew,
And the Yellow God forever gazes down.

(From a poem by J Milton Hayes)

Memories of my mother in a Crusader camp sketch wearing yellow oilskins and with an eye stuck to her forehead was as much as Kathmandu meant to me before arriving in Nepal.

While contemplating my elective I had decided to use it as an opportunity to learn more about working in mission overseas. Following time spent abroad in the past I had developed an interest in working in the developing world in the longer term, but knew I had a fairly romantic view so I applied to Interserve's On-Track programme, seeking reality. They sent me to Nepal.

Photo: Rebecca Underwood

The remoteness of Nepal

Photo: Rebecca Underwood

Patan Hospital, Kathmandu

Kathmandu

Reality greeted me in Kathmandu. I was travelling with Sarah, my flatmate who was spending her elective in a different hospital. We were met by someone from the United Mission to Nepal (UMN) and taken to the guest house. This was my base for the next seven weeks, while I worked at Patan Hospital.

The guest house proved a good place to start my mission to understand mission! It was the first port of call for anybody connected with UMN who arrived in Nepal. Some people who had come to work long-term were starting their five month language and orientation programme. The pain of leaving family and the stresses of starting still seemed to be fresh in everyone's minds.

They were faced with rice and *daal* on a daily basis, the seemingly insurmountable barriers of language and culture, the relentless pollution of Kathmandu streets and the discomfort of always being different to everyone else. All this without the luxury of knowing they would be leaving in a few weeks. I was challenged by their joy and enthusiasm and their unwillingness to complain. Even those who had to care for their children faced each day with a firm and constant trust in the Lord. They had come to offer their service and they were cheerful givers.

Patan Hospital

So what were the reasons for such people leaving the luxuries of the West for this very different place? Patan Hospital is jointly run by UMN and the Nepali government. There are a number of Christians from overseas working there as doctors, pharmacists, dentists and in hospital management. I spent three weeks shadowing doctors in different specialties and saw the remarkable as well as the usual. The 'remarkable' included tiny premature babies sharing a fullsize bed with their mothers - in England I'd only seen them nursed in high-tech incubators. The 'usual' included big outpatient clinics, overworked staff, and constant pressure on resources.

I was most challenged in all this that the work of these 'missionaries' was hardly different from my own life as a Christian in England. The romantic mission field of Nepal was the same as my mission field in the East End of London. They too shared

nderstand mission

the desire to witness to the gospel with colleagues and patients, and the continuing battles with fear, lack of boldness and the demands of a busy job.

Nepal is a Hindu kingdom. To change one's religion is a punishable offence. I found it difficult to know how I could communicate my faith with others without it being inappropriate and without putting others in the Nepali church at risk.

I began to realise however that there was more involved in the work here as Christians. I began to see the suffering and hardship with which the people of Nepal had to live. Initially the great differences in their culture blinded me to their poverty. Daily I saw people arrive at the hospital having walked or been carried for many days. I saw people leave the hospital inadequately treated because they could not afford to pay. I saw malnutrition of children and the debility of patients with untreated TB and leprosy.

All this reminded me that the Lord commanded us to love our neighbour as ourselves. To enjoy the luxuries of the West while so many others suffered so greatly didn't seem to me to be particularly loving. I was shocked and ashamed that it had taken me so long to become aware of such suffering. I learnt how hardened my heart had become by my wealth and the opportunities given to me in life. I began to see that coming to work in a less developed country might be one way in which I could love these neighbours, and use the gifts given to me for the sake of others.

Community Development and Health

Having spent three weeks in hospital medicine, I moved on to the Community Development and Health Programme (CDHP). This programme was working in the more rural areas surrounding Kathmandu trying to improve people's standard of living. This involved improving sanitation, providing a safe water supply, improving agricultural methods and basic health, and increasing adult literacy.

I stayed for nine days at a health post which was a six hour walk from the road. My strongest memory of that walk was my struggle to keep up with the porter. Even though he was walking in flip-flops and carrying a 40 kilogram load on his back, he still marched at a greater pace than I could manage. Work at the post involved running a general clinic and specialist clinics such as antenatal care, mother and child health, and family planning. As it was isolated I had to learn very quickly how to express my basic needs in Nepali, how to eat rice with my hands and how to survive on two meals a day.

While there I began to think about the contribution an expatriate doctor could make in such a country. The initial groundwork in CDHP was found to be more effective if it was done by Nepalis who could engage with the local people and encourage community initiative without fostering dependence. CDH interests me greatly but I left with more ideas about what I could not do rather than what I could do.

A remote hospital

I went up to see Sarah at her hospital. This meant a six hour bus journey and a four hour walk. It seemed incomprehensible that a fully established hospital could be so far from the road. There were a number of doctors from overseas doing an amazing job. Nepal does train its own doctors but very few are willing to work in such remote areas. Here, Christians have been able to provide basic health care. I found out more about the practicalities of living; for example, how to educate one's children, how to establish genuine friendships with local people, and how to be involved with the local church.

Photo: Rebecca Underwood

The author with a group of women waiting for contraceptive treatment, South Lalitpur

I set out to learn the realities of life on a different mission field from my own. I learnt much from living amongst the Nepali people as well as from meeting Christians from overseas. My willingness to work somewhere like Nepal has by no means diminished even though I have seen the less romantic side of the work.

Rebecca Underwood was a final year medical student at Bart's/The Royal London when she did her elective in Nepal in January and February 1998

reviews:

Heroes of Health Care in Africa 1780-1980 (Biographies of doctors and nurses arranged by country) Ralph Schram. Desk top published, 1998. 338 pp. £20 (+£3 p&p in UK). Orders from Dr Ralph Schram, Nile Cottage, Colwell Road, Freshwater, Isle of Wight, PO40 9NB

The biographies total 970. Most are of doctors but a few are of nurses and medical assistants, and a few are included from 1520-1780. There is a full index, so the reader can study a period of history chronologically, or the work of a particular missionary society, international aid agency, or university or government service.

A Hospital List appendix shows medical services in each country's capital, and all the church related hospitals. Excellent value for anyone wanting a single volume history of Christian health professionals in Africa.

David Clegg

The Sons of Want Harry Williams. Egon Publishers, Baldock. 1997. 207pp with illustrations by author. £7.95 Pb.

Commissioner Harry Williams OBE is a well-known plastic surgeon who has spent his life in India and has written a trilogy of novels set mainly in India and Burma. This is the second volume, each being a complete story on its own.

The hero is Jonathan Lindsey, born in India of a Salvationist family, and the story is set in the last years of the Raj and on to his death around 1965. His childhood with his mother and sister in India is happy, and is followed before the Second World War by pre-clinical training at Cambridge and clinical training at The London Hospital, where he stays in a Christian hostel that seems remarkably like the Medical Missionary Association's.

He specialises in surgery and later orthopaedics and returns to India, but with the Indian Medical Service not a missionary society. He gets involved in the war in Burma, Kohima and Imphal casualties coming his way. His New Zealand fiancee is a Salvationist but is killed in a theft incident. The immense upheaval of the 1947 partition leads to his decision to leave the IMS and return to his missionary roots.

In a simple style the novel beautifully describes how he returns to the Salvation Army in Pakistan and builds up one of their hospitals there, marries a fine Swedish girl and shares ministry with an international team including a German couple, gets deeply involved with TB and fractures, and spends his leaves in Sweden and Britain with holidays in Europe.

This carries the reader in imagination to all these countries and cultures and is the charm and value of this novel. In addition, the upright Christian behaviour of the key family including how they cope with disaster and Third World suffering makes it a good book for non-Christian friends and colleagues or anyone interested in a period in India or Pakistan.

Ralph Schram

resources:

Mental Health in the Developing World - A Challenge to the Churches

This conference from 1st-4th December 1998 is open to anyone interested. High Leigh Conference Centre, Hoddesdon, Hertfordshire. Organised by The Churches' Commission on Mission with The Evangelical Missionary Alliance. Booking forms from Chris Bocutt, 55 Prospect Way, Brabourne Lees, Ashford, Kent TN25 6RL. Tel. 01303 814115. E-mail chris@bocutt.demon.co.uk

Service in China and North Korea

HSE is a healthcare charity based in mainland China, with offices also in the United States and Hong Kong. It aims to improve medical conditions in remote areas of China and other Asian countries by co-ordinating:

update seminars

A team of two or three foreign doctors, or nurses, or dentists share current and applicable technology for three to five days.

clinics for the poor

Teams of six to ten from similar specialties come at their own expense with any necessary supplies and equipment for 10-14 days. About 500-700 patients with common ailments are seen or treated during this time.

work in Chinese hospitals

Opportunities can be arranged for foreign physicians to work in Chinese hospitals, and for Chinese physicians to have short-term studies abroad.

other work includes setting up an orphanage, providing for corrective surgery for orphans with congenital defects such as cleft palate, introducing a course on personal hygiene into schools, and relief work eg taking grain and medicines into North Korea. There are plans to set up a clinic there.

organisation

Medical and non-medical professionals are needed to volunteer their time, talents and resources. Individuals sensing a call to work in China or North Korea can come on one of the short-term trips, or work on a long-term basis. Please contact UK representative Sarah Peasey, 9 Mandeville Road, Hertford, Herts SG13 8JG. Tel. 01992 582407

vacancies overseas:

Please note that medical mission posts often require you to raise your own support (though some missions can help with this) and to have the support of your home church.

AFRICA

Benin

Bembereke Hospital need two nurses (short term with some French), a nurse teacher (fluent French essential), a surgeon (1-3 months or longer, French not essential) and a GP (2-6 months or longer with some French). Contact SIM UK, Joint Mission Centre, Ullswater Crescent, Coulsdon, Surrey CR3 2HR or David and Carol Thompson, e-mail heb@intnet.bj

Kenya

Short and long-term staff for the Africa Inland Church (AIC) hospital at Kijabe: GP, internal medicine, paediatrics, general/urological surgery, orthopaedic/ rehabilitation surgery, O&G, medical student electives. Contact Dr Raymond Givan, Medical Director, AIC Kijabe Hospital, Kijabe, Kenya. Tel. 00 254 154 64439/85/86. Fax 00 254 154 64287. E-mail Raymond_Givan@aimint.org or administration_KMC@aimint.org

South Africa

Manguzi Hospital needs Christian doctors, physiotherapists, occupational therapists, radiographers, and nurses. This is an ex-mission hospital (now government run) in a rural community on the South African/Mozambique border and still has a strong Christian ethos. Good place to gain mission hospital experience with support. Nearby are unspoilt beaches, Kosi lake and several game reserves.

Applicants from the UK would need to have registered with the South African Medical and Dental Council before June 1st or sit exams in order to be able to do so. Contact: The Medical Superintendent, Manguzi Hospital, Private Bag X301, Kwa Ngwanese, South Africa 3673. Tel./Fax: 00 27 035 5920150 ext 2203. E-mail supt@dhman.db.healthlink.org.za

Tanzania

Bugando Medical Centre is an 800-bed referral hospital in Mwanza, Tanzania, run by a partnership of local church (Catholic bishops) and government. Need hospital specialists in all fields, especially urology, who feel called to work in one of the poorest areas of the world, for short or long commitments. Contact Dr Ray Towey via Tel./Fax 0171 386 7018 (London contact Nanette Ffrench) or e-mail emach@AfricaOnline.co.ke

Uganda

Kisiizi Hospital. Urgent need for locum volunteer doctor to cover all or part of sick leave from early August to end November. Previous mission hospital or surgical experience preferable but not absolutely necessary. Fax Dr Lionel Mills 00871 761 587166

ASIA

Mongolia (Ulaan Baatar), Northern Pakistan (Gilgit), Uzbekistan (Tashkent) each require an ophthalmologist, optician, nurse administrator and workers with the blind. In addition GPs are required to work alongside the staff in the eye clinics. At each clinic four local doctors would be trained for three years by one or two GPs from the UK. Some of the admin and lab work would be shared with the eye clinic and there would be a pharmacy, records office and treatment room. Long or short-term welcome, including early retirement doctors and partnerships able to have one member at a time rotating through a clinic. Contact: Vision Administrator, Clifford Webb on 01892 518358 or Vision International, Box 248, Tunbridge Wells, Kent TN2 5BZ. E-mail 100142.3521@compuserve.com

Nepal

United Mission to Nepal urgently requires GPs with MRCGP or equivalent to work in rural hospitals, experienced doctor with admin skills for post of Hospital Director. Also, experienced psychiatrist, community medical officers, physician, general and orthopaedic surgeons. Tutors/nurse educators with Master's or Bachelor's degree needed to teach in national or UMN nursing campuses. Contact: Personnel Manager, United Mission to Nepal, PO Box 126, Kathmandu, Nepal. Fax: 977 1 225559. E-mail: personnl@umn.mos.com.np

Pakistan

United Christian Hospital, Lahore's charity work has suffered since the withdrawal of missionaries in the 1970s. It provides nursing and paramedical training (laboratory and X-ray technicians). Need volunteer medical staff, equipment and books. Accommodation available. Contact: UCH, Gulberg-III, Lahore, Pakistan. Tel. 00 92 42 576 3573/4/5 or speak in UK to Ron Pont, Tel. 01962 712332

AUSTRALASIA

Papua New Guinea

Doctors to replace Judy and Mark Fitzmaurice. They have been working and raising their family in Rumginae Health Centre in the remote West of the country for 10 years. They are due to visit the UK 16th-26th October. Contact Mr George Rabey, UFM Worldwide, 47a Fleet Street, Swindon, Wiltshire SN1 1RE. Tel. 01793 610515

LATIN AMERICA

Honduras

Tear Fund write: 'Community health nurse needed to work with Miskito indigenous communities along the Rio Patuca, promoting innovative community health and child nutrition programmes. You should be a community nurse with overseas experience in child nutrition and maternity care.' Contact: Andrea Fisher, Recruitment Advisor, People Programme Team, Tear Fund, 100 Church Road, Teddington, Middlesex TW11 8QE. Tel. 0181 943 7888. E-mail enquiry@tearfund.dircon.co.uk

Among All Nations is produced by the Medical Missionary Association and Christians in Health Care in partnership with the Christian Medical Fellowship as the international section of the CMF publication *Triple Helix*. The MMA also publishes its own magazine *Saving Health* which is aimed at those wishing to know more about, pray for, give to, or take part in medical mission. This is currently produced twice a year with a newsletter in alternate quarters. Both are sent to MMA supporters who donate £5 or more a year (£3 for students and missionaries). MMA is building up a database of those wishing to hear of specific types of service opportunities. Please ask for a database form.

Medical Missionary Association
Registered Charity 224636 General Secretary: Dr David Clegg. 157 Waterloo Road, London SE1 8XN. Tel. 0171-928 4694. Fax 0171-620 2453. E-mail 106333.673@compuserve.com

Christians in Health Care
Registered Charity 328018 Director: Howard Lyons MSc FHSM. 11 Grove Road, Northwood, Middlesex HA6 2AP. Tel. 01923 825634. Fax 01923 840562. E-mail howard-lyons@msn.com
Website: http://christian-healthcare.org.uk

a world of *opportunity*

'It's a great life!' say Papua New Guinea missionaries Mark and Judy Fitzmaurice

Would you like the freedom to integrate your Christian faith into your clinical practice? Do you want to spend more time with your family? Are you free to be mobile?

If you're willing to pluck yourself from material entanglements, then a stint as a medical missionary could be the life changing experience you're looking for! Medical missionaries are not super-special Christians, workaholics, ascetics, hermits, lovers of extreme climates, people who never have families. In short, they are not people who are 'not like me'!

From our ten year experience in the remote Western Province of Papua New Guinea, we can say something about what being a missionary is.

Photo: Chris Luxton, PNG Church Partnership

Integrating medicine and ministry

You will be vitally involved in spreading the Gospel in partnership with national evangelists and growing churches. Opportunities for evangelistic or Bible teaching activities will often be wide open. You are free to integrate your health work and ministry - to pray with patients and worship with staff. Good use will be made of your professional knowledge and every other practical skill.

It's tremendously fulfilling, making any associated hardships seem insignificant. Have we forgotten that 'those who come to me cannot be my disciples unless they love me more than they love father, mother, wife and children and themselves as well' (Luke 14:26)? You will learn from another people group to value people and relationships over activities and possessions and to see your own culture with more realistic eyes.

Great for the family

It's the most family nurturing lifestyle imaginable. You may be at home with the family most mealtimes. Without TV and shopping we all have more time together. Some missionary mums are able to teach their own children through Distance Education. You can bring children up in a Christian community, in societies where children are loved and nurtured, with wide open spaces. Our situation is like this, but of course not all are. Although families at home are missed acutely, you gain new members: 'Anyone who leaves home or wife or brothers or parents or children for the sake of the Kingdom of God will receive much more in this present age and eternal life in the age to come' (Luke 18: 29-30).

God changing you from the inside

You will allow God to form your character. As you venture out of your comfort zone you will learn to rely more on our intimate God. Yes, there are times of stress, frustration, sickness, loneliness, and lack of confidence or knowledge but we have all found God is trustworthy and close through these times. Living in community will cause you to learn about yourself and you will experience God graciously changing you from the inside as you learn to live in love.

Alternative lifestyle

* Exciting - where else can you fly in small planes over spectacular mountains and feel your pulse race?
* Exotic - or snorkel off palm-fringed beaches on holiday?
* Thrilling - when you save your first baby by Caesarean section.
* Breathtaking - when you wake each morning to the most beautiful view and thank God for his blessings!
* Uplifting - seeing people born into God's family and growing in it.

Not always overworked

You are not always chronically overworked with never-ending streams of patients. Ideally a health professional is part of a team who can support each other in working reasonable hours, sharing on-call and the stress of emergencies, taking regular holidays, and encouraging each other to be actively involved in ministry.

We invite you to come and taste mission for yourself. Most mission hospitals could use a hand for any length of time you have available. Why not go to the mission field 'for one or two years'? You may end up being there ten, like us!

Mark and Judy Fitzmaurice graduated as doctors in Sydney, Australia. Their mission works with UFM Worldwide and with the Evangelical Church of Papua New Guinea. They will be in the UK from 16th-26th October, and are keen to meet anyone interested in medical mission. Contact: MMA Office or see 'Papua New Guinea' on p15.

RevieWWWs

with CyberDoc

Jubilee 2000 campaign http://oneworld.org/jubilee2000

Debt and jubilee. What do these have to do with health professionals? Well, if you read through the many pages and links of this excellent site I am sure you will see the significance. Thanks to the burden of debt repayment, the poorest countries of this world actually pay the richest considerably more money than they receive in aid. If this were not enough, they end up paying far more on their debt than they can spend on health, and allegedly part of 'fiscal discipline' imposed by the international community involves limiting health expenditure.

So, concerned as I trust we are by the plight of the world's poor, this site encourages us to get involved with Jubilee 2000. This, in case you hadn't heard, is the campaign to make a one-off 'jubilee style' cancellation of debt owed by the developing world in the year 2000.

The arguments are put very forcibly and include the fact that similar debt relief was given to both Germany and Britain after the Second World War. Some economists argue that allowing countries a one-off chance to escape the poverty trap will be beneficial to the world's economy as a whole.

The site gives links to all the partners in this campaign, who include Tear Fund and many other Christian organisations. To criticise this excellent site seems harsh, but it would be nice to see the arguments against this campaign given a hearing. Perhaps there simply aren't any good ones to find! So, a challenge - tell me why we shouldn't all be joining this campaign?

Ratings (out of five)

Appearance ****

Content *****

Links to other sites ****

What the Internet says about 'Not For Resusc' orders

There seems surprisingly little on the Internet about this subject, despite its controversial nature. Thank you to one of our readers for setting me an impossible task! I could find not a single article on this subject written from a Christian perspective. It is a sign of the Internet's relative immaturity that one can find such holes in its coverage. Anyone interested in contributing articles in this subject will therefore find little competition.

One of the pages that was easily accessible on several search engines was an article from the *Student BMJ* **(http://www.bmjpg.com/studbmj/data/0397/data/0397s1.htm)**.

Unfortunately this article by Suzanne Docherty only included the subject in its title. The paper itself was an interesting anecdotal account of experiences on a resuscitation team.

Ironically, one of the most useful pieces I found was on the Euthanasia Society site **(http://www.euthanasia.org/saunders.html)**. These pages provide a concise background to the whole subject of non-resuscitation. The author quotes the BMA/RCN guidelines as follows: 'It is appropriate to consider a DNR decision . . where the patient's condition indicates that effective CPR is unlikely to be successful . .' and 'When the basis for a DNR order is the absence of any likely benefit, discussion with the patient, or others close to the patient, should aim at securing an understanding and acceptance of the clinical decision that has been reached'.

He also highlights the ethical basis for DNR orders where resuscitation is futile. He believes 'resuscitation training programmes should routinely include data on survival from CPR in differing circumstances'. The author was less impressed by the argument of poor quality of life as justification for non-resuscitation, pointing out that 'in a study of 21 patients with spinal injuries requiring ventilation, for example, only one wished to be allowed to die'.

A search of the electronic *BMJ* revealed two papers. In the first, Dyer reported that the legality of non-resuscitation of a baby where it was thought futile had been upheld despite the relatives' objections **(http://www.bmj.com/cgi/content/full/315/7099/7/g?maxtoshow=&HITS=&RESULTFORMAT=&FIRSTINDEX=&titleabstract=resuscitation&searchid=QID_NOT_SET)**.

The second paper is a letter in which Stewart states: 'Doctors have neither a moral nor a legal obligation to offer treatment that is ineffective, even if it is requested by patients'. He later highlights an example of futility in resuscitation - that terminal cancer patients almost never survive resuscitation **(http://www.bmj.comi/content/full/316/7138/1166/a?maxtoshow=&HITS=&RESULTFORMAT=&FIRSTINDEX=&titleabstract=resuscitation&searchid=QID_NOT_SET#resp1)**.

It would be nice to see more well-argued articles on this subject published on the Internet, which is, after all, the world's largest library. So get writing!

PS. Good to see that material from Triple Helix is appearing on the Web now: **http://www.cmf.org.uk/pubs/newmag.htm**. Apologies that the address given at the end of my column last quarter was not operative.

CyberDoc is Adrian Warnock, a locum clinical assistant in psychiatry based in London. He runs an Internet site for Christians and is small group leader in his church.

If you have an Internet site or subject that you would like CyberDoc to review he can be e-mailed at **warnock@bigfoot.com**

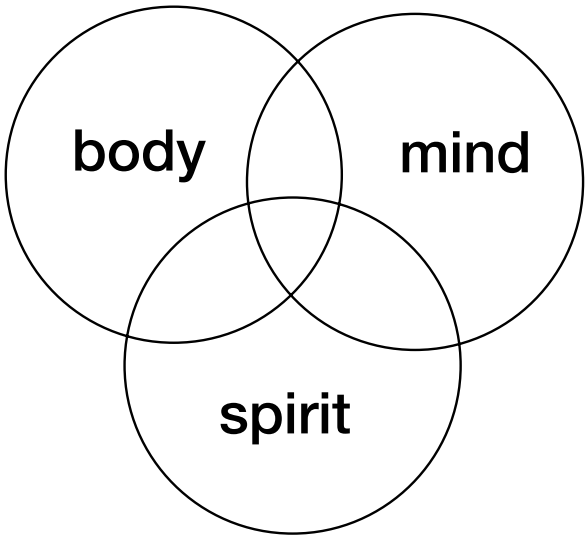
crossing professional boundaries

Steve Clark reports on a unique centre for healthcare and Christian ministry

Alongside the well known 50th anniversary of the founding of the NHS this year is another Golden Jubilee. Fifty years ago a remarkable lady called Dorothy Kerin set up Burrswood near Tunbridge Wells in Kent. This is a centre which from the outset has sought to combine a prayer ministry with the very best of medical care.

Our culture and often our churches have adopted an either-or attitude towards the Christian healing ministry and medicine. This springs from a model of personhood that separates its components of body, mind and spirit into three distinct entities and sometimes denies the existence or relevance of the latter. Broken body . . off to casualty; broken mind . . admit to the psychiatric unit; broken spirit . . send for the priest.

Photo: Burrswood



Scripture suggests that there are the three elements to personhood (I Thessalonians 5: 23) but does not endorse the notion that they are discrete entities. Maybe they are as intrinsically and mysteriously interwoven into one as our Trinity God. Certainly, an examination of the healing miracles of Jesus reveals a care for the whole person and not merely the relief of physical symptoms. In Matthew 8: 3 Jesus touches the leper; in Matthew 9: 2 he offers forgiveness; in Matthew 9: l0 he eats with 'sinners' and in Matthew 9: 22 he reinstates a woman within her community. Healing from rejection or the healing of forgiveness were just as much the concern of Jesus as physical well being.

The model of personhood suggested by the ministry of Jesus may be illustrated by three overlapping circles. The edges between body, mind and spirit are not always easy to discern. The more interesting question is probably to do with the extent of the overlap between the circles. Such a model points towards the importance of care and treatment that is aimed at the whole person.

It is this style of care that is the characteristic of Burrswood. The care team consists of doctors, nurses, chaplains, counsellors and physiotherapists. With the patient's permission, confidentiality is held by the whole team so that insights may be shared between these different professional disciplines and the patient's care co-ordinated.

Several times a week a report meeting updates team members on each patient's condition. This sharing of insights is a vital guide for the ongoing care. This interdisciplinary approach at Burrswood goes beyond a multidisciplinary team in that the edges between the disciplines can be blurred in a very positive way by the closeness of the rapport. This is important when the primary reason for admission is as straightforward as step-down care following a hip replacement, but is particularly critical when caring for someone with, for instance, chronic fatigue syndrome.

It is significant that at Burrswood when our doctors admit a patient, they will not only take down a medical history but also a family tree, a social history and a spiritual history. This gives an overview. It is also of great value to the rest of the team as a starting point, enabling each of them to bring their particular skills to the patient's care in a balanced and coherent way.

At the report meeting it may be contributions from other team members about how they have found the patient that help the doctor to decide on appropriate drug treatments. The physiotherapist may have heard a story of deep pain from a patient as he or she has relaxed during a hydrotherapy session. This may provide insights for the counsellor.

The crossover between the work of the counsellor and the chaplain is two way. Sometimes the chaplain will use material that has come to light through counselling to take the patient forward through prayer and various forms of sacramental ministry, asking for God's healing touch on the hurts that have come to light.

On one occasion we sensed that one of our patients was unable to get in touch with the emotions associated with her situation. This became the topic of much prayer within the care team. Afterwards a counsellor and I arranged to meet with the patient in order to pray with her. We were slightly taken aback when we arrived to find her in floods of tears. It was a very healing time as she safely expressed her feelings over past events, while being held and prayed for.

At other times counselling may seem to have reached an impasse. Prayers will be for God's Holy Spirit of truth to bring understanding and shed light into what are dark and hidden places. This is particularly relevant in a case where there may have been some form of childhood abuse. Repeatedly we see God honouring these prayers, thus allowing the next step forward with the counsellor. There are often times when counsellor and chaplain will pray and minister to a patient together, bringing to the situation their own insights and seeking guidance and healing. Such times can be powerfully releasing.

From this you may gather that prayer ministry is not limited to chaplains but is part of the normal pattern of work for the whole team. Indeed I have been amused on a couple of occasions when a doctor has been mistaken for a chaplain because he listened, held the patient in his or her distress, and prayed.

Photo: Burrswood

The author chats with a patient at Burrswood

For me as a chaplain it is only in the context of a team who believes in the value of prayer that I feel free to minister. Some of our patients are emotionally vulnerable with poor sleep patterns and bad nightmares. Even so I am rarely called out at night because of the abilities of the nursing staff. They will sit with the patient, pray with them, light a candle or make a cup of tea or a hot water bottle as is appropriate. Palliative care or terminal care patients have the freedom of knowing they don't have to wait for the chaplain for prayer. The rest of the team are adept at catching the moment when such a need surfaces.

Do we see miracles? Occasionally we will see apparently inexplicable physical improvement. We often see situations that seem to have ground to a halt suddenly move forward and an increased freedom within an individual in body, mind and spirit. It happens often enough to keep us praying and to give us high expectations. Our Head of Counselling has observed that her work with patients seems to progress significantly faster within Burrswood than in other counselling environments within which she has worked.

There is still much to learn as we constantly observe how mind, body, spirit and our associated dis-eases are so closely related. The benefits of the interdisciplinary team are such that they encourage us to seek further ways to integrate and cross the professional boundaries.

Steve Clark is hospital chaplain at Burrswood

readers' letters:

Relic of the Bedpan Age

*Semi-retired ophthalmologist **Ralph Heaton** sends a reassuring note from Bognor Regis:*

I read this article in the latest *Triple Helix* shortly after being discharged from a surgical ward of a nearby hospital, where I had undergone major urogenital surgery. My experience was inevitably anecdotal, but if Ann Bradshaw's words are meant to describe nursing as it is today (even allowing for intentional exaggeration) they are, thankfully, wide of the mark. The nurses were compassionate, competent and professional. As it happened, I only needed a commode once, but if a bedpan had been needed, I am sure it would have been provided cheerfully.

There is however prophetic truth in what Ann Bradshaw writes, and without the driving force of the love of Christ, the standard of nursing (and of all professions) is bound to fall. Thank God there are still Christian nurses setting the pace and acting as salt and light. And thank God that in at least one hospital, and I suspect in many others, the standard of nursing is nowhere near as bad as Professor Powers would have us believe. So, gentle reader (as Angela Plume might have called you), rest assured when you get to the top of the waiting list!

Creation-Evolution Debate

***Denis Alexander** responds to Antony Latham's letter in the last issue criticising his review of Michael Behe's book 'Darwin's Black Box':*

I think Dr Latham and I are in complete agreement that the Bible teaches a 'robust theism' in which a personal all-powerful God has not only brought the whole created order into being but also sustains it and upholds it moment by moment. We are not deists, who believe in a remote God who established the laws of the universe at the beginning and then left the universe to carry on by itself, but theists who believe in God's immanence as well as his transcendence. Just as the existence of the TV drama depends upon the continual targeting of electrons onto the TV screen to generate the necessary images, and there would be no drama if the flow of electrons ceased, so there would no scientists and nothing for scientists to describe were God to cease his ongoing creative and sustaining activity.

It is precisely for this reason that I am suspicious of the apologetic approach advocated by Michael Behe in *Darwin's Black Box*. I am all for apologetics, but not at the price of undermining the biblical doctrine of creation.

Dr Behe chooses not to start with the biblical doctrine of God, but with a natural theology which depends on: first, a working knowledge of biochemistry; secondly, the advocacy of gaps in our current biochemical knowledge as being in some sense the particular loci of God's 'designer' activity; and, thirdly, a curious division of biochemical events into those 'which appear to be the result of simple natural processes' and others which 'were almost certainly designed' (p208).

In contrast the Bible teaches a rather limited role for natural theology, which is accessible to *all* people with eyes to see, not merely to people with degrees in biochemistry (cf Romans 1:18-20). The wonders of creation are certainly extolled as signs of God's creative power - but when the Bible wishes to draw attention to God as creator, it nearly always does so not by invoking the mysterious, but by reminding its readers of God's creative actions in the mundane and ordinary events of everyday life in an agricultural society; not looking for God in their gaps in understanding, but pointing to his daily actions in familiar events. Within this theistic framework, 'chance' events, that is events which we are unable to predict, are as much under God's control as any other events.

lf Behe was simply claiming, as Dr Latham suggests, that the more science uncovers of the wonders of creation, the more our attention is directed towards God's creative power, then this approach would fit well with such a biblical natural theology. Unfortunately, however, this is not the case. *Darwin's Black Box* clearly states that God's 'designer activity' is restricted to those biochemical pathways for which the evolutionary origins are currently unknown, whereas the 'designer label' is not applicable to those 'natural processes' for which the biochemical origins are better defined. Such a division of the created order into a 'designed aspect' and a 'natural aspect' is quite incompatible with Christian theism. Either God is the Author of the whole 'novel', in all its detail, or not at all.

Pinning apologetic hopes on gaps in our current scientific understanding is a risky business. As it happens, *Darwin's Black Box* is scientifically inaccurate, not in what it describes, but in what it excludes. For example, a recent conference on the evolution of the immune system highlighted several important advances (see *Immunology Today*, 1998; 19: 54-56). Behe's 'god-of-the-gaps' is already shrinking as scientific knowledge advances.

Christians have no hidden theological investments in scientific ignorance. Christian theists will rejoice at each new scientific advance, be it to do with evolutionary origins or anything else, since each advance tells us more about God's activity in creation.

Gordon Wardall, *a consultant anaesthetist in Falkirk, also felt that several of Antony Latham's points merited further comment:*

It is understandable that Dr Latham should be disappointed by a negative review of a book which he has found enjoyable and helpful, and which has, incidentally, enjoyed considerable popularity, particularly in the USA. Nonetheless, this book has received criticism similar to Dr Alexander's elsewhere[1]. I would like to comment on some of the points made by Dr Latham.

First, he suggests that Dr Alexander 'is of the Christian school of thought that feels that God had little if anything to do with the details of creation once he had set up the laws of the universe at the beginning'.

This is precisely the sort of view that Alexander is refuting when he criticises Behe for suggesting that some parts of the created order have been designed, while others occur by natural processes. Alexander states (referring to Psalm 104) that biblically minded Christians believe that every aspect has been created by God and is continually sustained by him.

To point to 'irreducibly complex systems' in cellular biochemistry as evidence for a creator is indeed a classical 'God of the gaps' argument, however elegantly expressed by Behe. I believe we can see evidence for God's creating role as much in those processes for which science can already provide an explanation as in those which are - and may remain for a very considerable time - a 'black box'.

Like most Christians I would take issue with the reductionist attitude and use of language of Richard Dawkins (superbly analysed by Michael Poole[2]). A more balanced and very accessible analysis of the relationship of evolutionary biology to Christian belief can be found in R J Berry's recently published *God and the Biologist* (Apollos 1996).

Nonetheless, I can see no reason to doubt Dawkins' ability or integrity as a scientist. The scientific information contained in his books, although selective, is widely - although not unanimously - accepted in the scientific community, and certainly not just his own ideas. To dismiss Dawkins' work as 'made up stories' is, I believe, counterproductive to Dr Latham's case, however worthy his intention.

Dr Latham implies that the element of chance associated with some parts of the evolutionary process is incompatible with creation by design. However, when scientists speak of 'chance', the word does not carry the philosophical implication of lack of design or purpose that it does in everyday use.

In fact, it has been suggested conversely that the operation of chance in biological processes - all of which are continually held in being by God - is a means by which God might produce diversity in lifeforms. Further, Polkinghorne has suggested[3] that the unpredictability associated with some of the developments of modern physics - such as the relativity and quantum theories - creates an 'openness' that may help us to understand how human free will can operate at the same time as God's ongoing action in his creation.

Dr Alexander is editor of *Science and Christian Belief*, the journal of CMF's sister society, Christians in Science. The general views (as opposed to those on Behe's book) which he expresses - notably the complementary nature of biblical and scientific explanations, and the rejection of the 'God of the gaps' approach - would I think be shared by most of the scientist Christians who are members of this society. Most importantly, all believe - like Dr Latham - that the universe and all it contains is created and sustained by God. This unifying central belief must surely be borne in mind through all these other arguments in this often divisive subject.

References
1. Roberts M. *Science and Christian Belief*, 1997; 9(2): 191-192
2. Poole M and Dawkins R. The Poole-Dawkins Debate, 1994-5.
3. Polkinghorne J C. A scientist's view of religion, 1990.
(References 2 and 3 are reprints from *Science and Christian Belief* and available from Christians in Science.)

The Living Alternative

Dominic de Takats*, a Clinical Research Fellow in Sheffield, urges Triple Helix readers to get involved in secular ethics debates:*

A number of old chestnuts have surfaced again in public recently. Abortion and euthanasia have both featured in several recent issues of *Hospital Doctor*, and the *BMA News Review* recently carried a staunch defence of an ethical position on iatrogenic death, arguing how the motivation for an act rather than its consequence defines its morality[1].

I write to exhort the many readers of *Triple Helix* who no doubt hold strong views on such subjects to get involved. I myself and many others are heartened to read a well-argued defence of a Christian position in the medical press, and it is an important reminder to bystanders that there is a legitimate living alternative to the post-modern liberal consequential system of ethics reached by default or consensus, which seems so all pervasive.

Reference
1. Carmichael R. Double effect no excuse to kill patients. *BMA News Review*, May 1998

The Editor welcomes original letters for consideration for publication. They should have both Christian and health-care content, should not normally exceed 250 words, and if accepted may have to be edited for length.

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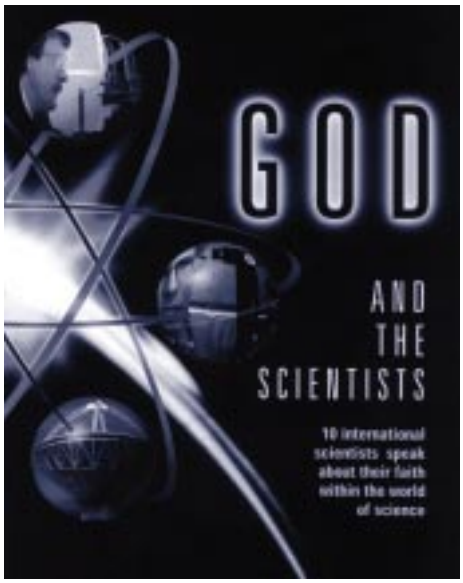
reviews:

God and the Scientists

Mike Poole. CPO, Worthing. 1997. 20pp A5 booklet. £1.25

'All scientists are atheists - hasn't science disproved religion?' is the issue addressed in *God and the Scientists*. Ten scientists of international renown write about their own experiences in the worlds of science and faith. They were chosen from a wide range of disciplines, from botany and ecology to astrophysics. The only health professionals are anatomist and ethicist Professor Gareth Jones, and respiratory physician Professor Margaret Hodson, incidentally the only woman among the ten. The linking factors are their faith in Christ, and their declaration that scientific knowledge strengthens their faith, rather than weakening it.



As Professor Colin Russell says: 'To portray Christian and scientific doctrines as persistently in conflict is not only historically inaccurate, but actually a caricature so grotesque that what needs to be explained is how it could possibly have achieved any degree of respectability. . .'

The booklet is well presented, co1ourful, and is written in a very accessible style, so you need be neither scientist nor Christian to enjoy it. There are also some short apologetic sections, dealing briefly with some of the more common objections to our faith. These are, however, quite concise, and not of much use for those wanting to go further into these issues.

In summary, this booklet is the testimony of ten leading scientists who refute the statement 'You can't be a Christian - you're a scientist'. It could be a great evangelistic tool.

Phil Underwood
(Medical student, London)

Pregnancy: A Testing Time

Pete Moore. Lion, Oxford. 160pp. £7.99 Pb.

This book is well-written and balanced in its approach to its complex subject. The author shows an excellent grasp of the problems facing mothers today. The book is fast moving, sometimes a narrative, sometimes a reference text packed with information. I felt that it was written for the well-educated mother especially and might not appeal to those less able to grasp pregnancy screening problems. Certain chapters would be particularly difficult to understand without some knowledge of the subject, but serve well as an excellent reference.

The book gives an honest and open exposé of the ethical issues without being prescriptive. The author takes the view, however, that there are a number of options as to when a baby attains the full status of human being. I personally think the baby cannot be any other than fully human from conception, as he or she is nothing else.

The screening tests with their benefits and hazards are well explained, especially the 'double' and 'triple tests'. There were some errors of obstetric management which were minor, and an error in the risk with regard to amniocentesis which is quoted by the Royal College of Obstetricians and Gynaecologists at a 1 in 100 miscarriage rate, and this certainly varies amongst units.

The chapter on specific genetic disorders was particularly good. A mention earlier in the book of the uncertainty of the meaning of the 'double' and 'triple tests' for people of other ethnic origins would have been helpful because they will have read most of the book before having the opportunity to evaluate properly the advice contained in it. The stories related were both relevant and poignant.

In conclusion this book will be a valuable asset to the antenatal clinic and GP surgery for staff and parents alike.

Sian Kerslake
(Consultant Obstetrician and Gynaecologist, London)

Man-Made Man

Ethical and Legal Issues in Genetics

Eds Peter Doherty and Agneta Sutton. Open Air (Four Courts Press), Dublin. 1997. 116pp. £14.95 Pb.

The title of this book is misleading and raised my feminist hackles, but the subtitle describes it, and for anyone wanting information on this topic here is a useful handbook. With its authors coming from a number of European countries, the emphasis throughout is helpfully European rather than British.

For non-geneticists an appendix answers basic questions and there is a chapter giving a full explanation of some of the technical aspects of genetic manipulation. This may well be too detailed for most of those likely to read the book, but it is a reader-friendly account.

Luis Archer, Professor of Molecular Genetics in the University of Lisbon and bioethics consultant to the European Commission, describes the genetic testing currently available and the concerns it should raise and then makes suggestions as to how these should be tackled. His discussion of the pros and cons of germ-line treatment is a model of cool sanity with justice issues stressed.

David King, editor of *GenEthics News*, writes the chapter that is relevant to all. He agrees with the establishment view that eugenic schemes as practised earlier this century are unlikely to be repeated. He accepts the dogma of free parental choice in the matter of genetic screening and prenatal testing, but points out how easily this can lead to what he calls 'laissez-faire eugenics'. Parental choice may appear to be free, but in reality it is usually driven by sociological pressures based on negative attitudes to disability and poor provision of services for the disabled. He argues for the voice of the disabled (or their advocates) to be more prominent in public debate. (Here perhaps is a role for the

churches and Christian health professional organisations.)

Christian Byk, Professor of Legal Studies in Poitiers University and a member of The Human Genome Organisation, gives an account of law and regulation in Europe. This is a useful source of information and is up-to-date enough to include the response to Dolly the cloned sheep. Emy Lucassen from Greenwich is rightly concerned about the validity of informed consent of those undergoing pre-natal screening, but finds the law of little help in rectifying this.

Although the authors may well all be Christians and adopt a thoroughly Christian attitude in their chapters, there is no overt Christian input to the book. There is also hardly any of the paranoia which so often clouds discussion of genetic technology. It is difficult to know quite which readers of this review would value the book but it is a useful resource for any who want information on the legal aspects of medical genetic developments.

Caroline Berry
(Clinical Geneticist, Kent)

Cohabitation or Marriage?
A report examines the evidence

Declan Flanagan and Dr Ted Williams. Belmont House Publishing, Sutton. 1997. 28pp A4 booklet. £2.99

While the Health of the Nation targets include reducing teenage pregnancies alongside reduction of smoking-related illness, advising abstinence from sex is much less 'politically correct' than abstinence from cigarettes. However, we have a responsibility to be aware of current trends and the social and health consequences of individual choices. This report, by a Baptist pastor and a public health doctor, provides a resource for those who have long suspected that cohabitation is not a reliable way to assess the likelihood of a successful marriage.

Some of the damages and negative consequences of cohabitation are highlighted and backed up by numbers, charts and references. These include increased divorce rates compared with those who did not cohabit, higher rates of smoking and infant mortality, higher abortion rates and a lesser commitment to faithfulness to the partner when compared with married couples.

The authors set out God's plan for marriage and extend an invitation to a 'better way', urging those who cohabit to 're-examine their relationship in the light of Biblical truth'. The information should help us to commend marriage to those around us. The report ends with the reminder of forgiveness and a note of hope, and has certainly given me food for thought.

Liz Walker
(GP, Southall)

The Healing Promise - is it always God's will to heal?

Richard Mayhue. Christian Focus Publications (Mentor Imprint), Tain, Ross-shire. 1997. 288pp. £9.99 Pb.

Even good books on healing tend to be unbalanced and incomplete. Theologians rarely understand the medical issues, while doctors usually tread lightly over the biblical material. Few authors engage adequately with the pastoral agonies, and there are very few books I would give to a Christian with an incurable illness.

I therefore picked up this offering from an American Bible teacher with reluctance, but quickly found I was breathing in fresh air. The first two sections present a devastating critique of the current healing movement, written with clarity, charity and accuracy. He hits the nail on the head.

I was pleased to see James Randi given the credit he is due and to find a whole chapter is written by illusionist André Kole. Steve Martin's film *Leap of Faith* is acknowledged as being an accurate expose of the techniques used by miracle healers today. Special attention is given to Benny Hinn to illustrate the thesis. An account of what is actually going on medically with those claiming to be healed fully accords with my own enquiries.

The third part of the book covers the biblical material. The key passages are tackled in a compelling and interesting way. He is not afraid to argue a fresh viewpoint - eg on James Chapter 5. He disagrees with other writers, including Dr Lloyd-Jones, for believing that Christians can be demonised - the idea, Mayhue asserts, is a contradiction in terms. He writes helpfully about the 'healing in the atonement' debate.

The final section faces the pastoral issues. One chapter records an interview with quadriplegic Joni Eareckson-Tada. Another looks at the place of prayer and medicine for sick Christians. There is lots of sound, Christian, common sense here.

Criticisms? Well, the book contains the best definition of a miracle I have seen but without an index you will be hard put to find it! If you want to know whether the work of Lourdes is tackled, or Verna Wright quoted, you will have to search without an index. This lack of an index adds a whole new dimension to debate about the 'unforgivable sin'! It is so unnecessary in a book which should be such a valuable reference work. Also, there are some Americanisms to endure. Every surgeon is 'world renowned' etc! We even have a few 'unto-s' to digest.

I can only hope this book is widely read, not least by those with incurable sicknesses. Certainly, it should be compulsory reading for anyone wanting to understand the nature of any distinctively Christian ministry of healing.

Peter May
(GP, Southampton)

UNFAIR GAME

Do we need new 'incest taboos' to protect psychiatric patients and disabled people?

As a working Christian minister I am becoming increasingly uneasy about certain groups in our society who are vulnerable to predators with nothing in mind except their own pleasure or profit. The two groups who have come to my attention are people in psychiatric wards and those with disabilities in the community.

I wonder whether, in our anxiety to avoid the charges of being 'judgmental' or of robbing our patients/clients/residents/friends of their freedom to 'make their own decisions', we are in fact dodging our responsibility to ask how much 'freedom' is involved on the part of the main person we should be caring for.

Sex on the psychiatric ward

Take the issue of an attractive young wife and mother, suffering from severe depression. She has been told by her husband he no longer loves her and wishes he had not married her. Friends in the church (for they are both Christians) suspect that the marriage may be saved - with counselling. Meanwhile, her self-esteem is in tatters.

Women in these sorts of situations sometimes wonder if they give off 'vibes' a certain kind of man can read from 100 yards. She discovers she is the target of unwanted sexual attentions, even from men friends and acquaintances whom she would never have imagined making advances. Regrettably, even so-called Christian men are involved. She tells me she feels that written on her forehead is: 'F--- me, I'm miserable'!

She goes into a psychiatric ward where they feel no responsibility to stand in the way of patients 'having relationships'. She ends up getting involved with someone even sicker than she is. It does her no good at all. It is many painful months before she disentangles herself, with some firm and loving help from Christian friends.

A specialist in eating disorders recently told me there was a time when she would not hesitate to pop some of her young patients into a quiet psychiatric ward for a few days. No way, now. They would be taken advantage of straight away. Thin little things with big eyes and no self-esteem? They wouldn't stand a chance.

Care in the community?

The second situation concerns those 'in the community' in a care home of some kind. It is not unusual for some residents to start sleeping together and for the staff to take no steps to prevent this. But no-one seems to take responsibility for checking this really is a free and informed choice on both sides. There is no provision for counselling about consequences and other choices. I cannot imagine what it must be like to be a Christian parent with a child in such a place - or destined to go into one when the parents are no longer able to care.

Will Christians have to set up 'special' homes where different standards prevail? If so, would the residents be able to take the management to court on the grounds of abuse of their 'human rights' if they were restrained from sleeping with whom they wanted? The mind boggles.

I married a couple recently. The man was disabled. He had met the woman, older than him, when she came to work as a cook in the home. They began a 'relationship' and were promptly provided with a double room. In the light of their subsequent history, I came to doubt her motives. I suspected she thought of him as her 'meal ticket' with his nice disability allowances. There did not seem anyone available to take responsibility for him.

Even more, those who live in the community in their own accommodation may be considered 'easy pickings' for the predatory. They get somewhere to live, a sexual partner and quite a lot else - for what? The price of a bit of flattery. But then, what? When the relationship grows stale, or becomes abusive, there is misery. If the predatory partner takes off, she or he leaves behind feelings of loss compounded with the low esteem those with disability and health problems can have anyway.

As a taxpayer, am I happy at the thought of merited allowances being taken advantage of by those who are doing the vulnerable no good at all? Am I sponsoring short-term, unsatisfactory relationships that will in the end produce situations needing even more tax-payer's money to sort out?

Name and address supplied