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# Triple Helix

Christian dimensions in healthcare

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Euthanasia: where are we now?

Morning after pill

Does Romania still need us?

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**Euthanasia: this won't hurt a bit**

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## editorial:

### *The fear of death*

*'The last enemy that shall be destroyed is death'  
(1 Corinthians 15:26)*

Friendly critics of *Triple Helix* are apt to chide us that we give too much space to the debate about euthanasia. 'Healthcare bristles with issues for discussion and debate', they say. 'Why give this one so much space?'

Our first response, always, is that euthanasia is a 'defining issue'. If the euthanasia debate were lost, the whole edifice of healthcare, as it has been practised in the West for centuries, would be totally undermined. To open the door to euthanasia would be to concede there is nothing in essence that distinguishes the human species from the animal kingdom.

But there is an even deeper reason. At the heart of the clamour for euthanasia is a very-human fear of death. Death has taken the place of sex as our chief taboo topic. We avoid talk about it. We have banished it from our homes.

But this is a fear that cries out to be informed by the radically different way of thinking. The New Testament tells us that a death has taken place that transforms everything we can know or even think about death. The claim is that in the death of Jesus Christ, something incredible happened: the immortal God tasted death and in doing so destroyed death.

So Christians do not accept that death is the end. Nor, even, can they regard it as 'the ultimate healing'. The Bible's claim is far more radical. With the death of Christ, death is itself abolished, and with it all the fears of the unknown it represents.

If we put our trust in Jesus, we can face impending death with a certain hope that in that moment, God will take care of us in just the same way as he took care of Jesus nearly two millennia ago.

**John Martin**

# Postcoital ‘contraception’

**Postcoital contraception may sometimes work by preventing the continuing development of a fertilised egg, and therefore arguably be abortifacient. GP John Holden finds it his biggest problem**

Requests for postcoital contraception (PCC) cause me more ethical discomfort than anything. They raise practical problems that can be greater than those surrounding requests for abortion, and GPs as well as those working in A&E, gynaecology and family planning have to decide what their attitudes and practice must be.

## Christian teaching

One of the glories of Judaeo-Christian teaching is the understanding that human life is special. For Christians it therefore follows the main issue is when human life starts, and whether we have any right to take away that life. In the absence of a clear biblical statement about conception as we now understand it in biological terms, there are two concepts I find particularly helpful.

The first concerns the conception of Jesus. Part of the supreme mystery of God’s plan for the redemption of humanity is that God could not only become a man, but experienced (by implication) nine months of intra-uterine life (Luke 1 and 2, slightly expanded by Matthew). Furthermore, after explaining that the universe was made through Jesus, Hebrews 2: 17 tells us ‘he had to be made like his brothers in every way’. So I see no reason to doubt that God could for a short time become a single cell just as we all once were, or that the sovereignty of God extends to our conception just as it did to that of Jesus.

The other passage is Psalm 139 which in poetic language tells us, in the context of man’s place in creation:

*‘You created my inmost being;  
you knit me together in my mother’s womb.  
I praise you because I am fearfully and wonderfully made.’*

Prenatal life is spoken of as an integral part of our whole life, lived in the context of a universe where we cannot flee from God, where my individuality started before my birth and where it will continue indefinitely into the future. Furthermore, until the last few years Christian teaching has been consistently anti-abortion. If we believe life starts at conception, we must examine our attitudes to PCC as rigorously as towards abortion.

## In practice

Requests for PCC are almost always ‘emergencies’, since the hormonal method must be started within 72 hours of unprotected intercourse, or an IUCD inserted within five days. Women are naturally anxious to avoid an unwanted pregnancy, and

expect prompt treatment. Posters and other publicity lead them to assume doctors they contact will comply with their request. The request is often reasonable. The woman has acted swiftly to avoid a pregnancy which apparently no one wishes. There is unlikely to be any serious physical complication following PCC. Furthermore, since any embryo is still microscopic, it can hardly be considered abortion, can it? To add even more weight to the PCC argument, the chances are usually fairly slim that the woman is indeed going to have an implanted embryo in her uterus at all.

In such a situation, a doctor refusing PCC needs to be certain he or she is doing the right thing. In my view, there is no utilitarian or medical reason to refuse except in the rather unlikely event of contraindications. Refusal on ethical grounds is going to put the woman, and to a lesser extent a colleague, to some trouble for reasons they will probably not appreciate.

## What I do

If we are going to refuse PCC requests we need a clearly thought out procedure we actually put into practice. I discover the facts. If there seems only a remote risk of conception (ie very early or late in the menstrual cycle) I will often check my facts with a partner better informed about contraception. If PCC seems indicated the choice is between referral to:

- another doctor in the practice
- a local family planning clinic (I keep details handy, and usually give them to the woman if I suggest this)
- the A&E department (I have checked with my local hospitals about this)

I try and emphasise that the woman should return if there are problems (rare in practice) and document my actions. Whenever I have explained why I am unwilling to prescribe there seems little comprehension - getting the tablets is a far more pressing concern. I cannot remember an occasion when a young woman requesting PCC was accompanied by a man, an absence that speaks loudly.

## Conclusion

Most people in Britain today think that one’s sexual behaviour, if involving another over-16 year old who is consenting, is a matter for self alone. I think this is a cheap lie, and anti-Christian. Flaunting God’s rules brings with it unpleasant consequences, not only for those indulging themselves, but for those around them. This includes those unable to protect themselves, especially children.

Unfortunately, if we teach the contrary view that God is concerned about everything we do and considers sex so good it must be kept between husband and wife, we are seldom heard.

**John Holden is a GP in Wigan**

# Euthanasia:

*where are we now?*

## Following the recent murder trial of a British GP, *Triple Helix* reviews some headline issues in the worldwide euthanasia debate

In late 1992, after Dr Nigel Cox had been found guilty of attempting to murder a patient in a euthanasia scenario and after the first court ruling that food and fluid could be withdrawn from Tony Bland, the Hillsborough victim in a persistent vegetative state, the UK House of Lords set up an enquiry into euthanasia and related issues. Initially it was expected to favour legal moves towards euthanasia, or at least be divided, but in February 1994 it reported unanimously that 'there should be no change in the law to permit euthanasia'.<sup>1</sup> What has happened since then?

### The Dr Moor case

Although the case came to trial this April, the story began in July 1997. Dr Michael Irwin, Chairman of the Voluntary Euthanasia Society, former GP and former medical director of the United Nations, made the front page of *The Sunday Times* under the heading 'Doctor admits killing 50 people'.<sup>2</sup> The same day an enterprising reporter in the north east asked local GP and media celebrity David Moor about his views. He too admitted helping patients to die - his claims in subsequent interviews ranging from 100-300 over 30 years - and one of these had been that week.

The police halted a planned cremation, began investigations, and Dr Moor was later charged with the murder of his patient, 85 year old George Liddell, a retired ambulanceman who had undergone surgery for bowel cancer. At the committal hearing in September 1998 the 'Friends of Dr Moor' with the support of the Voluntary Euthanasia Society hired a six piece Dixieland jazz band to perform outside the court: 'We wanted Dr Moor to be uplifted by what he saw'.<sup>3</sup>

The murder trial began in Newcastle this April. The prosecution alleged intentional killing with diamorphine and said of Dr Moor 'By all accounts he was a dedicated, caring and hard-working GP and well-liked. But no man, whatever his station in life or private views, is above the law'.<sup>4</sup> Dr Moor's defence in court was that his only intention had been to relieve Mr Liddell's suffering, a statement under oath inconsistent with his many claims in live interviews in July 1997 about ending patients' lives.

For a guilty verdict, two criteria had to be proved: Dr Moor's use of diamorphine had to have caused Mr Liddell's death, and



he had to have intended that. The acquittal was largely because the prosecution failed to prove the facts of the cause of death, the judge late in the trial ordering the jury to ignore much of the toxicological evidence. This meant that the second aspect of the charge, Dr Moor's real intention, perhaps received less scrutiny. After 18 days the jury of eight women and four men took just 69 minutes to clear the 52 year old doctor.

Much of the media coverage that day and the next predictably called for changes in the law so doctors should not have to practise in fear of prosecution, but in the days to follow more reflective comment recognised the value of the present ethical

and legal position. Jeremy Laurance, the respected health correspondent of *The Independent*, wrote<sup>5</sup> reversing the paper's line of the previous day:

'Easing the passing of those at the end of their lives demands skill as well as sensitivity. Opponents of the present law, based on the double effect doctrine, claim it leaves doctors vulnerable and confused about what is permissible. But it does not. The intention to relieve suffering is clearly distinct from the intention to kill. The doctrine of double effect has the virtue of allowing doctors to bring life to a peaceful and dignified end without jeopardising the patients' trust. It may not be the ideal option - no law can accommodate every eventuality - but it is the least worst. No other country has shown conclusively that there is a better way.'

Whatever Dr Moor really intended, Melanie Phillips<sup>6</sup> recognised that 'By acquitting him, the jury effectively upheld "double effect" and the crucial legal principle that intention is what matters', and went on the offensive against the Voluntary Euthanasia Society:

'So the VES now faces two ways at once. Far be it for the cynical observer to suggest that having championed Moor as a possible martyr to the cause, the VES now finds itself stuck on the fact that his acquittal has upheld the very doctrine it has tried so hard to destroy.'

*Triple Helix* has already covered intention in an editorial<sup>7</sup> and explored some of its Christian dimensions. In terms of short-term propaganda we were bound to lose whichever way the Moor verdict went; in terms of professional and public understandings in the medium and long-term, the case has been helpful in endorsing this key ethical principle. We now need to put that principle into practice, honestly and openly, and we need to give better palliative care than Dr Moor did.

### Physician assisted suicide

Because worldwide the euthanasia lobby is losing the battle for lethal injection euthanasia, there has been a marked shift of tactics towards physician assisted suicide (PAS). Most people can see no morally significant difference between the two, but some say they can. Perhaps they could tell us what that difference is?

The British Medical Association is currently committed to holding a conference 'to establish a consensus' on PAS and has to announce the arrangements for that conference at this July's Annual Representative Meeting. At its ARM in 1997 it 'overwhelmingly' rejected voluntary euthanasia. (Perhaps Michael Irwin's *Sunday Times* headlines a week or so later were a consequence of that decision?) It is unlikely the BMA can be persuaded to endorse PAS, but the arrangements for that conference are clearly of great significance . . .

PAS was of course what the citizens of the US State of Oregon voted for in 1994 when earlier referenda on voluntary euthanasia had failed in Washington (1991) and California (1992). The Oregon decision was put on the back burner for a while by an Appeal to the US Supreme Court, which in June 1997 decided

unanimously (much against expectation) that US citizens do not have a constitutional right to physician assisted suicide.<sup>8</sup> And this in the most rights-based society in the world! Ironically that ruling had the effect of putting the decision back to the State of Oregon. In November 1997 its citizens voted 60-40 for PAS, and despite some further challenges, a double figure number of patients have now been helped to die under the new law.

Elsewhere in the USA, maverick Michigan pathologist Jack Kevorkian - 'Dr Death' - finally went too far when a video of him giving a lethal injection was shown on nationwide television. Whereas he had got off repeatedly before on assisting suicide charges this time he was found guilty in March 1999 of second degree murder and sentenced to 10-25 years in prison.<sup>9</sup>

It is arguable that Dr Philip Nitschke practised something between euthanasia and PAS under the Northern Territory of Australia's short-lived Rights of the Terminally Ill Act (in force between July 1996 and March 1997 when it was overturned by the Federal Senate). He connected seven patients up to a computer controlled pump that sent a lethal cocktail of drugs intravenously, but the patients themselves pressed the space bar three times in answer to on-screen questions to start the infusion. A critical *Lancet* review<sup>10</sup> of his cases emphasises disagreements about prognosis and the difficulty of assessing the effects of depression.

### Withholding and withdrawing treatment

Although the practice of good healthcare means it may be perfectly proper not to start treatments, or to withdraw treatments which have been started if for example the burden of them comes to outweigh the benefit, the whole issue of withholding and withdrawing treatment can be related to the euthanasia debate if there is any suspicion of intention to kill.

A 51 year old British GP who withdrew a high protein food supplement from an elderly stroke patient (who died 58 days later weighing just 24.5 kg) escaped criminal charges but was found guilty this year by the General Medical Council of serious professional misconduct and suspended from the Register for six months.<sup>11</sup> (Like Dr Moor he too has retired from practice.)

This January *The Times*<sup>12</sup> ran a number of articles alleging that withholding food and fluids without court sanction from patients who were not at the ends of their natural lives had caused the deaths of at least 50 patients in five hospitals in Derby, Surrey, Kent and Sussex. Police and health officials are still investigating. Whilst probably some of those claims will turn out to be describing acceptable practice but poor communication with families and staff, the suspicion remains that in some there will have been an intention to kill.

In the light of these and (perhaps) other cases, in autumn 1998 the British Medical Association held a wide-ranging public consultation about withholding and withdrawing treatment. Its Report is expected this July. Christians have argued<sup>13</sup> we must all recognise that life has a natural end, but we continue to prohibit unnatural ends. They also expressed concern that rigid guidelines were not the answer, but rather there were time-honoured principles such as 'no intentional killing' which set

the boundaries within which the difficult and sensitive decisions can be taken in each individual case.

### Mental Incapacity

Advance directives (advance statements, advance refusals, living wills) are statements people make while they are mentally competent about the treatments they would like to receive and the treatments they would not like to receive should they ever lose competence and be unable to express their wishes. They can be useful general indicators of patients' feelings but those opposed to euthanasia have argued they should not have the further force of statute law.<sup>14,15</sup>

If implemented too rigidly they can force doctors and nurses to practise with one hand tied behind their backs. If they seek to enshrine suicidal intention in law this could be a backdoor approach into legally sanctioned euthanasia. One of the most widely accepted definitions of euthanasia ('the intentional killing by act or omission of a person whose life is felt not to be worth living'<sup>16</sup>) makes clear that patients can be intentionally killed by omissions as well as by positive acts.

The UK Law Commission held a series of consultations in the early 1990s on legal and medical aspects of mental incapacity, which led to draft legislation within a consultation document from the Lord Chancellor's Department<sup>17</sup>. There was widespread concern about backdoor euthanasia within the health aspects of the proposals and so far they have not appeared in Parliament as potential legislation.

On the other hand, of course, patients with mental incapacity do pose significant ethical and legal problems and deserve the very best care. British law dealing with these areas is patchwork and in need of modernisation and much that is uncontroversial in the proposals does need to be enacted.

### Conclusion

There are many other euthanasia-related issues which cannot be covered in this brief five year review of the headlines. How novel, for example, to see no reference to the Netherlands! What is clear is that throughout the second half of the 1990s there has been increasing international recognition by the professions and by policymakers that euthanasia is fundamentally wrong, is unnecessary, and cannot be policed.

But even if the front door is safely closed that leaves issues like physician assisted suicide, withholding and withdrawing treatments, and matters related to mental incapacity as potential back door approaches.

We have done well in the 1990s but as long as patients have bad deaths there will be pressures for euthanasia. Let's leave behind all thoughts of intentional killing by act or omission and go forward into the next millennium committed to practising high quality palliative care. That way may appear costly - but the alternative will cost us all far more.

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## Half all pregnancies outside marriage now

A report from the Office for National Statistics shows that around half of all the 800,000 pregnancies in England and Wales in 1997 occurred outside marriage, compared with one third ten years ago. It is further predicted that in ten years married people will be a minority for the first time in Britain, and the number of singles and cohabiting couples is expected to double within 25 years. (Source: *The Evening Standard*, 16 March 1999)

## Under-16 abortions rise 10%

Another ONS report shows that the number of girls under 16 who had abortions in 1998 was the highest recorded ever, at 3,748. This is a rate of 6 per 1,000 under-16s. The rise in abortions for all teenagers was 11%. 'Inequalities in life, low life expectations, a lack of sex education and the inability of young girls to say no are all to blame' said a Family Planning Association spokesperson. (Source: *The Independent*, 28 May 1999)

## More contraception for under-age girls

The government's Social Exclusion Unit has been looking at ways of reducing Britain's teenage pregnancy rate and amongst 'wide-ranging plans' hinted at is a commitment to making contraceptives more freely available. However, the government denies that school nurses will be empowered to prescribe the Pill in schools - 'That is not what school is for' a senior Whitehall source said. (Source: *The Independent*, 10 May 1999)

## Abandoned baby cases treble

This catalogue of social disintegration continues with the news that more than one baby a week is now abandoned in England and Wales, a figure that has trebled in the last decade. Poverty, teenage pregnancy, family break-up and the pressures of trying to be the perfect parent are blamed. Mother and child are reunited in 85% of these cases, though amongst the remainder some babies are found dead. (Source: *The Independent*, 20 May 1999)

## AIDS now fourth biggest killer worldwide

A WHO report reveals AIDS has now overtaken TB and moved up from seventh to fourth place among all causes of death worldwide. It is beaten only by heart disease, stroke and acute respiratory infections. This was brought home to Eutychus recently when he heard in church of two Zambian schoolgirls who died of AIDS just after completing their GCSEs. (Source: *British Medical Journal*, 22 May 1999; 318: 1370)

## The heritage of humanity?

Article 1 of the UNESCO 'Universal declaration on the human genome and human rights' states: 'The human genome underlies the fundamental unity of all members of the human family, as well as recognition of their inherent dignity and diversity. In a symbolic sense, it is the heritage of humanity.' Are they perhaps talking about the image of God? (Source: *Bulletin of Medical Ethics*, March 1999; p8-11)

## Dolly ageing fast

One of the two pieces of biological evidence published in May constituting consequentialist arguments against human cloning was in a report in *Nature* that telomeres on Dolly's chromosomes are shorter than they should be for a three year old animal and are more consistent with a sheep aged six. As commentators have put it, maybe at birth she was 'mutton dressed as lamb'. (Source: *The Independent*, 27 May 1999)

## Doctors last in safe driving league

When insurance company Zurich Municipal conducted its annual survey of claimants, doctors ranked last out of 11 groups of public sector workers. Zurich said doctors tend to drive under great strain after working long days and at all hours. Perhaps Jehu was medically qualified? (Source: *BMA News Review*, April 1999, p11)

## 'Gay gene'- jury still out

A team of scientists from Canada and the US has failed to connect male homosexu-

ality with Xq28, the chromosomal segment controversially suggested six years ago. They studied 52 sibling pairs and found that gay brothers were no more likely to share Xq28 markers than would have occurred by chance. They are now looking elsewhere in the genome for a genetic basis for sexual orientation. Even if they find one, what will it mean? (Source: *Science*, 1999; 284: 665-666)

## Children have rights to 'spiritual comfort'

The World Medical Association's Declaration of Ottawa on 'The right of the child to health care' includes at section 30: 'Religious assistance. Every effort should be made to ensure that a child patient has access to appropriate spiritual and moral comfort, including access to a minister of the religion of her/his own choice.' (Source: *Bulletin of Medical Ethics*, February 1999; p9-11)

## Love not science puts meaning in our lives

Reflecting the explosion of discussion on genetics and ethics, the *Journal of Medical Ethics* recently devoted almost an entire edition to the subject. Eutychus was particularly touched by an article from Australia by a mother who described the impact on the family of discovering that two of their three sons had adrenoleukodystrophy. She concludes 'If you came to our house and made the medicine milkshakes you would see little boys not disorders. My sons are special people, beyond their genetic flaw and it is love not science that puts meaning in our lives.' (Source: *Journal of Medical Ethics*, 1999; 25: 195-199)

Eutychus

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# Among All Nations

Summer 1999  
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Christian healthcare worldwide

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Photo: Liz Anderson

## Is health policy rational?

We kid ourselves we are rational beings, with a capacity for reason we use as and when we want. The World Bank sees health, nutrition and population as integral to its economic policy. It admits it does not have the technical competence of WHO, but it has a lot of money and intends to use it, one Bank economist saying 'Policy based lending is where the bank really has power - I mean brute force'. The Bank also sees itself as a 'knowledge bank', but if it thought brute force could win patient concordance or community participation it would possess knowledge without wisdom.

Part of Christian mission is interpreting God's view of his creation. The age of medicine as pure public service is not over. Unless there is more reason than economic policy to care for the

1.3 billion people living in absolute poverty, mankind is likely to destroy himself and commit 'globicide'. But there is a creator who has given man rationality and in Christ has given reason to use it for a higher purpose than self interest.

Why are Christians not having more effect on world health? It must be the result of the combined choices of every individual who could have been involved. Yet one individual's choice based on truth is ultimately more powerful than all the brute force of a policy that is not. That choice is to implement faith by action and not succumb to the brainwashing of the world, however weak the action based on faith may appear. The cross is inevitable in the Christian life but it is the way that leads from truth to God's kingdom.

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*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.

# Who is the true mission doctor in Africa?

**asks surgeon Michael Cotton as he suggests Africa's greater need is for managers and administrators**

Gone are the days when European doctors went out to join fellow senior staff in a remote but well-equipped and well-organised mission hospital. Most nursing staff and many of the doctors are now locally trained, and a European may arrive to head a team of locals with little knowledge of the local set-up and no experience of it.

## **Sense of alienation**

It may come as a surprise to find that in strictly missionary terms, there is no need for the doctor at all! African churches are more alive, more spiritually aware, and have many more faithful members than those at home. Furthermore, the institution is now in the control of a local organisation, and has its own hierarchy, often more traditional and immovable than its parent European body. That organisation may have lost its vision, and be wracked by internal division, social scandals, and, most commonly, frank embezzlement. No wonder the doctor just gets on with medical work, only too happy to get out of the long-winded committee meetings at which little is decided and less resolved.

The European may find himself or herself working alongside a local practitioner with more experience, and indeed more expertise. This colleague does not struggle with the local language. The doctor may be surprised to find his or her standing locally is not as high as expected and that recommendations and medical orders are not universally accepted. Frequently, the apparently good ideas meet with an overtly positive response but nothing changes, because the local staff are too embarrassed or too polite to argue their case openly. A sense of alienation develops.

The European remnant in a hospital may stick together socially in an enclave, often regaling each other with stories of the locals' incompetence or ignorance. The tendency for superior racist thinking to encroach is then great, and this further alienates the European doctor, who anyway often has a living standard far above those around (simply in terms of books, furniture, cooking facilities, video/TV/computer etc). An outsider who questions how much impact the medical missionary has is met with bemused silence.

## **Radical rethink**

It may well be that the role of medical mission must be radically rethought. Where a national government fails to provide medical services, a mission can step in to fulfil this function - but this needs great sensitivity and tact, and a deep knowledge of local tensions, needs and politics. The mission should probably co-operate rather than compete with government in

providing medical input. Yet whenever a mission begins to work with official national agencies, it seems that financial support from Europe flies out the window. Support is based on individuals, and one person on his or her own can generate a lot of valuable backing.

A major need in Africa is not for doctors and other health professionals but for administrators. The singularly vital role of the administrator is too frequently downplayed by mission societies; yet even in a small hospital many thousands of pounds pass through the system. What a temptation for a local, however well-meaning, who sees his lifetime earnings pass before his eyes (on paper at least) in a month! How tempting to use these funds to help out a distressed relative in genuine financial difficulties! How easy to forget this misdemeanour when it is never noticed because no audit is kept! How readily money disappears into personal projects . . .

Not only is the European manager unaffected by these peculiarly African temptations, but he or she has administrative skills gained from working in a well-ordered society unlike the chaotic African *melee*, is computer literate, has a good knowledge of accounts, etc. However, most importantly, he or she has contacts in Europe and hopefully knows how to write appropriate proposals to donor agencies for obtaining funds. These are highly developed skills that doctors neither have, nor have time to acquire.

## **Who is the true mission doctor?**

In all this, the position of the doctor working in the government institution (usually for a pittance owing to drastic devaluation of the local currency) has been overlooked. He or she has very little control over the work situation, over colleagues, and over disposal of the resources available. Yet he or she is in the real world, battling to provide a good medical standard when many colleagues have disappeared after 10am because the demands of private practice supervene. The poorest of the poor patients is someone for whom Christ died, created in the image of God Himself, and the doctor refuses to allow them to be shunted around by officious or uncaring hospital clerks.

The doctor covers for colleagues who have vanished on their night on-call, does not get pushed around or compromised by the big-shot politician, may even have to dirty hands in the muddy waters of local politics for the benefit of those with no voice, and is willing to treat the patient with HIV who is shunned by the rest of the staff.

This doctor is the true mission doctor of 1999 . . . yet how many mission societies recognise or support such a person?

**Michael Cotton is a consultant surgeon in Bulawayo**

# Handing on the baton

## Peter Taylor, another missionary surgeon in Africa, argues there's still work for expatriates and Kisiizi needs several!

In a mission hospital today the doctor needs a broad based clinical competency, and in addition often needs skills in personnel management, financial accountability, stock control, building maintenance, continuing medical education and liaising with central government about district health policies. One minute he or she will be devising staff rotas, the next approaching donors abroad, then assessing the future clinical development of TB work, then helping out in outpatients. Running a mission hospital can appear like juggling balls in the air, but there seem to be many more balls than at home and often there is a strong wind blowing in your face at the same time.

Here at Kisiizi Hospital the staff comprises five doctors (of whom two are expatriate), five clinical officers, 40 trained nurses and 40 student nurses and untrained assistants. There are many areas of recent development. The surgical theatre is busy every day, and the range of cases was recently expanded with the appointment of a surgeon.

Kisiizi has just been approved by the Ugandan government to train enrolled nurses. The hospital is trying to make its services accessible to the disadvantaged and has pioneered a community-based health insurance scheme and a community programme for the physically disabled. A rehabilitation centre is being built offering physiotherapy and occupational therapy and a mental health programme encourages the community to bring people to the hospital for treatment. Kisiizi is becoming more integrated within the government's health policy by being given responsibility for the local sub-district.

Kisiizi has always had the spiritual witness of the hospital at its heart, with the holistic vision of its founder to 'bring life in all its fullness'. It has had a strong impact in the local church and many of its staff have moved on to appointments in the government service far and wide.

However, there are two key vacancies coming up. First, the medical superintendent is returning to the UK in a year's time. At present there isn't a national doctor ready to take his place. Secondly, the surgeon will also be returning, in two years. A national doctor is going for specialist surgical training but there will be a two year gap before his return. Why do we need to replace these people with expatriate staff?

One key reason is money. Kisiizi was deliberately set up in a rural area to meet the needs of the poorest. Today, only half the budget comes from patient fees. The rest comes from individual supporters overseas, NGOs, and the government, which provides less than a quarter of the budget deficit.

Expatriate staff come free of charge and with a wide network of contacts they can use to promote the development of the hospital. An equivalent national doctor would cost more than the hospital could afford. It is also a difficult reality of life that when expatriates leave, the readiness of NGOs to support projects also declines. National doctors are under huge pressure to employ their relatives and friends and provide financially for the school fees of their dependants. In their own comments to us here at Kisiizi, they are fearful that if development slows down or salaries are not paid under their leadership, then they will be accused of 'eating the money'. They are glad to be free of these pressures.



Photo: Peter Taylor

A second reason for wanting to use expatriate staff is less obvious. Although the development of Kisiizi has been marked by a steady improvement and expansion of services, it lives permanently on the edge of sustainability. When crises come, adaptability and lateral thinking are needed to get round the problem. Equipment tends to lie broken. Staff do not have the background of Meccano sets. It is sometimes easier for the expatriate to mend a broken suction machine or design a new computer database. In the NHS, doctors become exposed to many different styles of management which can be used for mission hospital problems.

The work represents a deep and testing challenge with a unique level of satisfaction. A previous medical superintendent said 'Working here is like a marathon relay race and each runner does his best until handing on the baton to someone else'. Are you up to the challenge?

(See job descriptions under 'vacancies overseas')

**Peter Taylor works at Kisiizi Hospital in Uganda**

# Does Romania

## Joy Moore is convinced the answer is 'yes'

Ten years ago we watched our television screens in amazement as Laszlo Tokes, a priest of the Hungarian Reformed Church in Romania, preached to his congregation in Timisoara. His faithfulness to the gospel and determination not to succumb to the directions of his bishop, who was a communist lackey, resulted in the 1989 revolution and the downfall of the Ceausescu regime. Before long our screens were full of dreadful pictures of Romanian orphanages and of the impoverished population who had spawned them.

Many charities moved in to help. Amongst them was The Hawkesly Christian Romanian Trust (or to use the Romanian abbreviation, ATCH-S) established by an English couple, Steve and Mandy Hughes. Seeing that aid was not enough they settled in Sibiu, a university town in Transylvania graced by beautiful Saxon architecture.

## Medico-social and spiritual needs

Steve was an Anglican clergyman and Mandy was a health visitor. Two needs were apparent to them; one medico-social and one spiritual. On the medical side the hospitals were ill-equipped, the status of nurses was very low, and community care was pretty well non-existent. Those with the greatest need received least. Those who were the most able received most. No one received much.

On the spiritual side the population had a number of ethnic groups, each with its own predominant denomination, worshipping in its own language and ministering to the cultural as well as the spiritual needs of its people. There was a need to meet together across the divides of history, race, language, politics and denomination and to be reconciled through Christ with each other.

Two interdependent centres were started, a health initiative in Sibiu and a reconciliation centre with residential facilities and conference rooms in a village 12 km outside Sibiu.



Photo: Joy Moore

Romanians love being photographed

## Fact finding visit

In 1997 I was coming up to retirement as a consultant community paediatrician. One of the clergy at my church suggested I help the Hughes. I went on a fact-finding visit. My work had been mainly advisory to the Local Education Authority and to Social Services on children with special needs. I had also been much involved with child protection work. I did not know whether this type of experience could be translated to the Romanian situation.

By the time I arrived in Sibiu in April 1999 Steve had been appointed to the post of Chaplain to the British Embassy in Bucharest. Mandy remained a director of the Trust, keeping a watching brief from a 6 hour train journey across the Carpathian Mountains.

The work of both centres had been left in the hands of a young enthusiastic team of Romanians who had just welcomed an



28th April 1999 - the church is derelict

Photo: Joy Moore

# still need us?

English health promotion officer working with VSO.

In the ATCH-S offices I found this Chinese proverb framed on the wall:

- If you are thinking one year ahead sow seed
- If you are thinking 10 years ahead plant a tree
- If you are thinking 100 years ahead educate the people

It was clear this sentiment has been at the heart of the work.

## Nursing links

Mandy had established a link with Lancaster University and a number of Romanian nurses are on British nursing courses. A School of Nursing is currently being established in Sibiu by an English nurse tutor from Lancaster University. There are regular visits to the ATCH-S centre from a British health visitor and a group of British family planning nurses have run courses for the staff. Good relationships have been developed with the Sibiu hospital medical staff and the ATCH-S centre is used for parentcraft classes. It is also used by the newly established Romanian Down's syndrome group for whom ATCH-S is running literacy classes with a group of Down's children.

The hospitals in Sibiu are staffed by able doctors and much equipment has been given by Belgian, German and Dutch hospitals. Nevertheless the levels of staffing, equipment and patient care cannot be compared with those prevailing in UK hospitals. There was for instance no adequate equipment for testing the hearing of handicapped children.

Many of the conditions treated are rarely seen in England - for example rickets, congenital syphilis, and ascari infections, to name but a few. There is ample scope



Ada, the ATCH-S nurse, dispenses antibiotics in the open ... the family hut is rat-infested

Photo: Joy Moore

for accident prevention. Parents work in the fields and children are often left unattended. There is no child protection system in Romania. One nurse told me when showing me a one year old with syphilitic anal condylomata that child sexual abuse does not exist in Romania! Other nurses asked for teaching on child protection.

## Can anybody help?

One day I was asked to do the clinic at a village some 75 km from Sibiu. Whatever was said about a health service for everyone, the reality was far removed from the theory! We drove in the ATCH-S jeep over the hills on a mud track. The village street was a deeply rutted mud quagmire. The clinic room was primitive; there was only a stethoscope and a very unreliable sphygmomanometer. It felt as though the whole village had turned out to see us! We had few drugs; what we had were German and most people could not afford to buy them. Hypertension was a major problem.

I met many very well educated young people but the village schools I visited were extremely impoverished. None of the children in the literacy classes was wearing spectacles. At least two of the pupils had very marked squints and one of these took no part in the lesson at all. Do these children really get hearing and vision tested as in the UK? I doubt it.

Back in the office of ATCH-S in Sibiu I watched the literacy class for the Down's children. Nuti who takes the class is a village girl who is gentle and kind and who needs some input from someone skilled in teaching children with special needs.

So is there anyone reading this who feels they may be able to help?

(See 'vacancies' overleaf)

**Dr Joy Moore is a retired paediatrician who lives in Surrey**

# vacancies overseas:

Please note that healthcare 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. A much longer list of Opportunities of Service mostly through UK-based mission societies is available in the MMA magazine *Saving Health* (see box).

## AFRICA

### Kenya

The Children of God Relief Institute care for HIV orphans and abandoned babies. State-of-the-art laboratory with viral study capability. A competent person could act as teacher as well as work in the laboratory. Room, board and pocket money can be provided. Contact Angelo D'Agostino, Founder and Medical Director, PO Box 21399, Nairobi. Tel. 716829. Fax 718711. E-mail nyumbiani@users.africaonline.co.ke

Chogoria Hospital urgently require surgeon from September for two years until a Kenyan doctor returns from training. Job description includes teaching surgery to interns and trainee GPs. Contact Dr Gordon McFarlane, Medical Officer in Charge, PCEA Chogoria Hospital, PO 35, Chogoria, Kenya. Tel. 0166-22620. Fax 0166-22122. E-mail chogoria@africaonline.co.ke

### Malawi

Children of the Nations in partnership with African Bible College of Malawi plan a medical team October 16-31. Need surgeons, OR technicians, nurses, O&G, anaesthetist. The team will be establishing services in a new hospital in Lilongwe. Cost \$3000. Contact Chris Clark, 12804 Lake Ave, Suite 101, Poulsbo, WA 98370, USA. Tel/Fax 360-598-5437. Email chrisclark@integrityol.com

### South Africa

Links International in partnership with Pioneer Network - project manager for the basic health care courses run twice a year in South Africa is looking for health professionals to join teams in Transkei. Contact Peter Doherty, 3 Home Close, Harlow, Essex CM20 3PB. E-mail gcf@globalnet.co.uk

### Tanzania

Murgwanza Hospital (Anglican mission) requires short term (up to 3 months) or long term (2yrs+) doctor from November. Busy 170-bed hospital in the NW serving local population and Burundi refugees. Surgery and obstetrics very useful. Swahili not essential for short term work. Three other doctors. Contact Stephen Reaney, Murgwanza Hospital, PO Box 7, Ngara, Kagera region, Tanzania. Fax (c/o UNHCR) +255 66 22507. Or contact Janet Horsman, Crosslinks, 251 Lewisham Way, London SE4 1XF

### Tunisia

GP urgently required to head a project with ACT. Contact Paul Bendor-Samuel, E-mail 100450.625@compuserve.com or in UK, John Passmore, E-mail johnpassmore@compuserve.com

### Uganda

Future staff needs envisaged at Kisiizi Hospital (see p11) include: medical superintendent in a year's time. Applicants should have GP or similar medical training and preferably previous experience in mission hospital work. Could be considering early retirement and post could be restricted to mainly admin and supervisory duties. Surgeon in two years' time as a short term replacement until a national doctor returns from specialist training. Contact Dr Lionel Mills, Kisiizi Hospital, PO Box 109, Kabale, Uganda. Fax 00871-761-587166 or Chris Hindley, Personnel Secretary with MAM, 157 Waterloo Road, SE1 8UU. Tel. 0171-261 1370

Kiwoko Hospital (See Issue 2 Winter 1997/98). Surgeon needed from January 2000 to run growing surgical department and train local doctors. Contact Dr Nick Wooding, Medical Superintendent, Kiwoko Hospital, PO Box 149, Luwero, Uganda. Fax 00 871 761 890 389 or 00 256 41 610132

## ASIA

### Bangladesh

Mark Pietroni at the Lamb Hospital has a short term project and would value support from a physician/GP at least until end July. Work mainly children and infectious diseases and he will be able to provide support if needed. English can be used. Hospital also needs short term anaesthetists to train their nurse anaesthetists. Contact Mark and Theresa Pietroni, Lamb Hospital, Parbatipur, Dinajpur 5250, Bangladesh. Tel. +880-552-69011. E-mail lamb@citechco.net

## Pakistan

Jane Sampson wants GP replacement for herself in an isolated valley. Married couple may be best. Christian schools available. She sees 80 outpatients a day. 15-bed hospital opening this year under Dr Haroon. Knowledge of Urdu, TB, leprosy, obstetrics and child care an advantage. Contact Dr Sampson, Kumhar Christian Clinic, Balakot Road, Garhi Habibullah, Mansehra District, Hazara, Pakistan. E-mail kcc@kccsample.undp.org

Surgeon to replace CMS New Zealand partner at Peshawar Hospital. Contact Kevin Haskins, Mission Hospital, Dabgari Gardens, Peshawar, Pakistan. Tel. 00 92 91 212371. Fax 00 92 91 214157. E-mail healing@pes.comsats.net.pk

## EUROPE

### Kosovo-Albania

CORD (formerly Christian Outreach) is responding to this emergency with MEDAIR and ZOA. Urgently looking for health professionals to work in Albania with refugees. Contact Kay Bugg, CORD, 1 New Street, Leamington Spa, CV31 1HP. Tel. 01926 315301. E-mail CORD\_UK@compuserve.com

### Romania

(See article page 12/13) Opportunities for: GP to work in rural clinics for at least a year, audiologist, health professional able to run courses on developmental assessment and on child protection. An elective might be arranged for a medical or nursing student. Also teacher with experience in learning difficulties and spiritual leader for Reconciliation Centre. Contact Dr Joy Moore, 72 Newton Wood Road, Ashted, Surrey, KT21 1NP

### Russia

Three doctors known to CMF have started the first hospice service in Samara, one of Russia's five biggest cities. Most people below poverty line. A businessman has made available some facilities. Need healthcare professional who can share the experience of similar work. This will open a way to the church for many. Contact Olga Korkunova, Hospice Director, E-mail agape@mail.radiant.ru or this office

## resource:

### New location for *Care for Mission*

CFM expects to be moving between June 18-July 7. New contact details: Care for Mission, Elphinstone Wing, Carberry, Musselburgh EH21 9PW. Tel. 0131-653 6767. Fax 0131-653 3646. E-mail (unchanged) 100633.2065@compuserve.com

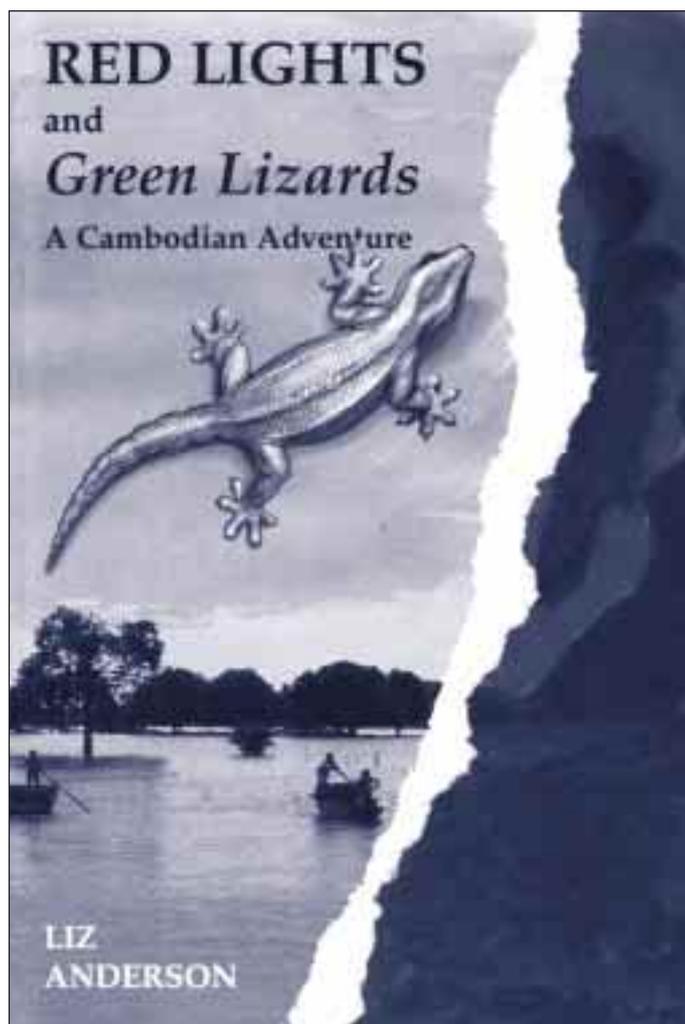
## request:

### Drug information centre in Indonesia

Dr Diana Dunn working with OMF in Singapore passed on a request from a colleague. He is opening a Drug Information Centre and would be glad to receive relevant publications which pharmacists and doctors receive free in the UK. Any extra copies would be sent to Indonesian hospitals which are using *BNFs* 3 to 4 years old. The *Drug and Therapeutics Bulletin* is also a useful tool as are any medical journals or their continuing education sections.

Contact: Dr Adji Prajitno, Kepala, Pusat Informasi Obat, Pusat Informasis Obat dan Layanan Kefarmasian (PIOLK), Fakultas Farmasi, Universitas Surabaya, Ji Raya Kalirungkut, Surabaya 60293, Indonesia

## review:



**Don Cormack, bestselling author of *Killing Fields*, *Living Fields* writes a review specially commissioned for *Triple Helix*:**

### Red Lights and Green Lizards

Liz Anderson. Wayfarer Publishing, Maidenhead. 1998. 298 pp. £7.99 Pb. ISBN 0 9534012 0 0

If not as a fly on the wall, then certainly as one of those ubiquitous little green lizards clinging to the ceiling, I was privileged to eyewitness some of the Cambodian adventures of British doctors Liz and Tim Anderson, now accessible to all in this outstanding book.

You know at once this is not going to be just another paperback. It is authored by a woman who matriculated from Newnham College, Cambridge in 1948, the first year in which women were accepted as full members of Cambridge University. But here is no self-important crusader. Dr Anderson's strength lies in her spirit of self-forgetfulness, winsomeness and pure delight in bringing pleasure to others. The Cambodians dubbed her Lok Yiey, 'Madam Grandma', a title of high esteem and affection. In Cambodia, age and wisdom are honoured.

*continued on p.16*

**Among All Nations** (AAN) is produced by the **Medical Missionary Association** (MMA) and **Christians in Healthcare** (CHC) in partnership with the Christian Medical Fellowship (CMF) as the international section of the CMF publication *Triple Helix*. The MMA also publishes its own magazine *Saving Health* (SH) which is designed for those wishing to know more about, pray for, give to and take part in medical mission. *Saving Health* is currently produced about once a year and a newsletter twice a year. *SH* and/or *AAN* 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 based in the UK wishing to hear of specific types of service opportunities in medical mission and who may be available as locums at short notice. 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. Websites: [www.cmf.org.uk/mma/home.htm](http://www.cmf.org.uk/mma/home.htm) and [www.healthserve.org](http://www.healthserve.org)

#### **Christians in Health Care**

Registered Charity 328018. Director: Mr Howard Lyons MSc FHSM. 11 Grove Road, Northwood, Middlesex HA6 2AP. Tel. 01923 825634. Fax 01923 840562. E-mail [howardlyons@msn.com](mailto:howardlyons@msn.com). Website: [www.christian-health-care.org.uk](http://www.christian-health-care.org.uk)

continued from p.15

How refreshingly 'foolish' are these two elderly 'naive' doctors from middle England, who throw caution to the wind and head off to one of the armpits of the world with VSO, an organisation generally associated with adventurous youngsters. Nevertheless, into the chaos, trauma and serious danger of post 'killing fields' Cambodia went Dr Liz and her devoted husband Dr Tim to whom the book is dedicated.

First they face the massive cultural divide and complexity of the Khmer language. They must learn to cope with the extreme climate and harsh realities of a nation still reeling from the prolonged terror of Pol Pot's Khmer Rouge, followed by occupation by communist Vietnam. With generosity of spirit and a seemingly unquenchable sense of humour, they plunge into a maelstrom of corruption and impurity where life is cheap, guns and gold rule, and the law of the jungle is supreme. They were sheep among wolves and herein lay the secret of their success. They were humble, teachable, aware of their inadequacy.

Pitchforked into the 'vanity fair' of contemporary Phnom Penh with no pre-negotiated blueprint to follow, Liz has to find her way through the physical and metaphorical wreckage of the capital's medical scene. Willing to fit in where she can and do virtually anything and everything by year two, Liz, along with her Cambodian colleagues, is able to pioneer a strategic medical initiative in Phnom Penh's largest red-light slum.

The medical, financial and bureaucratic challenges she faces, the ethical dilemmas, and the lengths to which she is prepared to go to actualise this revolutionary concept of a clinic and education centre right where the girls are, inside a local brothel, is the climax of the book. We learn much about the lives of the thousands of teenage girls swept up in the massive sex trade, the madams, the clients and the plague of STDs and spiralling HIV-positives which result: 'These are the prostitutes, frightened children hiding behind their clowns' masks of powder and paint, only their eyes betraying their misery' (p242).

Material for the book is drawn from vivid reflections distilled in her personal journal at the time. It is therefore a most thoughtful, intelligent and beautifully written work. She writes with great artistry and turn of phrase, whether describing a delightfully tacky hotel, a perilous journey through Phnom Penh traffic or detailing tropical diseases and medical procedures.

The book provides interesting political and religious background and is complete with helpful photographs. We learn to

share her genuine admiration for Cambodian doctors like the unsinkable Dr Vathiny, working tirelessly for long hours in unimaginable filth and inadequacy, for a mere ten dollars a month. We eagerly await news of the latest escapade of the incorrigible 'artful dodger' Ret S'mai, their guard. We are transported to Cambodia by this book.

You will not be able to put it down. It clips along, propelling the reader through laughter and grief. But its real strength is the spirit of the author which radiates from every page, an authentic spirit of simplicity, dogged faithfulness and courage. This account of the author's two whirlwind years in Cambodia reminded me of a kind of a latter-day Bilbo Baggins, who, with a simple willing heart and a gentle good-naturedness, unself-consciously takes on all the accumulated darkness and naked evil of Mordor, 'killing fields' Cambodia.

My wife and I laughed and wept, sighed and prayed our way through all the ups and downs, encouragements and setbacks. It was grieving to see how much of the time and energy of these two quite outstanding doctors was expended just on keeping body and soul together. They might have accomplished so much more with better support. And yet, therein, lies the irony. The fragrance which flowed from them to the Cambodian people might not have done so had they not been so 'weak', so physically and emotionally crushed. And I do not want to be on the side of Judas, protesting 'Why this waste?' They did something beautiful for God which gave him pleasure.

And for this most tragic and enchanting of nations, I covet workers with the heart of Liz Anderson. Anyone considering humanitarian service in Cambodia or in any other part of the world's cesspools, near or far, should read this book; not because it is an excellent case study, a 'how to do', but because it is a 'how to be', in the spirit of the greatest of all who went forth with healing in His hands.

I cannot recommend this book strongly enough. It is a rebuke to the growing spirit of ageism and narcissism in our culture. It lays bare the vital issues of cultural sensitivity and partnership in such overseas work. It declares how much needs to be done and can be done even in the most unpromising situations. It encourages us to realise just how much one single-minded person can do, even with minimal resources, if they possess resources of the heart.

**Don Cormack wrote *Killing Fields, Living Fields* (OMF/MARC)**



Photo: Liz Anderson

# ReviewWWs

## CyberDoc investigates Internet views on euthanasia

(The blue web-style underlines indicate hyperlinks on CyberDoc's website)

The Internet may be guilty of many things, but unlike Viagra you cannot yet purchase euthanasia online! An online [Encyclopaedia](#) defines euthanasia as 'either painlessly putting to death (positive, or active, euthanasia) or failing to postpone death from natural causes (negative, or passive, euthanasia), as in cases of terminal illness'. Most of the debate surrounds active euthanasia, although practices such as withdrawing nutrition might be considered in either category.

Probably the most helpful Internet resource is [www.euthanasia.com](http://www.euthanasia.com), full of links to articles from all over the Internet. The site is pro-life and includes such gems as the position of [the American Medical Association](#), and an article suggesting most [euthanasia requests will disappear with antidepressant treatment](#).

The [BBC News site](#) special report proved informative. The introduction cites the important 1992 Dr Cox case where a rheumatologist was found guilty of attempted murder by injecting potassium chloride. He was given a suspended sentence and continues to practise. Coverage of the recent [Moor case](#) succeeds in making the vital distinction between death as an unintended result of a painkilling injection and an intentional killing such as occurred in the Cox case. In many ways the Moor case simply confirms this principle of double effect - a doctor is ethical if s/he runs the known risk of a fatal outcome of a treatment, provided the intended outcome of that treatment was, eg, to relieve pain. This [principle](#) and its [limitations](#) are discussed in recent *BMJ* editorials.

Rather amusingly, on at least one of their pages, the BBC's link to the [voluntary euthanasia society](#) sends you instead to the Virginia Episcopal School! Adding the suffix 'UK' to the address takes you

to the correct site, where amongst other interesting points is their view that in fact many doctors do intend to kill when prescribing painkillers to terminally ill patients. They argue 'this is a hypocritical way for doctors to avoid accepting responsibility for the consequences of their action. In no other area of law is a good intention the only means of avoiding prosecution.'

It might be argued doctors should have to show they used sufficient discretion in the prescription, including perhaps considering using opiate antagonists where clear signs of opiate poisoning occur. Any doctor has seen, however, that the progress of a patient placed on an opiate drip is by no means certain. Doctors who wilfully prescribe massive doses without first trying smaller doses to control pain might legitimately be charged with such hypocrisy.

Unfortunately the BBC page entitled [Euthanasia and the law](#) was neither complete nor accurate. It states only a few cases have occurred in the UK in recent years. A false statement that Anthony Bland had a life-support machine switched off, when in fact he was deprived of nutrition (which the BBC itself states elsewhere) was removed when CyberDoc complained to the editor by e-mail. It is good the BBC was so responsive and shows how the Internet allows easy influence over such a prestigious information provider.

Unfortunately many significant cases are still not described and the CMF's [Euthanasia Update](#) page provides a much better summary of legal cases in the UK. Reading this, a disturbing picture of the UK situation emerges. Cases many would see as serious including depriving an elderly lady of food and drink are withdrawn from prosecution. On the few occasions a conviction occurs, the sentences passed seem grossly inadequate. It would appear from this reading that the UK is moving towards a position where euthanasia is unofficially tolerated. Conspiracy theorists among us might be forgiven for thinking that Moor was allowed to come to trial precisely

because it was so clear he would be found not guilty. One wonders how long it will be before a de facto legalisation of euthanasia occurs? - law that is not enforced is surely no longer law. This is the way other countries have gone.

The CMF pages also explore the biblical view on euthanasia, and include copies of submissions to governments, together with an article which strongly links euthanasia and abortion. The BBC provides an update on Dr Jack Kevorkian, an American promoter of euthanasia, who was thought unlikely ever to stand trial again. This April he was sent to prison having been convicted of murder. Somehow the existence of a website which portrays this ex-doctor (like a [BMJ editorial](#) before it) as a hero and proudly lists [his 120 victims](#) negates any sense of satisfaction this news might bring to pro-life professionals. For more information on this man and the American situation [Yahoo](#) has a comprehensive page of links, the best of which describes graphically [Kevorkian's lack of scruples](#).



The connection with abortion is interesting, with the medical establishment currently at least generally in favour of the pro-life position on euthanasia but not of course on abortion. (See for example the [BMA's response to Moor's acquittal](#).) Now 30 years have passed since abortion became acceptable, one wonders whether [euthanasia of the elderly](#) may shortly be firmly on the agenda, as one of the BBC pages seems to imply. Perhaps the generation that began killing its children will indeed be killed by its children.

CyberDoc is Adrian Warnock, an SHO in psychiatry on the Royal London Hospital rotation. Links can be found at <http://xtn.org/cyberdoc/euthanasia/>

# Learning *can* be fun!

## Dr Hilary Cooling believes in mutuality in care and learning

You don't need a classical education to know 'doctor' means teacher. Doctors are expected to teach, and the traditional apprenticeship model epitomised by 'see one, do one, teach one' is only gradually being replaced by skills-based teaching aimed at competencies which can be assessed.

From my early days of teaching groups and lecturing I wanted to know if it worked. Did my students actually learn? Did I pitch it right? After a two-day course on teaching for doctors in 1986 I enthused to my schoolteacher husband about knowledge, skills and attitudes, aims and objectives. I was met with a glazed expression, and realised he had spent a year learning this stuff! But I could now assess what the students knew initially, could assess whether they were learning, and could evaluate my teaching.

### Lifelong learning

How do we learn? We learn by mutual interactions and some pathways are obvious - we hope that patients learn from doctors, and that students or trainees do the same. Lifelong learning was not of course invented by the present government, nor even by the previous regime! A few years ago my attention was drawn to Isaiah 50: 4

*'The Sovereign Lord has taught me what to say, so that I can strengthen the weary. Every morning he makes me eager to hear what he is going to teach me.'*

I meet many patients and colleagues who are weary. The fact that the Sovereign Lord can continue to teach us so that we have something to give them is profound.

### Learning from patients

Learning from a patient bearing a newspaper cutting about the latest new treatment can be challenging! But more subtle learning takes place when, for instance, I think of Georgina. Pregnant at 15 and in a hostel for single mums when we first met, then several unsatisfactory relationships during which time we tried to help her with acceptable contraception, and now at 24 contemplating social work training with an attractive and self-assured nine year old daughter. People can change. This encourages me when I meet Sophia, now aged 20, in whom I diagnose yet another sexually transmitted infection. She had 'crabs' at 14, and her 16th birthday present was primary genital herpes. Maybe she too will be able to take more control of her life and relationships, while we offer non-punitive health education and necessary treatment.

As I listen to patients, especially those from ethnic minority backgrounds, I learn about varying health beliefs and tailor advice accordingly. The woman who believes 'bad blood is building up inside her' when she has amenorrhoea with Depo-

Provera injectable contraception requires more than the easy reassurance that having no periods is not harmful. If an explanation does not start with her health beliefs, she may discontinue the contraception method and risk pregnancy even though she does not want another child.

### Learning from students

One of the nicest letters I have received came from a gynaecologist who a few years earlier had undertaken training in family planning under my supervision. She wrote that the clinic was 'a model of how medical care can be offered with time and respect'. She had learned attitudes along with knowledge and skills, and this feedback, as well as giving me a warm glow, was evidence that teaching attitudes is worthwhile.

A question from a trainee or student which I cannot immediately answer is an occasion for learning as I resolve to look it up, or suggest we both go away and find out more.

### Learning from colleagues

Mutuality in learning is perhaps easiest to recognise here. Clinical meetings or grand rounds where a difficult case is discussed are an obvious example of such learning. Informal discussion with colleagues at the end of a clinic encourages reflection on my practice. A colleague whose training background, skills and consultation style differ markedly from mine has been a stimulus for me to learn new ways of working with patients, particularly those who are distressed. My attitudes have been challenged and I am more willing to live with uncertainty.

Alongside this I have had the rewarding experience of seeing her enhance her practical skills with my supervision. I have used her feedback to improve further my teaching of practical skills. This mutuality in learning is extremely stimulating and enjoyable. Learning with colleagues can be fun! A workshop for doctors on teaching in small groups included one group observing another attempt to complete a jigsaw - it was amusing seeing who was bossy and who ploughed on without regard for anyone else. This was a vehicle for looking at differing learning styles and how we can tailor our teaching accordingly.

Continuing medical education (or continuing professional development) is of course here to stay. However the mere accumulation of these 'brownie points' does not equate with better practice any more than reading the Bible or attending church of themselves confer spirituality. We need to learn and to incorporate what we learn into our day to day practice. For most people this is best achieved through a variety of learning opportunities, including problem-based learning with our peers and in multidisciplinary teams. It is an exciting time to be involved in undergraduate and postgraduate medical education.

## Hilary Cooling practises and teaches Family Planning in Bristol

# readers letters:

## What is 'a Christian practice'?

*On behalf of The Mission Practice, referred to under its previous name by Richard Montgomery in his letter (Spring 1999), Paul Jakeman replies:*

Having been a focus for Christian medical work for most of this century, we should perhaps have a pat answer, yet the present doctors in the practice are currently asking the same question! There are some things we are sure of: all the doctors and employed staff are practising Christians and we all believe that the Christian gospel has something to offer everyone who walks through our doors. We have a heavy workload among a deprived and needy population, and the partners would all cite our Christian motivation as the reason for being in the East End of London. We try to run the practice in as 'Christian' a way as possible, in terms of our clinical responsibilities to patients, students and PCG, and in our business probity in dealings with the Health Authority and commercial suppliers. We try to maintain the tradition of a five minute devotion (a 'thought for the day') immediately before morning surgery, to which any patients in the waiting room are invited, and we have recently established a role for a part-time chaplain, who is available for patients who wish to contact him, and who runs an Alpha course on our premises. We pray regularly together, and we hold ourselves accountable to a 'Council of Reference' made up of local church leaders.

Our vision is for a healing ministry in the name of Christ. The tension is what this means within a 'normal' NHS practice - we have to be professional in our dealings with our patients who have very different worldviews from our own. The six partners come from a spectrum of evangelical traditions, and we do not have uniform thresholds for raising spiritual matters within the consultation, any more than we have identical views on thorny ethical issues, though we do have a remarkable unity of purpose. We have recently been invited to take our exploration of Christian healing ministry further by supporting a non-NHS 'Whole Person Clinic'. This is seeking to minister to body, mind and spirit holistically and is currently under discussion.

We would welcome the opportunity to discuss these issues with others who wrestle with them, or equally with those who may be appalled at the comfort of our Christian ghetto - perhaps we should be spread around (as are many other Christian doctors in the East End and elsewhere) being salt and light individually in secular practices!

## Transplants: are the donors really really dead?

*David Hill's claims (Spring 1999) that brainstem death is prognostic and not diagnostic of death, and that this matters in transplant practice, have provoked some strong responses. Oxford consultant urologist and transplant surgeon David Cranston writes:*

As a surgeon who continues to be actively involved in transplantation, I would like to take issue with some of David Hill's

comments. He raises a number of important points which need further discussion.

All the transplant surgeons I know are acutely aware of the complex issues surrounding cadaveric organ donation and the care that is needed in dealing with the relatives, the staff and the wider public over these issues. It is one of the reasons why there is a clearly defined separation of the medical staff looking after the patient on the intensive care units from the transplant team. The staff in the ICU are responsible for doing all they can for the patient, and deciding when brainstem death has occurred. Two clinically independent doctors who have been registered for five years or more and have experience in intensive care normally carry out the diagnosis of brainstem death. (Two, not because of doubt, but for the reassurance of staff and the wider public.) One of the doctors is usually the consultant in charge of the patient and he should be experienced in intensive care and acute medicine.

At this point the transplant co-ordinator may have been contacted, but no other member of the transplant team is involved. The transplant surgeon has nothing to do with the diagnosis of brainstem death apart from checking the records before he operates to ensure the correct documentation is present. After the second set of tests has been done a death certificate can be issued. The transplant co-ordinator will speak with the relatives, openly and sensitively, about the possibility of organ donation. Many find a small measure of comfort in the prospect of helping other people in this way at this time of desperate sadness.

The transplant surgeon is now involved for the first time, and for the benefit of the recipient has an ethical responsibility to keep the organs in good condition during their removal. This may involve giving certain drugs to maintain blood pressure and a good urine output.

Finally, it is important to make it clear that the concept of brainstem death has not arisen because of the increased need for donors for transplantation. It has arisen because of the increasing medical technology with modern techniques of resuscitation that are now part and parcel of all ICUs. If transplantation were superseded tomorrow by better treatment of organ failure, patients who are brainstem dead would still occur wherever ICUs are established and ventilators would continue to be switched off. This is a code of practice that has evolved over the last 30 years from Harvard in 1968, Minnesota in 1971, and from the British Royal Colleges in 1976 and 1979.

*Former consultant anaesthetist and ICU director John Searle from Exeter also disagrees with David Hill:*

The discussion raises important issues about the definition of death and the ethics of removing organs for transplantation from brainstem dead individuals. If David Hill is right when he

says that the brainstem death tests are only prognostic and not diagnostic tests, his concerns about current practice are justified. The key question is: 'What is the relationship between death of the person and death of the brainstem?'

David Hill is correct when he points out that historically death has been diagnosed on the basis of there being no respiration and no heartbeat and no circulation. When the brainstem is irreversibly destroyed by disease or accident, respiration ceases, oxygenation fails and within a few minutes the heart stops beating and there is no circulation.

By the early 1970s doctors were able to interrupt this process by intubating a patient's trachea and ventilating the lungs with a machine. Thereby oxygenation was maintained, the heart continued to beat, and blood circulated, despite the patient being in the deepest coma. The question was 'Were such people dead or alive?' This situation is in no way comparable to patients who require mechanical ventilation of the lungs because respiration has ceased due to some cause which does not affect the brainstem or the level of consciousness, such as polio or demyelinating diseases.

Since, biologically, neither the lungs nor the higher centres of the brain can function without the brainstem it seems entirely reasonable to conclude that death of the brainstem is death of the person. Indeed, in my own unit it was always our practice to give the time of death as the time when brainstem death was diagnosed. What was then taken to the operating theatre for the removal of organs was a corpse, albeit with the processes of oxygenation being maintained artificially. The purpose of the brainstem death tests is not to determine whether or not the person is going to die but whether or not that person is dead.

Two ethical questions follow the diagnosis of brainstem death. First, can any medical intervention benefit that individual? Clearly the answer is 'no' which is why mechanical ventilation should be withdrawn. There is no benefit from ventilating a corpse. Secondly, can benefit be provided for anyone else? Clearly the answer to that is 'yes'. It is these answers to these questions which are the ethical foundation for the removal of organs for transplantation.

*Manchester pro-life commentator Stuart Cunliffe agreed with the article and believes something has to be done:*

The traditional criterion for death was irreversible cessation of respiration and heartbeat. Brain death criteria were introduced to provide prognosis of death if life support were withdrawn. Then the 1979 Memorandum of the Medical Royal Colleges<sup>1</sup> said brain death represents the stage at which a patient becomes truly dead. Doctors who said death would occur were now willing to say it had occurred already. 'Commonly,' the Memorandum said, 'death is not an event: it is a process, the various organs and systems supporting the continuance of life failing and eventually ceasing altogether to function, successively and at different times'.

We are Christians. We know that man is body, soul and spirit<sup>2</sup>. We believe that soul and spirit reside within the body and leave

the body at death. Life and death are absolute opposites. A patient cannot be alive and dead at the same time; there must be a moment at which death occurs. But when? When brain damage prevents communication and makes unassisted breathing a problem, or when the body ceases to function and evident signs of life cease?

'Brain death,' says the Memorandum, 'represents the stage at which a patient becomes truly dead, because by then all functions of the brain have permanently and irreversibly ceased'. I would challenge the truth of that last statement, which has not been and cannot be demonstrated. Proponents of the idea that brainstem death equals death may put forward a medical argument for moving from heart to brain in diagnosing death. But where is the moral and spiritual justification for it? Let it be produced.

Brain death was intended as a prognosis of death, not a diagnosis. Is it not true that the only time brainstem death is used as a diagnosis of death is when a patient's organs are wanted for transplant? Is it not significant that after two decades of organ transplantation, 'death' has not replaced 'brain death' as the diagnosis? Permanent lack of awareness is not necessarily death, even if it could be proven. The possibility cannot be excluded that some donors retain some degree of awareness during the surgical removal of vital organs.

I do not believe that brain death is death. Moreover, it is unethical that knowledge of the fact that the patient will be breathing and his heart will be beating when his organs are removed is being kept from potential organ donors and from next of kin being asked their approval for excision of organs from donors.

Something needs to be done.

#### References

1. Conference of Medical Royal Colleges and their Faculties in the United Kingdom. Memorandum on the diagnosis of death. *British Medical Journal*, 1979; i: 332
2. 1 Thessalonians 5:23

The Editor welcomes original letters for consideration for publication. They should have both Christian and healthcare content, should not normally exceed 400 words, and if accepted may have to be edited for length.

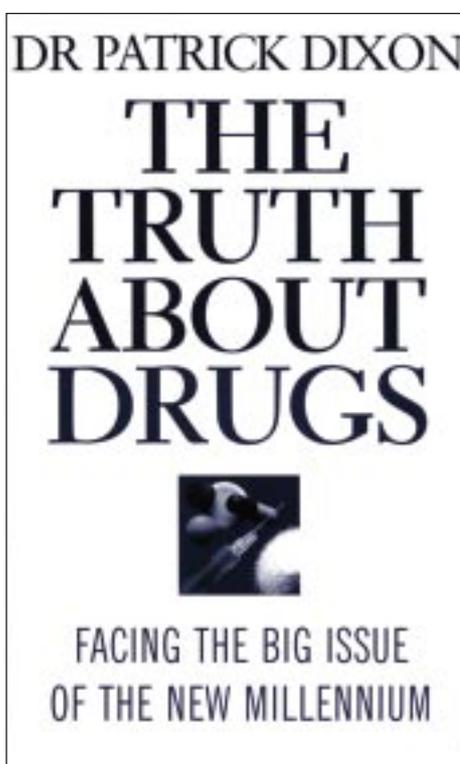
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# reviews:

## The Truth About Drugs

Patrick Dixon. Hodder & Stoughton, London. 1998. 279pp. £7.99 Pb. ISBN 0 340 66505 X

Setting out to read this book I recalled how blessed I had been by reading *The Truth About AIDS*. In it Patrick confirmed so succinctly the validity of unconditional love as the paramount approach of Christians in the caring field, authenticating the way a Christian drug agency should operate.



Sadly my anticipation that this latest book in the 'Truth' series would have the same seminal effect was not met. The book felt rushed, as though produced just to fill a niche, rather than being an expression of a burning concern on the part of the author. This so affected me that I found myself being very critical about details, rather than concentrating on the principles being illustrated. Where for instance he says 'current laws on smoking turn every smoker under sixteen into a criminal', I wanted to say that's not the truth. It's one of the absurd anomalies of our legislation that it's illegal for a shopkeeper to sell

cigarettes to a person under sixteen but the youthful purchaser commits no offence, either then or when he smokes them.

Whilst agreeing 'more research is definitely needed' to quantify more accurately the extent of UK drug use, his concentration on US figures (which 'have no parallel in Britain') was unhelpful to the point of irritation. Many of the American statistics he quotes seem irrelevant. In those cases where the UK figures are relevant, I would suggest they are available, eg 'preventable deaths'. Neither are they 'soft estimates, based on hunch, intuition and educated guesswork'.

Again, who could argue that future generations will find our approach to tobacco ludicrous? Surely though we could find the UK equivalent to 'If a single ten-year-old boy or girl in a school can be persuaded to start, the total extra sales will be up to \$100,000 over seventy years. Ten pupils are worth a million dollars.' Such a sober reminder of the potential to suppliers of getting someone 'hooked', whatever the drug, needs to be culturally explicit to make the point as forcefully as possible.

Despite previous cynicism about Government action to tackle drugs, I don't share Patrick's pessimism concerning the Government's new ten year strategy. Now, having been given substantial additional funding since this book was published, the signs are more promising.

Adding a question-mark to the title would, for me, give the book the credibility it lacks, making it a greater challenge, helping people to question more radically the morass of man's allurements to states of altered consciousness.

**Peter Farley**  
(Director of The Matthew Project, a Christian drug agency in Norwich, and member of the executive committees of the Standing Conference on Drug Abuse and the Evangelical Coalition on Drugs)

## Why Do They Do That?

Nick Pollard. Lion Publishing, Oxford. 1998. 160pp. £5.99 Pb. ISBN 0 7459 3760 8

Nick Pollard is a specialist in sixth form moral and religious education and this book is based on his experience of working with teenagers in schools and colleges. It examines issues associated with today's youth culture. Chapters cover the use of drugs, the soaring rate of self harm, eating disorders, sexual activity, etc. Many books have been written on this topic but I found Nick's approach to be stimulating and challenging. The reader is encouraged to look beyond some of the superficial explanations for adolescent behaviour such as peer pressure, self image, boredom. His personal knowledge of so many young people's dilemmas and problems is combined with an understanding of the development of Western thinking. In this way he sets these issues in the context of a post-Christian society in which belief in absolutes has been rejected, and scientific determinism has eliminated the belief in free will and hence responsibility for one's actions. He demonstrates how self image is now derived from the temporary icons created by society rather than from a belief in the absolutes associated with faith in God.

The final chapter is a challenge to the reader to respond to the needs of today's teenagers and those of the generations to follow. The task is twofold. The first part is to get alongside teenagers, to listen, and to begin to question the basis of their beliefs and choices. Secondly, Christians need to engage with our society so that belief in a Creator and Father God can replace the nihilism of post-modernism.

This is a book which will set you thinking, whether you are a parent, someone who works with young people, or are just wanting to understand the issues which face teenagers today. The analysis is lucid and pertinent. The only criticism would be that the final chapter is too brief to do justice to the challenge he outlines in it. When will you be writing the sequel, Nick?

**Elaine Crutchley**  
(Consultant Child and Adolescent Psychiatrist, Guildford)

## Being a Person - Where Faith and Science Meet

John Habgood. Hodder & Stoughton, London. 1998. 307pp. £8.99 Pb. ISBN 0 340 69073 9

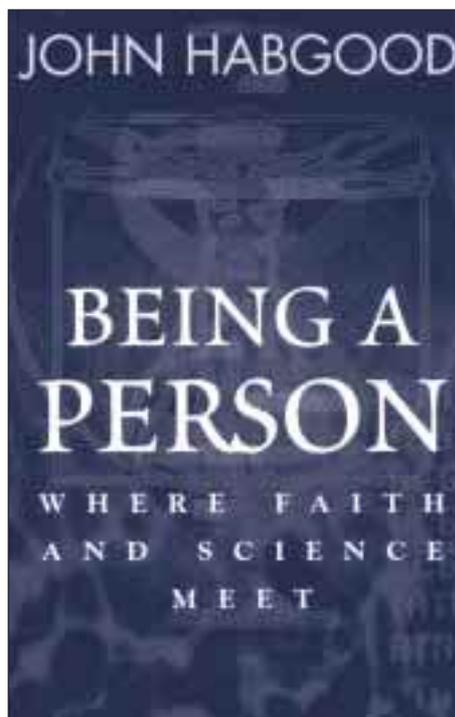
Described as a 'modest non-technical book for general readers', this is a remarkable success in exposing ethical problems about people. The style is transparently lucid, carefully expository and subtly humorous. An immense array of historical, philosophical and literary scholarship is used, with life experiences, in a light and open way which draws a reader on. The exposition of ethical dilemmas is deep, and carefully meticulous without burden, thanks to elegant language and illustration. An easy read indeed.

Careful exposition occupies the first two thirds. One looks to the rest for some good solutions; there are some indeed, but others are weak or questionable. So, a parson's egg, but extremely good in many parts.

The account begins with and refers back to two hard cases, the tragedies of Tony Bland and abortion. Others might have lacked such courage and started with 'normal' persons. The perspectives presented are postmodernism, science, consciousness, the role of language, evolutionary theory and theology. The first chapter deals with denying personality, dictators' techniques, illustrated from Lewis Carroll, Nietzsche, Kafka and post-modern 'demolitions'. The freedom issue figures prominently. Then Hillsborough; how may the possession of brainstem but not cortex constitute a person? There are long preliminary glances towards embryos and disabled persons. Factors which condition 'persons' are described - culture and communication - with that central problem of personal development, gradualist versus instantist acquisition of 'personhood'.

Then another key problem for today: is 'personhood' atomised independence or mutuality? There is an excellent presentation of the history of ideas from Greek and Roman projections on. Here the origins

and pivotal importance of the Trinity to the 'person' idea are exposed. 'Person' lacks self evident meaning; like a stocking it takes the shape of the packing. Trinity defines person, not vice versa; the 'image of God' concept contributes strongly; 'knowing God' is relation to him, not imagining him. 'Personhood' is evident to self. 'I AM THAT I AM' is self-existence; we are the same. There is a splendid critique of 'self-realisation' and 'self-fulfilment' philosophies. Descartes' dualism and Pascal's critique, and the importance (seen now, not then) of 'webs' and 'networking' are explained. (Cognosco ergo sum would have been wiser, Descartes.) 'Person' is largely recognisable by relationship, human and divine.



The mind-brain problem is presented, lucidly; 'emergence' is organised complexity; dualism and reductionism demolished (with Dennett), excellent stuff.

But there are some problems; the 'Word of God' is presented, but with a seeming implication which does not cohere with its biblical context. Its meaning is seen as the role of language in the declaration of personhood; but scripture presents this as divine authority, creative revelation, 'Godhead'; about how God declared personhood not singly about the importance to personal identity of declaration.

An evolutionary view of man is pervasive; we are told that this rules out a 'fall' (odd, in a text about persons and their relations to creation). The basic view is 'Darwinian' throughout in that it gives reason and observation prior place, at times alone. 'Miracle' has no place in personal evolution; God is not permitted to speak about who are persons, even if what he has said is analysed; the stance is 'observer' not 'listener' oriented. There appear to be two logical concerns here: if 'person' transcends observation, is greater than the body and its parts, then how is this entity recognised by observation? And if transcendent, why can't the revelation in scripture of I AM be authoritative for 'I am'? Is this a new version of 'God of the gaps'? Is what we can't explain what we are, persons? In presenting this view of the Word, does Habgood saw off his sedile?

This style follows; what it is to be a Christian is said to be 'an invitation to share an exploration of the human condition in the light of Christ . . .' Man again is agent, not God. But the 'on and up' Teilhard and Huxley view of evolution is demolished well, albeit on evolutionary grounds, not scripture. Paul, it seems, was seriously wrong about 'original sin'. But we do have the resurrection (with apologies, it is the only miracle to be mentioned).

So, with this background we draw near - to memory loss, to personality change, to PVS, to embryo loss and research, to abortion. The key arguments are gradualism, scientific fact, 'attributes' (cell differentiation into embryo and 'support services') and therapeutic intent. Genetic impact is discussed particularly well. But even if it were agreed that scripture can be taken variously on the earliest embryos or on the brainstem, there is a curious failure to record the clear scriptural statements about 'normal' persons, whether children in- or ex-utero, the elderly or the infirm. The key to understanding 'persons' is said to be 'theology'; God's personal revelations about it don't seem to figure. Again, oddly, the problem of 'attributes' is presented simply as the impossibility of knowing them in the

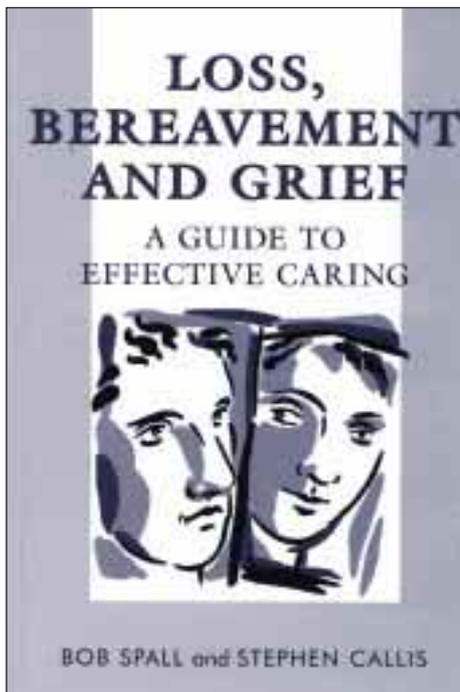
grossly diminished (Tony Bland), not for the genuinely theological if debatable reasons adduced by, for example, O'Donovan.

**Duncan Vere**  
(Emeritus Professor of Therapeutics,  
University of London)

### **Loss, Bereavement and Grief - a guide to effective caring**

Bob Spall and Stephen Callis. Stanley Thornes, Cheltenham. 1997. 198 pp. £14.99 Pb. ISBN 0 7487 3322 1

Books about counselling often suffer from two problems: they can be highly theoretical and can fail to address the needs of the healthcare professional. This book avoids those pitfalls. Alongside a review of various theoretical models, the authors draw on their experiences of real situations and people - professionals as well as patients - in the healthcare environment.



Bob Spall is a consultant clinical psychologist and the Rev Stephen Callis is a hospital chaplain and GP practice counsellor. They bring over 40 years' experience to this book, which is designed to help nurses, midwives, doctors, paramedics and social workers answer the question: What is required to be an effective helping professional?

Each of the 16 chapters ends with a summary of the main points and includes questions with which the reader can explore issues in more depth. Topics covered include dealing with change; being 'professional'; personal loss and its impact on work; understanding the death and bereavement process and dealing with it; techniques for breaking bad news; religious, spiritual and cultural needs; recognising when further help is required, and when to seek personal support. A comprehensive list of references for further reading is also included.

The book is designed to be read as an integrated unit but readers will undoubtedly also want to dip into particular aspects for help with specific questions. One of the great strengths of this book is that, with its compelling easy-to-read style, it will help healthcare professionals understand themselves. This leads to more effective and appropriate understanding of the needs of patients.

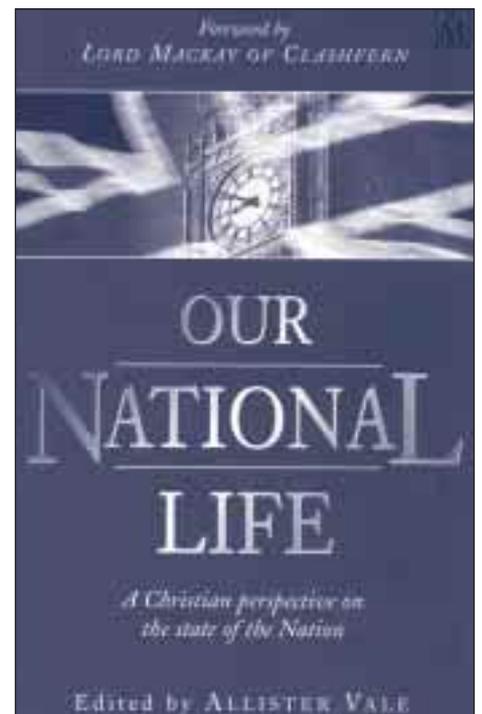
**Mike Wilman**  
(Lecturer and Consulting Analyst in private practice, Hampshire)

### **Our National Life - a Christian perspective on the state of the Nation**

Edited by Allister Vale. The National Club/Monarch, London. 1998. 250pp. £12.99 Hb. ISBN 1 85424 391 8

To mark 150 years from its foundation in 1845, The National Club of the United Kingdom produced this book as 'a clear statement of what the The National Club wanted to see on the nation's agenda for the future'. It is a collection of essays by leading Christian experts and makes both a state-of-the-art summary of where we are now and a clear statement of where we could and should be going. Most readers of *Triple Helix* would be familiar with at least half the authors. Perhaps recent changes in Britain mean that perceptions of the old political understandings of 'left, right and centre' are fading, but overall I did not detect such a right-of-centre feel as might have been expected.

Edited by a consultant physician, five of the fifteen chapters are specifically about healthcare issues, and all the others are relevant to the big-picture understanding needed by health professionals, whether committed Christians or not. The book covers 'What makes a nation great?', national values, the role of the monarch, morality and the marketplace, education, the family, personal money management, the National Lottery, priorities for health, euthanasia, genetic manipulation, pornography, substance abuse, the environment, and 'a Christian lifestyle'.



I enjoyed every chapter and because of my own areas of ignorance found those on the economy, education and gambling most rewarding. The book is a beautifully produced hardback, which to be sold at £12.99 must have had considerable subsidy. It is a pity therefore that the standard of proofreading falls off dramatically towards the end and mars the presentation.

This is a timely snapshot which should concentrate our thinking and praying about our personal, our professional, and our national lives.

**Andrew Fergusson**  
(Editor)

**Bear one another's burdens . . .**



**. . . and so fulfil the law of Christ.**