Triple Helix

Christian dimensions in healthcare

Population and the planet
The Church and the homosexual
From Belarussia with love

six billion and rising...

Winter 1999/2000 £2.95

ISSN 1460-2253

Triple Helix is published quarterly for the health professions by:

Christian Medical Fellowship
A registered charity No. 1039823

157 Waterloo Road
London SE1 8XN

Tel. 020 7928 4694
Fax 020 7620 2453
E-mail admin@cmf.org.uk

Web http://www.cmf.org.uk

Subscriptions

Triple Helix is sent to all members of CMF as part of the benefits of membership, but individual subscriptions are available at £2.95 a copy including postage (UK only).

For special offers, see the coupon opposite. Enquiries: telephone 020 8559 1180 (Mon-Fri, 9am-5pm).

Contributions

The Editor welcomes original contributions which have both Christian and healthcare content. Advice for preparation is available on request.

Authors have reasonable freedom of expression in so far as their material is consonant with the Christian faith as recorded in the Bible. Views expressed are not necessarily those of the publishers.

Acting Editor - Peter Saunders

Associate Editor - John Martin

Editorial Board
Andrew Brown (Chairman)
Rachel Field
Mandi Fry
Janet Goodall
Howard Lyons
Paul Vincent
Sarah Whitfield

Design - Armadillo Systems

Print - Stanley L Hunt (Printers) Ltd

Copyright Christian Medical Fellowship, London.
All rights reserved. Except for a few copies for private study purposes, no part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior permission of the Christian Medical Fellowship.

contents:

Winter 1999/2000
No. 10

Editorial - 'A step further than Sodom?' 3
Peter Saunders

Population Contol - two views 4
John Guillebaud and Greg Gardner

Eutychus 8

Among All Nations 9
Christian Healthcare Worldwide

Tradition in Transition 10
Ian Campbell and David Clegg

Learning About Leprosy 11
Miriam Noble

Urologists United - Mongolia and USA 12
Doug and Nancy Soderdahl

Resources, Reviews, Requests 14

Vacancies Overseas 15

From Belarussia with Love 16
Alex Bunn

RevieWWWs 17

The Church and the Homosexual 18
John Martin

Readers' Letters 20

Reviews 21

editorial:

'A step further than Sodom?'

Is six billion people too many? At one extreme are those who see human population growth as the planet's major problem - through exacerbating starvation, environmental destruction and slaughter. At the other are those who see advancing technology and international collaboration producing a world where everyone reaches the consumption levels of California.[1]

In this issue of *Triple Helix* John Guillebaud and Greg Gardner represent neither pole of opinion and agree that there is a huge difference between coercive population control on the one hand and responsible family planning on the other. But there is less meeting of minds on the environmental impact of increased numbers and on who should do what.

Whether the world is overpopulated is debatable. All the world's buildings would fit in Scotland or Ireland alone and the world's population could currently stand shoulder to shoulder on the Isle of Wight. World per capita food production has more than kept pace with population and Europe's own past demonstrates that fertility can be managed effectively - even without contraceptives - as living standards improve. Furthermore citizens of the developing world choose large families for good reasons, as insurance against an uncertain future in circumstances of high infant mortality, low and insecure income and labour intensive farming.[2]

Family planning combined with economic development allows couples to plan the number and spacing of their children in the light of their own circumstances and beliefs. But imposed population control, with all that involves, coupled with mounting developing world debt and economic austerity measures which slash health and education budgets, is nothing short of brutal exploitation.[3] Our stewardship of the earth is not a licence to exploit but to govern wisely. We cannot impose solutions on the world's poor without addressing our complicity in unjust economic structures, environmentally destructive technologies, and consumptive lifestyles.

Sodom came under God's judgment, at least in part, because she was 'arrogant, overfed and unconcerned; (she) did not help the poor and needy' (Ezekiel 16:49). This description fits our Western World well - but if we actively exploit and manipulate the developing world we are in real danger of going a step further even than Sodom.

'Do not exploit the poor... and do not crush the needy... for the Lord will take up their case and will plunder those who plunder them' (Proverbs 22:22-23).

Peter Saunders

References

1. McMichael T, Guillebaud J, King M. Population - the two 'wisdoms'. *BMJ* 1999; 319:931-932
2. Bunn A. Contraceptive Commotion. *Nucleus* 1995; July:8-16
3. Paul J, Saunders P. Taking an Interest in Debt? *Nucleus* 1998; October:12-20

Population Control

good stewardship?

John Guillebaud argues that regulating global population is part of good stewardship

I first became interested in population issues when a lecture on human numbers from my Tutor at St John's, Cambridge in 1959 'rang many bells'. Born of CMS missionaries and brought up in the Great Lakes Region of Africa, I have since seen how many of Africa's problems have been compounded by a four-fold increase in population. I believe that we will never meet human needs without stabilisation of human numbers, and that 'family planning could provide more benefits to more people at less cost than any other "technology" now available to the human race'.[1]

The Environmental Cost of Population

Unremitting population growth is not an option on a finite planet. We have just celebrated 2,000 years since Jesus' birth. Then, world population was around 200 million. Continuing to grow exponentially for just 2,000 more years would lead by one calculation to the mass of human flesh equating to the mass of the earth. By 2025, centuries before such *reductio ad absurdum*, our species will eliminate an estimated one fifth of all the world's life forms. Most of this destruction is not so much wanton as thoughtless. It occurs through competition from sheer numbers of humans, leading to the destruction of other species' habitats (wetlands, woodlands, coral reefs).

Too often the 'P' factor is overlooked in the IPAT equation as follows:

$$I = P \times A \times T$$

WHERE:

I is the *impact* on the environment of a given society/civilisation

P is *population,* the number of individuals in that society

A is their per capita *affluence* (with consequential invariable 'effluence' = pollution and resource/energy consumption per capita)

T is a composite factor accounting for the per capita impact of the *technologies* in use (lowered by 'greener' technologies, with lower energy use and maximum recycling)

The Need to Stabilise Population

In many resource-poor countries the people deserve that the A-factor, affluence, should significantly increase, along with an increase in per capita disposable income. Although this will mean greater energy consumption and adverse effects on the local and global environment, this is something the 'haves' of the world must accept - and Christians rightly take a lead here. But it makes global reduction in the average per capita A-factor even less probable. There are strict scientific limits to the reductions possible in the T-factor, so it would seem logical that Christians should have a positive view on stabilising (rather than just adapting to) the P-factor, population, the only other factor in the IPAT equation.

Fortunately, birth rates are declining in most countries (small thanks to the opponents of voluntary birth control services). But all of tomorrow's parents are already born, so many in number that even if their family sizes were improbably to average two, population growth would not cease until about 9 billion. This is a 50 percent increase on October 1999's 6 billion and it will occur despite the ravages of AIDS. The choice about stabilisation is not whether, but when - and at what total. If we wish to preserve a halfway tolerable global environment, and achieve a halfway decent life for those in degrading poverty, this must be as little above that unavoidable 9,000 million as possible.

The Vicious Cycle of Population and Poverty

If we see population growth just as something to adapt to, a vicious circle emerges: population increase maintains poverty, and poverty maintains population increase.

Population increase maintains poverty, because the finite 'cake' of any resource-poor country has to be divided amongst ever more individuals. Without stabilising the number of individuals to share it, an increase in a country's GDP can produce (as in my home country of Rwanda) a fall in the per capita GDP and more poverty. The increase in population keeps wiping out the gains, whether in agriculture, education and literacy, or healthcare.

In turn, poverty maintains population increase, because in rural poverty 'every mouth has two hands'. The labour of each new child in the family is welcomed, especially in the absence of social security for sickness and old age. High child mortality also tends to reduce interest in birth planning.

Ultimately, the medical and social consequences could be catastrophic. Hence my Kew Gardens 2044 Time Capsule,[2] which included an apology. We have not inherited the world from our grandparents, we have borrowed it from our grandchildren. My prayer is that they should not need to accuse us of damaging their loan beyond repair.

Short of that, while definitely not the cause of all major world problems, increasing population is the unrecognised multiplier of most. Some were in our recent BMJ editorial:[3] 'poverty and malnutrition, resource shortages and pollution, the loss of bio-

diversity and wildlife habitats, increasing global inequality, and conflict and violence'. Medical consequences are obvious within that list, others are predicted from global warming (more humans burning ever more fossil fuels).

Not Coercion, but Planning and Social Justice

I doubt Maurice King's notion that the USA is in some kind of alliance to downgrade the importance of population so as to continue, as now, profligately consuming resources. However I am perturbed by the prevalence of ostrich-like laissez-faire views, given the 200,000 additional individuals that humankind somehow has to care for with each new day. The notion that we need do nothing to regulate population[3] is dangerously complacent.

On the other hand, I am strongly opposed to every agency, government or individual that practises or permits compulsion, whether overt or covert, regarding birth planning methods or family size. I therefore teach avoidance even of the word 'control', after 'population' or 'birth'. I reject one-child policies and coercion in any form. We should not so much count people as ensure that people count.

I believe the best way for the world to deal with the 'problem' of population is through the relief of poverty and all its consequences combined with the means for women to achieve their human right to control their fertility. In short, we must work for birth planning and social justice with equal vehemence! Wealthier smaller families mean less population growth, fewer to share the 'cake', and hence still less poverty and even smaller families. The vicious cycle of population causing poverty and vice versa can then become a virtuous, upward spiral - as has happened, with average family sizes dropping below three in countries as different as Thailand and Costa Rica.

'Social justice' includes many components: education, reproductive health care, and women's empowerment.[4] If we take care of the people, the population will take care of itself. But part of that 'taking care' involves ensuring that people can enjoy God's gift of sex within marriage while at the same time being able to plan the number and spacing of their children. For this they need universal, easy access to culturally appropriate reversible contraception methods through subsidised user-friendly services. We know from large scale social surveys of 240,000 women in 38 countries[5,6] that it is now a myth that most women in the South do not want to plan their families. We are failing to push at an open door! Doing so could greatly reduce both maternal mortality and the abomination of 50 million induced abortions annually.

In the real world it is medically necessary to make methods of contraception available to unmarried as well as married people. However I dissociate myself from any agency or individual which promotes intercourse outside marriage, and from policies or practices that undermine the family as our Designer's intended setting for child-rearing.

Sensible Stewardship

Many non-Christians see Christianity as the problem - seeing in Genesis 1:26,28 a biblical justification for riding roughshod over the biosphere - a licence for humankind to exercise 'dominion over' the world rather than (the more correct) 'stewardship for' the world.

Yet if one looks again it is striking that God exhorted plants and animals to be fruitful and multiply before giving that instruction to us humans. The Creator did not and does not intend us to multiply so much that we prejudice the fruitfulness of all his other creatures. This would be contrary to his immanent nature.

I believe there is implicit in the Bible another attribute of our God, additional to his omnipotence, omniscience, and omnipresence; namely omni-common sense! Population growth has happened as a result of vastly improved survival through modern medicine but without adequate birth planning. If obeying the 'multiply' instruction would lead to human numbers which exceed the carrying capacity of the land available - and so wipe out millions by starvation, disease or violence - godly common sense suggests this is not obeying his other instruction to us and the rest of creation to 'be fruitful'! Christians should be enthusiastic supporters, often through their own tithing, of voluntary birth planning within God's ordinance of marriage - worldwide. I believe this is squarely within God's plan for these times.

Conclusion

We must ask ourselves new questions relating to the two great commandments of Jesus:[7]

First, 'Love the Lord, your God': are we really doing that if we do not cherish and care for his creation - just as we would for something made by a human loved one? Our love for God should surely ensure *inter alia* that there are not more of one species (humans) than can possibly live full lives, while permitting the survival of all his creatures.

Second, 'Love your neighbour as yourself': should we not as well as loving our overseas neighbours, also love our future neighbours? And doesn't this involve helping to ensure that there are not ultimately so many future neighbours that God's world becomes uninhabitable?

References

1. Grant J. In: *The State of the World's Children* 1992; Oxford University Press for UNICEF, Oxford. 1993: 58-60
2. Guillebaud J. The environment time capsule project. *BMJ* 1994; 308:1377-1378
3. McMichael T, Guillebaud J, King M. Population - the two 'wisdoms'. *BMJ* 1999; 319:931-932
4. Guillebaud J. After Cairo. *Br J Obstet Gynaecol* 1995; 102:436-438
5. Guillebaud J. After Cairo (Letter). *Br J Obstet Gynaecol* 1996; 103:92-93
6. Hopes and Realities: closing the gap between women's aspirations and their reproductive experiences. Alan Guttmacher Institute: New York, 1995:1-49
7. Matthew 22:37-40

John Guillebaud is Professor of Family Planning and Public Health at University College London

Population Control

a sinister ideology?

Greg Gardner argues that population control is a sinister ideology which Christians should resist

My interest in population issues was first kindled as a medical student when I heard Catholic Priest and writer Rene Bel talk about 'a conspiracy against the poor' in West Africa: a neo-colonialism based on contraception, abortion and sterilisation was being heavily funded by certain groups in the West who did not want to share the world with too many other people. Later I discovered the eugenics movement and found that the same organisations (and often the same people) were active in both fields.

Eugenic Roots

The Population Control Movement with its roots in Eugenics and a desire to control people's lives has a history of progressive and lasting damage to the social fabric in every nation in which it has had influence. Population Control is the decision taken by governments or other agencies that couples should restrict the number of children they have, followed by measures to enforce such policies. What lies behind this sinister ideology?

In the early years of the 20th century, the Population Control and Eugenics movements were indistinguishable. One of the early population activists was eugenicist Margaret Sanger who opened the first birth control clinic in New York in 1916. She wrote, 'The unbalance between the birth rate of the unfit and the fit is admittedly the greatest present menace to civilisation....The most urgent problem today is how to limit and discourage the over-fertility of the mentally and physically defective.'[1] Change the wording from 'unfit' to 'poor' and you have a good description of modern population control.

Radical Social Engineering

There has always been a debate within the Population Control/Eugenics movement about what degree of compulsion is necessary to restrict numbers of births. Kingsley Davis in an article in Science[2] in 1967 and Bernard Berelson at the Dacca population conference in 1969 proposed radical social engineering. Their idea was to change the structure of the family through a combination of tax measures, law and ideology. According to Davis, 'Changes basic enough to affect motivation for having children would be changes in the structure of the family, in the position of women and in the sexual mores.' Some of their ideas included: abortion and sterilisation on demand, payments to encourage contraception, the distribution of contraceptives non-medically, modifying tax policies to discriminate against married people, encouraging (or compelling) women to work outside the home, the postponing or avoiding of marriage, altering the image of the ideal family and educating for family limitation. These ideas have been introduced, to some extent, in every country in which Population Control has infiltrated. The International Planned Parenthood Federation (IPPF), to which the British Family Planning Association is affiliated, has advocated the provision of all forms of 'fertility control' to children from age ten without parental consent. This deliberate destabilising of the traditional family and its replacement by serial cohabitation and other alternatives leads inevitably to low birthrates.

Coercion of women

Another key assumption of the population controllers is that there is an 'unmet need' for contraception and abortion - but this 'unmet need' is often generated by the population controllers themselves. A careful reading of their own literature reveals the needs of the population controllers to control the lives of other people. The International Planned Parenthood Federation has published detailed suggestions for disincentives for couples who fail to follow national population control policies.[3] IPPF (with British taxpayers' money), together with the United Nations Fund for Population Activities (UNFPA), continues to help finance the Chinese one-child-per-family programme where forced abortion, sterilisation and female infanticide are common. 'Planned-birth supervision teams usually exercise night raids, encircling suspected households with lightning speed. If we do not apprehend the women themselves, we detain their family members until the women agree to the sterilisation and abortion surgeries.'[4]

UNFPA is a major donor to the Chinese population programme praising it for its 'high commitment' and has provided the funds for at least 600 vans, each one equipped with an abortion suction machine, a bed and clamps. That's right. The shackles are put on to the women who try to resist.

Harassment and Intimidation

In Peru a brutal coercive sterilisation campaign carried out in often filthy conditions and causing at least 18 maternal deaths and much morbidity was started in 1990. One woman reported that her daughter's participation in a programme for low birth weight children was made conditional upon her acceptance of a sterilisation procedure.[5] Harassment, threats and intimidation were common. None of the women interviewed by investigators reported being offered anything resembling informed consent. In Kosovo the high fertility of the Kosovar people drew the wrath of various international Population Control agencies. Kosovar people smile broadly when told they have the highest fertility rate in Europe. They are happy with large families. UNFPA was invited into Kosovo by Slobodan Milosevic in

December 1998 at the height of his ethnic cleansing campaign. They gladly accepted his invitation. Abortion kits, IUD's and other contraceptives were foisted on the Kosovar people. Although Milosevic was forced to withdraw his troops, the continuing presence of UNFPA in Kosovo ensures that a kind of silent ethnic cleansing under the guise of 'reproductive health' will continue.

'Overpopulation' is an idea which dictators and despots from all parts of the political spectrum have embraced. The poor are convenient scapegoats for the misdeeds of politicians. The 'overpopulation' argument has been used in retrospect about the genocide in Rwanda. Yet authors such as Fergal Keane, Alain Destexhe and Philip Gourevitch who have studied Rwanda in depth give no credence anywhere to the idea of 'overpopulation' being even a contributory cause to the genocide, let alone the principal cause.

Wrong Assumptions

Since the publication of Paul Ehrlich's book, *The Population Bomb* in the 1960s the Population Control Movement has argued that as world population grows, increased scarcity of arable land, food, raw materials and energy will inevitably develop. These assumptions are false. In contrast to popular belief the notion of a fixed supply of farmland is misleading.

If increasing population led to increased 'pressure' on land we would expect to see more people working on the land. The opposite has occurred in both rich and poor countries. The proportion of those working in agriculture has continually declined, and may well decline forever. In addition, the absolute number of acres each farmer cultivates eventually rises when income becomes high, despite increases in population.[6] In Sub-Saharan Africa, which is under populated, agriculture is inefficient. Population growth is actually necessary to force communities to abandon inefficient farming practices. Since Ester Boserup developed this theory in 1965, world population has doubled and yet food production per capita has continued to increase. As each set of arguments for restricting population becomes untenable, the population control lobby moves on to others. The latest one is the conntroversial global warming theory. This is based on computer predictions which some have criticised for their crudity - by contrast temperature measurements from satellites over the past two decades show a slight cooling of the earth.

The Real Answer

The Population Control Movement in its attempts to reach into people's private lives has demonstrated its disregard for the ability of people to regulate their own fertility. In Kerala, India, lower birth rates followed on from higher female literacy rates (75% versus 30% in India as a whole), together with lower infant mortality rates. When communities see that their children are not going to die they usually decide to regulate their own fertility. Yet in Sub-Saharan Africa which is being wasted by AIDS and where life expectancy in some countries is down into the forties again, there is no let up in the campaign to deal with the population 'problem'. The main point missed by the Population Controllers is that population growth stimulates development over the long term. The Bible looks on population growth and large families as a blessing not a curse. Each generation inherits its own stock of knowledge and ingenuity which is then added to. The most effective long term way of augmenting that capital stock is through population growth and good education.

Conclusion

The Population Control movement, as well as demonstrating scant disregard for human rights, has consistently attacked the institutions of marriage and the family. Its promotion of amoral sex education, free contraception and easily accessible abortion in country after country has had devastating results. The assertion in a recent BMJ editorial[7] that 'overpopulation leads to war, famine and disease' could not be more wrong. It is the destruction of the family and consequent fatherlessness which leads to such things as child abuse, crime, drug addiction, self harm, low educational achievement and a perpetuation down the generations of problems such as teenage pregnancy. Ask any resident on a heart-sink estate about the real problems affecting their lives (including especially violence) and the answer in some way will be related to family breakdown. The destruction of a nation's moral ecology has a far greater effect on people's lives than any putative effect of population growth on the physical ecology. Population Control with its roots in eugenics, its fear of people, its appalling human rights record and its antagonism to marriage is an enemy of the family and therefore of the Church.

References

1. Sanger M. *The Birth Control Review* 1921; October
2. Davis K. Population Policy: Will current programs succeed? *Science* 1967; 158:733-738
3. Report of the Working Group on the promotion of Family Planning as a basic human right. London: IPPF, 1984:21-23
4. Population Research Institute Review. 1998; 7(3):11-13. www.pri.org
5. Morrison D. Population Research Institute Review. 1998; 7(2):5. www.pri.org
6. Simon J. The Ultimate Resource 2. Princeton: Princeton University Press. 1996
7. McMichael T, Guillebaud J, King M. Population - the two 'wisdoms'. *BMJ* 1999; 319:931-932

Greg Gardner is a General Practitioner in Birmingham

Italy says no

Now what's the question? The questions are about gamete donation, embryo research, embryo adoption and embryo freezing and Italy has said 'no' to all these in stringent draft laws to regulate fertility services. The law has yet to be passed by the Italian Senate but would be by far the most restrictive in Europe. (Source: *Catholic Medical Quarterly*, August 1999; p16-18)

Japan to ban human cloning?

An advisory committee to the Japanese prime minister has ruled that current guidelines to prevent human cloning are inadequate and recommends a legal ban. The panel 'argued that cloning has no positive utility, runs counter to respect for human life, and poses safety problems'. If passed, the draft government bill would be the first legal prohibition of life science research in Japan. (Source: *British Medical Journal*, 27 November 1999; 319:1390)

Human ova auctioned on Internet

Pornographer Ron Harris has offered the eggs of eight attractive young US models for sale on the Internet to the highest bidder. His site is called 'ronsangels'. Within hours, more than a million Americans had logged on. What does this say about the future of parenthood? What about some global legal action to prevent this? (Source: *The Independent*, 26 October 1999)

Egging them on

A month earlier there was another egg story. Scientists at Leeds University have successfully reversed a (premature) menopause with ovarian grafting. While the technology offers the possibility of restoring fertility to young women with medical problems (such as sterility after cancer treatment), it could in theory allow women to bank tissue and choose to reproduce at an advanced age. (Source: *The Independent*, 24 September 1999)

UK to import Danish sperm?

Meanwhile, the men haven't been getting a look in. Or rather, British men haven't. Because sperm donations are plummeting in the UK after suggestions that donors could lose their anonymity, a leading fertility specialist has asked the UK government to lift its ban on importing human sperm from abroad. He had a supply from Denmark lined up. (Source: *The Independent*, 6 October 1999)

Record AIDS deaths

A report from UNAIDS has predicted that a record number of people will die from AIDS in 1999 despite improved survival achieved with anti-retroviral therapies in wealthier countries. UNAIDS estimates 2.6 million deaths in 1999, 5.6 million new infections, and that 32.4 million adults and 1.2 million children will be living with AIDS. 13.7 million Africans have already died. In the West, gay men have become complacent now life-prolonging therapy is available, while in Eastern Europe and Central Asia injecting drug use has caused the world's steepest increase in HIV infection. (Source: *AIDS Epidemic Update*: December 1999, UNAIDS)

'Will to live' waxes and wanes

Canadian researchers assessed 'the will to live' twice daily in 168 mentally competent cancer patients admitted to palliative care and found substantial fluctuation 'due to changes in both physical and mental factors'. Psychological factors often weigh more heavily in a desire to die than factors such as physical pain. Palliative care helps manage reversible distress. Another nail in the coffin of the euthanasia and physician assisted suicide movements? (Source: *The Lancet*, 4 September 1999; 354:816-819)

'You shall not give false testimony . . . '

There does not seem to be much support for this Commandment amongst British medical students. In a survey '36% said that they would be prepared to cheat in exams, falsify patient information, plagiarise other people's work, or forge signatures'. (Sources: Exodus 20:16 and *British Medical Journal*, 6 November 1999; 319:1222)

'Honour your father and your mother . . .'

And Britain's aging parents don't seem to want this Commandment followed either! At a final regional conference of the millennium 'Debate of the Age' a majority agreed 'Our generation does not want to be looked after by our children. We should not expect it.' (Sources: Exodus 20:12 and Millennium Debate of the Age Newsletter, September 1999)

Evidence-based prayer?

A double blind randomised controlled trial suggests prayer for healing does work. Researchers recruited a cross-denominational team of Christians to pray for half the patients admitted to a coronary care unit and they (unaware of the prayer) had lower scores than controls on an unvalidated instrument for measuring adverse outcomes. Length of stay was unaffected and mortality was not studied. (Source: *Archives of Internal Medicine*, 1999; 159:2273-2278)

Religion and mental health

In a Health Education Authority funded report the UK government admitted in October that religion can be good for your mental health. It quoted American studies linking religious belief and wellbeing, and suggesting that religious faith can protect against depression. (Source: *Promoting Mental Health, The Role of Faith Communities*, Health Education Authority)

Do you believe in God?

This *BMJ* 'Soundings' headline caught the eye. In a challenging piece about a young patient (who asked his doctor this question) dying badly as an unbeliever, GP Kevin Barraclough ends entertainingly: 'I am reminded of the story of the erudite theologian who was sometimes suspected by the zealots of heresy. A journalist confronted him. "Do you believe in God?" he asked. The theologian eyed him cautiously. "I can answer you," he said, "but the answer is complex, and I can promise you that you will not understand my answer. Do you want me to go ahead?" "Certainly." "All right. The answer is yes."'(Source: *British Medical Journal*, 2 October 1999; 319:929)

Eutychus

Among All Nations

Winter 1999/2000
No. 10

Christian healthcare worldwide

Out of the frying pan into the fire

Jesus spoke of the rich man who neglected the beggar at the gate of his estate. Then of the beggar resting in heaven at Abraham's side and the rich man cut off and tormented in hell. The message that challenges me most powerfully in this parable is not the lostness of the lost but the selfishness of those who thought they were saved.

We may be able to debate the theology of hell but are we willing to help those in torment now? There are so many diseased or orphaned by AIDS. Others face hunger and ignorance resulting from economic domination by the rich or are left with wounds and bereavement resulting from wars often waged with Western weapons. If we can not respond to their needs can we confidently claim to belong to the Kingdom of Heaven ourselves? How will we relate to these people when we meet them there?

And yet medical mission is not just healthcare. The medical mission partner aims along with secularised aid workers to bring relief from poverty, ignorance and disease. As a member of the fallen human race he or she is also liable to bring materialism, pride and new lifestyle diseases. This bad news must be counterbalanced by good news.

The good news is of a Kingdom where all things are restored. Relationships between both God and man and amongst human beings are made new. Working alongside overseas Christians and their churches we may have the reward of seeing them escape from the poverty trap. Living alongside them we can learn from their lifestyle of the dangers of a materialism we have left behind. We can then warn them of the dangers of a purely secular salvation. Jesus came healing but also preaching the Kingdom of Heaven. Without this dual role we shall only encourage others to jump from the frying pan of poverty into the fire of decadent Western materialism.

Living below street level in Mongolia

David Clegg

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.

tradition in transition

Ian Campbell and David Clegg describe how AIDS in Zambia has made the hospital for the community become the hospital in the community

The past

Chikankata Hospital in Zambia was founded on the edge of the Gwembe valley in 1946 by The Salvation Army to provide a health service for some of the poorest people in the country.

The present

The AIDS pandemic in a situation of economic restructuring and declining net national and international aid has made the hospital in its present form unsustainable. At the same time the community's existence is threatened. Continuity between past, present and future is valued highly. AIDS is seen to kill individuals and their extended families slowly and this causes loss of hope for a better future and produces a fatalistic response which further destroys community structures.

A programme of home-based care that is clinical, pastoral and educational has been linked to family and neighbourhood-based counselling. This has enabled the neighbourhood groups in the areas covered by the programme to recognise and respond to the problem of HIV infection. The response is seen in the expression of care for each other, and in sustained commitment to change, where this is needed, in attitudes and behaviours. Thus a process of care is seen to have an emerging prevention impact.

This process has happened in both low and high prevalence areas. A team approach both in hospital and in home visits to those infected, to those affected, to those in danger of being infected, and to those connected in other ways, widens the circle of prevention.

The future

Led by its traditional headmen, the community around the hospital has begun to recognise that it has the capacity to care for its own health and to accept the responsibility to do so. It can discuss its own problems, recognise their causes, decide how to solve them, and determine the priorities in the light of the resources available. This process can extend to all aspects of its healthcare and not just to HIV/AIDS.

The hospital and home care staff, most of whom are Zambian and many of whom are locally employed, need increasingly to become identified with the community in this process. They can facilitate change by:

- drawing attention to problems
- exploring concerns and hopes when people discuss what they see
- encouraging the living and giving hope to the dying by working for better relationships and a more secure future
- planning with the community a sustainable use of hospital resources
- seeking within the church a holistic spiritual response to sickness and poverty
- helping home care programmes in other areas and countries

Maureen and Thadeo ... facing the future together

This process of using care to facilitate participation and change becomes community-owned rather than being the imposition of solutions from outside. The hospital and clinics become resource centres for the community. A community confidentiality develops. A degree of 'community informed consent' is found which may allow HIV testing without time-consuming pre-test counselling.[1] The process of care resulting in change 'is as simple and yet as profound as the recognition that the love of Christ tranforms'.

Maureen and Thadeo

Maureen and Thadeo are a married couple and both are HIV-positive, diagnosed in 1988. They have two children. Through home visits from a Chikankata team, and because of an increasingly supportive neighbourhood, influenced through some committed senior headmen, they worked through a difficult separation, reconciling after a year or so when they realised they could face the future better together than apart. They were visited regularly. The process of community counselling in the neighbourhood of their home helped their families to lose their fear and to include them in the wider family circle.

Reference

1. Campbell I and Radar D. Community Informed Consent for HIV Testing. *Tropical Doctor*, 1999; 29:194-195

Captain Dr Ian Campbell is Medical Adviser to the Salvation Army International HQ

learning about leprosy

Miriam Noble reports on the nursing elective she and Tamsin Gilbert did in India

Tamsin and I went to Salur, a town near the east coast of India where The Leprosy Mission (TLM) has a hospital with 125 beds of which 77 are for leprosy. We were met at Calcutta airport by a TLM worker and taken to the hospital for a few hours. My first impressions were vivid: a very distinct smell, the clothing the people wore (we stood out blatantly from everyone else), it was raining but warm, the journey in the TLM jeep - there seemed to be no organisation on the road and a lot of hooting! We had our first taste of the food and noticed the small lizards on the walls.

We were put on a train, travelling first class with air conditioning but I was very scared and held onto my luggage tightly for the whole journey. This took 17 hours but we had beds, so got some sleep. We were met, taken to another TLM jeep, registered with the Superintendent of Police, and then had a two hour journey to Salur. Here we shared a basic but comfortable room.

Nursing

The first day we attended an eye camp. They selected over 30 people to have cataract operations the following week and these were completed in one day by the same surgeon. For the first week we took part in the Prevention of Disability Workshop. About 20 workers from TLM hospitals all over India came to Salur to have lectures and be examined.

The patients washed themselves or were helped by relatives. The equipment used was very basic and nothing was thrown away unnecessarily. Needles were rather blunt for giving injections! Very large pieces of gauze were cut and folded into the small squares by the staff. The patients were given rice and curry at lunch and tea times with meat or egg twice a week.

I learned about the multidrug therapy and spent a morning with the community team going to villages, assessing and treating patients and trying to contact others. I learned about the treatment of ulcers and watched reconstructive surgery on the hand and the foot. I visited the physiotherapy department, watched double rocker shoes being applied and window Plaster of Paris casts made, spent time in the shoe department, watched part of an artificial limb being constructed, and spent time in the pharmacy and the laboratory. The hospital staff were all very keen to explain to us their area of work.

The nurses were very dedicated and busy. At night, there was just one nurse for the whole hospital! They gave anaesthetics for eye operations. They were very much answerable to the Superintendent of Nursing, who was keen to glean from us any ways in which we felt nursing practice could be improved. She was keen for us to send her research and any other things that would be useful to guide nursing practice in the hospital.

Reliance on prayer

I found coming to terms with the difference in culture and the great poverty extremely difficult. Each day I had to rely on God for everything, which I hadn’t been used to. I found great help from Bible reading, prayer and fellowship with Tamsin and from the English service on Sundays. We saw answers to prayer at times when we were feeling lonely and were invited to people’s houses. We saw the reliance on prayer in the hospital - at the beginning of any journey in the jeep and before any operation was performed. I was moved whilst watching some of the leprosy patients sitting by their beds singing hymns. There is much Hindu opposition to Christians in India. Even while we were there, reports came of churches burned and people killed.

I am very appreciative to TLM for arranging our elective. We were able to spend our last week travelling up to Agra to see the Taj Mahal, and also to Delhi.

Miriam Noble received an MMA grant towards her recent nursing elective in India

Urologists United

American urologist Doug Soderdahl and his wife Nancy, a nurse, who travel the world under their World Medical Mission, visited Mongolia. We have their kind permission to publish the following extracts from their e-mail reports. They were associated with a team of 10 from the US Christian Medical and Dental Society's Commission on International Medical Educational Affairs (COIMEA). They went believing 'Wherever I cause my name to be honoured, I will come to you and bless you' (Exodus 20:24b)

Advice received before departure

. . . The lecture one might be prepared to give may not be the lecture they want to hear. Operating facilities are limited. Patient privacy and modesty concerns are decidedly not Western. Mongolian surgeons, nevertheless, accomplish a great deal. The visitor has much to learn and should be quick to compliment and slow to criticise. If an attitude of love is amplified by lecturing, operating, rounding, etc then all the better, but the basic motive of love in Christ must be expressed.

First prostatectomy by vaporisation

We started out meeting the top surgeon in all of Mongolia, a gracious older gentleman of about 70 years, who is still considered everybody's teacher. Doug had examined two patients, but after they had been given a time slot on Tuesday's schedule they both informed the Mongolian urologists that Tuesday would 'not be a good day' for surgery. Even comparatively minor events only take place with concurrence of the religious practitioners, who consult charts and books. The patients had been switched unbeknownst to Doug!

A senior urologist had come by bus across town to watch the procedure. No interpreter was available among the 25 plus people milling around in the OR but the chief of urology spoke English a bit better than Doug speaks Russian. Two electricians were on hand. The OR and Nancy worked as a team by sign language. Men and women change clothes together in the coffee room for the surgery. Mongolia's single television station videotaped the operating theatre for two-hourly nationwide broadcast for the subsequent 24 hours!

Mongolia - a long way from Georgia, USA

Drapes and gowns were in tatters. Gloves in only one size are re-used until they break. Blood pressure monitoring and ventilation is done manually by a second anaesthetist. Our instruments were soaked in 'spirit' in a glass, such that about half of each instrument was not in contact with the antiseptic. There was no prophylactic antibiotic given. The grounding pad (to prevent electrocution or severe burning of the patient) remained a source of anxious concern right up to the last moment.

'Lights, camera, action!' Everything worked smoothly . . . minimal bleeding, excellent view for everybody on the monitor, no patient complaints. The hospital has all the equipment it needs to do the procedure, save for a $140 electrode which can be used 10-15 times. Between the two cases of the day we remove gloves, wipe our hands with

The Soderdahls in conference with Mongolian colleagues

Mongolia and USA

Learning new techniques

alcohol and don new gloves. The surgical gowns are not changed. The second case went more smoothly and quickly.

Urban poverty

In the afternoon we loaded clothes from churches in the States into a van. Traffic was chaotic and speedy, with near misses of vehicles and pedestrians exceeding one a minute. Among dilapidated buildings and potholed roads, the sunshine was a sharp contrast to the black, white and grey of the city. Trolley buses, dangerously overloaded, chug down the thoroughfares.

Having negotiated the potholes and large rocks of an alleyway we spotted a young lad perching atop a manhole as a sentry. The van halted and soon the occupants - a group of children, an older man and two middle-aged women - all had scrambled up ladder rungs to the light of day. One lad came up shirtless - it had snowed the night before. What joyful faces as the parcels (typically a sweater and a jacket) were passed out. Gospel tracts were included. The old man said the children could read.

Dining with our hosts

Thursday evening our entire team hosted our hosts at the Ulaanbaatar hotel. We reserved the private dining room with a single table for 52 people. Exactly 52 turned up! What a wonderful evening of camaraderie! Doug explained our mission in some detail with a chief surgeon through a translator who turned out to be a senior manager. We capped the evening with a contest of song between our team and the various Mongolian speciality teams. The nationals won hands down!

The national cancer centre

The Soviet-built building is spare by any standards. Patients mostly present late and are admitted for the duration of their radiation therapy. They receive totally free care from the Government. Common cancers include liver (secondary to viral hepatitis, and thus preventable), lung (smoking and heavy pollution contribute), oesophageal, stomach and cervix. Futile surgery occurs regularly while chemotherapy and radiotherapy are applied quite aggressively. No palliative care unit exists. Doug lectured on bladder tumours to a very eager audience of about 50. The evening temperature had dipped to well below freezing, and heat had not yet been turned on centrally by the government so that we had to change venues three times before we could find some reasonable comfort from the cold.

Lasting memories

Later off to fellowship with 100 or so exuberant young folk. An English teacher, in Mongolia for seven years, has offered to train the entire urology group (eight in a country of 3 million) in English free of charge. They are on cloud nine. Recall that their salary maxes out at $50/month, which makes private tutoring totally out of the question. They wish to study the Word in Mongolian as they learn English.

Just 20 minutes ago a young paediatric urologist came to our room as we were packing to tell of her spiritual journey. We are overwhelmed, with needs of every kind being met by our gracious, loving and merciful Father.

Doug and Nancy Soderdahl are based in Georgia, USA

resources:

Dentaid

Dentaid which has links with the Christian Dental Fellowship, is refurbishing dental equipment donated by dentists in the UK and sending it to overseas projects, often with dentists or dental engineers to help assess programmes and provide training. Places mentioned in the August newsletter *Extractions* include Rwanda, Azerbaijan, Russia and Kosovo. Contact Dentaid at The Old Bakery, Mount Road, Llanfair Caereinion, Welshpool, Powys SY21 0AT. Tel. 01938 811017. Fax 01938 811107. E-mail: info@dentaid.freeserve.co.uk

EQUIP

The leaflet for 2000 with the programme of training courses for Christians wishing to serve at home and overseas (and return home) is available from The Administrator, EQUIP, Bawtry Hall, Bawtry, Doncaster, S Yorks DN10 6JH. Tel. 01302 710020. Fax 01302 710027. E-mail: equip@bawtryhall.co.uk

MEDAIR

MEDAIR has programmes in Kosovo. It has supplied drugs to north eastern Congo (700 tons by DC-8) to an airstrip never before used by such a big plane, and which were immediately distributed to 80 hospitals by every form of transport down to bicycle. It works in Southern Sudan where it has seen a base bombarded by warplanes and then villages burnt by ground troops. A large number of trachoma cases need surgery. It has workers in Afghanistan in spite of the humanitarian moratorium on aid, aimed against the Taliban.

MEDAIR also runs crisis situations seminars. The next one will be held in Sweden at the YWAM base 18th-27th February and will be exclusively in English. (Closing date January 14th.) Ask to be put on their mailing list. Contact MEDAIR, Chemin de la Fauvette, 98, 1012 Lausanne, Switzerland. Tel. +41 21 654 32 30. Fax +41 21 654 32 40. E-mail: info@medair.org Website: http://www.medair.org

Medical Expenses and Travel Policy

The Banner Group has issued new premium rates for EMA/EA members, for both UK residents and those habitually resident outside the UK. Both CMF and MMA are members of the Evangelical Missionary Alliance. Contact The Banner Group, Banner House, Church Road, Copthorne, West Sussex RH10 3RA. Tel. 01342 717917. Fax 01342 712534. E-mail: info@bannergroup.com

International Health and Education Exhibition

Tuesday 1st February, 12.30-4.30, Jeffrey Hall, Institute of Education, 20 Bedford Way, London WC1 (around the corner from Senate House). Organised by the Centre for International Child Health (CICH), Institute of Child Health, Institute of Education and the International Health Exchange. Enquiries CICH, 24 hour answerphone: 020 7404 1096, or E-mail: cich@ich.ucl.ac.uk

Student elective days

Dundee Saturday 12th February
Leeds Saturday 11th March
London Wednesday 22nd March

Overseas Update (Residential Refresher Course)

10th-21st July at London Bible College. Brochures available from CMF office.

reviews:

The Care of Neuropathic Limbs - a practical guide

Grace Warren with Sidney Nade. Parthenon Publishing Company, Casterton Hall, Carnforth, Lancs LA6 2LA. 1999. 192 pp with 195 illustrations. £45 Hb. ISBN 1 85070 048 6. (May be available from The Leprosy Mission and /or TALC).

Intended for physicians working with leprosy sufferers in developing countries, the authors believe the application of the same programmes applied to patients with neuropathy from other causes will result in better outcomes than are currently achieved. The other causes include diabetes, accidents, infections, spina bifida, other congenital abnormalities and inherited neuropathies including Charcot Marie Tooth disease. Grace Warren is a CMF member based in Australia.

requests:

Disaster Relief - 'Stop Propagating Disaster Myths'

The Chief of Emergency Preparedness and Disaster Relief Co-ordination, Dr de Ville de Goyet, in a letter distributed by the Pan American Health Organisation writes of the need to reassess the myths and realities surrounding disasters. These include the following myths:

- dead bodies cause a major risk of disease
- the affected population is helplessly waiting for the Western world to save it
- any kind of international assistance is needed and it's needed now
- that things go back to normal within a few weeks

He comments

- it is often better to wait until genuine needs have been assessed
- cash . . . ensures that allocation of resources is field driven
- millions of dollars spent to dispatch search and rescue teams . . . a small part of this money could have been more effectively applied in preparedness and prevention activities

Emmanuel Hospital Association

sent a team of eight to Orissa following the cyclone. Details: EHA (UK), PO Box 43, Sutton SM2 5WL. Tel: 020-8770 9717. E-mail: info@eha.org.uk

EHA surgeon Sam Thomas visited this office and would welcome any journal, but especially a surgical one. This could be sent after it has been read or sent by CMF at a reduced rate if someone can pay the subscription. He can be contacted at Herbertpur Hospital, PO Herbertpur, Dist. Dehradun UP, Pin 248142, India

vacancies overseas:

Posts often require you to raise your own support (some missions can help with this) and to have support of home church. Longer list of Opportunities of Service mostly through UK based mission societies is available in Saving Health (see box below).

AFRICA

Gambia

WEC International - doctor for Sibanor Hospital. Minimum 2 years postgraduate experience preferably including paediatrics, O&G, DTM&H and completed GP training.

Hospital 85km from coast on a main highway. Work includes all hospital specialties except major surgery and involves visiting dispensaries. MCH and primary eye care service. 40 beds. 35,000 outpatients and 3,500 inpatients a year. Basic lab services and blood transfusion. Teaching and in-service training of nursing staff. Preferably 1-2 years and to start asap, latest April.

Applications: Medical Director, WEC International, Box 86, Banjul, The Gambia. E-mail: sibanor@commit.gm. Tel. 00220 488040. Fax 00220 373104

ASIA

Bangladesh

The Lamb Hospital in the north have a couple coming to UK to study. Mark Pietroni writes: 'As a result we will be short staffed (again) in O&G. We are still looking for another long term obstetrician in general, but in particular need short term cover May-July.

150 deliveries/month, 70% complicated by UK standards. 3 national doctors in training, 1 expat MRCOG, advanced trained midwives (do suturing, ventouse, initial management of eclampsia, initial resusc of baby etc), academic atmosphere with ongoing research programme (MAGPIE trial, STD/HIV study of antenatal women), medical and paediatric units with expat neonatologist, part of a larger community oriented project.'

Contact Mark Pietroni, Lamb Hospital PO Parbatipur, Dist Dinajpur 5250, Bangladesh. E-mail: lamb@citechco.net Please name recipient in subject line. Avoid attachments if possible as download very slow.

Pakistan

Murree Christian School needs school nurse. This boarding school for the children of missionaries has about 130 students and national staff workers. Job Description in this office, or contact Director, Murree Christian School, PO Jhika Gali, Murree, Pakistan 47180. Fax +92 593 411668. E-mail: mcs@mcs.sdnpk.undp.org Website: http://www.hafggis.ndirect.co.uk/mcs/

Dr Jane Sampson (see *Triple Helix* 8) is still looking for a GP to replace her in her remote valley. E-mail address corrected below. Contact: this office or Kunnhar Christian Hospital, Balakot Road, Garhi Habibullah, Mansehra District, Hazara, Pakistan. E-mail: kcc@kcc.sdnpk.undp.org

AUSTRALASIA

Papua New Guinea

Medical officer for Rumginae Health Centre (see *Triple Helix* 9). Inpatient and outpatient care and training of community health workers for isolated rural areas. Obstetric skills desirable. Contact UFM Worldwide, 47A Fleet St, Swindon, Wilts SN1 1RE. E-mail: ufm@ufm.org.uk or, direct: rumginae@datec.com.pg

CARIBBEAN

Trinidad and Tobago

Medical mission teams invited. Contact Brian Lushington, PO Box 3246, Diego Martin, Trinidad.
E-mail missions-international@uas.net
Website: http://www.missionsinternational.com

MIDDLE EAST

Yemen

Jibla Baptist Hospital. Following could be filled immediately: general surgeon, obstetrician, physicians, paediatrician, anaesthetist/nurse anaesthetist, family/general practitioners, nurses, midwives, theatre nurse, nurse practitioner, pharmacist, laboratory technician, mechanic/maintenance personnel, secretary.

Committed Christians qualified in above areas welcome, short or long term. Some knowledge of Arabic helpful, but not essential. Currently 60 international expatriate staff. 6,000 feet above sea level in a cool green mountainous region.

Contact William Koehn, Jibla Baptist Hospital, PO Box 70080, Ibb, Republic of Yemen. Tel. 967 4 400039. Fax 967 4 400058. E-mail: jbh@y.net.ye

MISSION SOCIETIES

Interserve

Vacancies for a wide range of Christian healthcare professionals to serve in Bangladesh, Central Asia, Middle East, India, Gulf States, Nepal, North Africa, East Asia, Pakistan, Red Sea. Contact: 325 Kennington Park Road, London SE11 4QH. Tel. 020-7735 8227. Fax 020-7587 5362.

E-mail addresses for Interserve England and Wales have changed: offers of service overseas from 2-12 months and applications for student electives by e-mail should be addressed to ontrack@isewi.org

For short term service (one term of service - usually 3 years plus 6 months home assignment but sometimes 2 years and 4 months home assignment) and long term (more than one term of service), offers should be addressed to personel@isewi.org

Salvation Army

Doctors including surgeons and nurses/midwives including tutors for Zambia Chikankata Hospital (see p10) and Zimbabwe Howard Hospital and Tshelanyemba Hospital. Nurses/midwives for Ghana and Nigeria. Physiotherapist (single) required for Ghana. Health Programme Co-ordinator for Lagos, Nigeria.

Contact Mrs Lt Colonel Audrey Burrows, Resources Department, Salvation Army, 101 Queen Victoria Street, London EC4P 4EP

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. 020 7928 4694. Fax 020 7620 2453.
E-mail: 106333.673@compuserve.com.
Websites: www.cmf.org.uk/mma/home.htm and 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
Website: www.christian-healthcare.org.uk

from Belarussia with Love

'Your mission, Bunn, should you accept it, is in Eastern Europe.'

'Certainly, M. Whereabouts?'

'Somewhere near Chernobyl.'

It was with trepidation that I accepted my mission from MMA/CMF to go to Belarus last summer. Andrew Greenfield, Annie Leggett and I joined a conference near Minsk, organised by the International Fellowship of Evangelical Students.

The Chernobyl fallout, equivalent to nine Hiroshimas, ruined eastern Belarus. Whole villages were razed, communities dispossessed, hundreds of thousands mobilised for the clean-up operation. The highest reward for suicidal acts of sacrifice was a 'hero's bus pass'. Geiger counters are still used to test food bought at market.

The students we met have far less materially than students here. Textbooks are prized items to be shared amongst a large group. Most live on less than £7 per month, and work on a farm is essential to survive. And qualification does not bring the prosperity and freedom we expect in this country. Even doctors working on punishing rotas would find a car or foreign holiday unaffordable. Yet despite material disadvantage, the students we met were highly educated. Students who had never met a native English speaker corrected my grammar on more than one occasion!

The conference was a great success. One hundred and thirty people came, arriving on two buses. The blinds were tightly pulled down to avoid prosecution! A whole generation has been withheld from church, in a state policy intended to stamp out faith. But the 'God-shaped hole' in the human heart is universal across cultures. Even in a country devastated by Chernobyl and stifled economically and politically by communism, the most pressing need is spiritual. The students were hungry to hear news about God's rescue plan for man through Jesus. And it was embarrassing to receive gratitude for passing on a message I take for granted.

I was left to reflect on how much I have received at no cost. Yet my reluctance to share some of my abundance contrasts sharply with Jesus' example: 'For you know the grace of our Lord Jesus Christ, that though he was rich, yet for your sakes he became poor, so that you through his poverty might become rich' (2 Corinthians 8: 9). Will you accept the mission?

Anyone interested in a trip of this kind next summer should contact the CMF office, or e-mail alex@cmf.org.uk

Alex Bunn is an SHO in general medicine and part time student staffworker, funded by MMA

RevieWWWs

CyberDoc examines Internet answers to the 6 billion person question

6 billion people - a cause for celebration or commiseration? The Population Research Bureau site makes no secret of its views. Medical abortion is advocated as an answer to this crisis on its front page. Although there seem to be pages of information I cannot bring myself to hang around for long. Time to surf elsewhere!

The Paris-based Musée de l'homme has a rather interesting interactive presentation which uses some of the best in web technology. It is well worth a visit and a good place to start. It makes some interesting points about resource allocation and the fact that famine has reduced in the last 200 years despite population growth.

There are three editorials and several papers on population growth from the 9th Oct 1999 edition of the BMJ available online and they prove quite balanced in their treatment of the subject. They address well the issues of resource consumption and almost the whole edition is devoted to the 6 billion person question.

BBC Online is very clearly on the side of the overpopulation view. They do however make some interesting points - for example that the state of Texas is big enough for a house for everyone in the world today, and that standing up they could all fit on the Isle of Wight.

An American campaign for zero population growth has some interesting but very one-sided pages about the subject and even request online donations to their campaign. According to them the growing population is responsible for extinction of flowers, overcrowded schools, global warming and traffic jams.

The United Nations population division have a very helpful page full of statistics and figures describing the world population in terms of its growth and the way it is changing in its age distribution. The relative decline in the numbers of children is shown graphically by a pyramid graph. There is also a fascinating page which updates the estimated world population every second.

The population research institute has a rather different view of the 6 billion people question. They point out that there is more than enough food in the world to feed every mouth, that world wealth is growing, that life expectancy even in developing countries is rising and that, far from overpopulation in Europe, the threat is a loss of half the population by 2100. The site is refreshing in its celebration of human life and achievements.

One of the pitfalls of searching the internet is that it is easy to throw up apparently irrelevant sites. In researching this article I was using the keywords '6 billion' to search. Imagine my surprise to find a story about Clinton cancelling 6 Billion dollars of third world debt. The page spoke of the poor realising that there is a God who has caused this act of generosity. The announcement occurred only days before the birth of the 6 billionth child. I couldn't help but wonder if this was God's birthday present to one who was likely to have been a poor child.

CyberDoc is Adrian Warnock, an SHO in psychiatry and a leader of a small group in his local church. Links for today's websites can be found at http://xtn.org/cyberdoc/6billion

The Church and the homosexual

With UK Parliamentary discussion expected of 'Clause 28' and the homosexual age of consent, long-term commentator on issues of church and society John Martin reviews the background to the current situation

A series of recent events seems to suggest that public opinion in the Western world is moving inexorably in favour of tolerance of homosexuality. In France in October, the National Assembly and Senate approved partnership contracts giving a new legal status to cohabiting non-married couples - heterosexual or homosexual. Non-sexual partnerships and friendships are included. but the main beneficiaries will be common law and gay relationships where the parties sign a contract 'with a view to organising their life in common'.

These contracts can be registered with a clerk of a magistrate's court and thus have the force of law. The debate took up a massive 106 hours of parliamentary time. To appease conservative critics, it was agreed that the legislation should make it clear that such relationships did not have the same status or enjoy the same advantages as traditional marriage.

In California, even some of the mainline churches have agreed to grant rights to employees with homosexual partners in order to retain receipt of public funding for their welfare programmes. Now every employee can designate either a spouse or a 'spousal equivalent' in the same household, to share in the married person's health insurance cover. There is no requirement for the employee making such a declaration to specify the nature of the relationship.

Here in Britain, reform of the House of Lords leaves open the prospect for fresh attempts to lower the age of consent for homosexual acts. Meanwhile, the Children's Society has added its name to a growing number of fostering and adoption agencies unwilling to rule out placement of children with gay couples. More far-reaching still was a legal judgement which found it possible to regard two homosexual men living together, though not married, as a family. Thus the surviving partner could inherit a tenancy after the death of the other.

The Church and sex

So where does all this leave the Christian Church? The tradition of the Western Church over many centuries maintained that sex was for procreation. Sexual intercourse was seen as the transmission of seed, making procreation possible. Sexual intimacy was allowable only in the context of a relationship between a man and a woman in marriage. Sexual acts which did not allow the possibility of procreation were deemed to be 'sins against nature'.

Thomas Aquinas, who is still regarded by Roman Catholics as one of the Church's greatest teachers, identified four 'sins against nature': bestiality, homosexual acts, non-procreative heterosexual acts, and masturbation. His thinking, which follows the thought world of Aristotle, the Greek philosopher, had an enormous influence on all Christian ethical thinking until early modern times.

During the course of the twentieth century, many of the building blocks forming the traditional view of sexuality have been eroded. In the field of moral philosophy, for example, Cambridge professor George Edward Moore (1873-1958), who grew up as an evangelical but became an agnostic, said Aquinas and his successors had indulged the 'naturalistic fallacy'. Just because something was perceived as 'natural', he argued, it did not necessarily follow that it should have a positive moral imperative. Nor should something traditionally perceived as 'unnatural' necessarily be deemed 'immoral'.

Anthropology was another discipline that eroded older Western theories, with studies of the sexual behaviour of Pacific communities feeding a growing mood of cultural relativism. The forces of erosion were at work in popular culture as well. But not all the insights on offer were necessarily hostile to Christianity. One of the great weaknesses of Aquinas' teaching was its failure to offer an adequate account of feminine sexuality. It did not need the twentieth century feminist movement to expose the shortcomings of his understanding of women as receptacles for male 'seed'.

What spawned the twentieth century sexual revolution was growth of the popular belief that as well as being the means for the procreation of children, sexual intimacy was a source of delight that could of itself strengthen the married relationship. The Churches, recognising that the advent of birth control spelt a break with traditional teaching on sexual morality, fought a rearguard action.

Lambeth Conferences of Anglican bishops successively rejected birth control up until 1930. Even then Lambeth opened the door somewhat grudgingly, and with no small amount of obscurantism, declaring that birth control was acceptable within marriage 'where there is a morally sound reason for avoiding complete abstinence'.

Roman Catholic leaders followed a somewhat different course. During the 1960s the Church conceded the value of sex for its own sake within the marriage bond, but at the end of the decade took its stand against birth control through Pope Paul VI's controversial Humane Vitae encyclical. For a Western Society that for more than two generations had lived with the fruits of the rejection of the traditional moral consensus, the Papal teaching was greeted with incredulity. How could a system whose priests were sworn to celibacy possibly teach anything about sexual relations?

Traditional views eroded

So we live in a culture where the traditional consensus on sexual ethics has been eroded. It is not surprising, then, that a great deal of confusion exists about homosexuality as well. How, then, does the Christian disciple approach the issue?

A few years ago Ian McKellen, the actor and gay activist, publicly tore up a copy of the Bible. For McKellen, at least, the teaching of the Bible was patently clear: there was no room for homosexual acts within its teachings. The ground has been well worked over, so in a short article I do not intend to go over all the key texts.

I would argue, however, that the biblical texts need to be examined within their cultural context and that this adds to their potency. The ancient Hebrews lived on part of the Mediterranean basin. They lived among a plethora of peoples who followed a legion of fertility cults and approved sexual intimacy between men and men, and between men and boys. For their part the Hebrews uniquely refused to accept the sexual norms of their neighbours.

Early Christianity shared a similar situation within the sexual mores of the Mediterranean basin. Peter, Paul and the rest of the Apostles engaged in a series of controversies about which parts of Judaism should be insisted on as normative, and which could be jettisoned by Christians. Paul insisted that he was willing to 'become all things to all men so that by all possible means I might save some'. But there is never a hint that any of the Apostles even considered accommodation to sexual norms less stringent than those Jews insisted on.

So the implication is clear. A biblical Christianity insists that the only allowable context for sexual intimacy is between a man and a woman in the bond of marriage. But, as anyone who has been following Church events over the last year or two knows, there are growing numbers of Christians who would insist that this cannot be the last word on the subject.

Bible References on Homosexuality

Genesis 2:24; 19:1-29
Leviticus 18:22, 20:13
Judges 19:1-30
Romans 1:24-27
1 Corinthians 6:9-11
1 Timothy 1:10

Re-interpretation of the Scriptures and history

The late Michael Vasey was a leading exponent of a position that was both pro-gay and seeking to live under the authority of the Bible. He has argued at length and with no small amount of ingenuity, that what we know as gay lifestyle at the end of the twentieth century has no common ground with that sexual behaviour which the Bible condemns. Likewise the late John Boswell won a big following in the USA and to some extent in Britain by historical research that tried to show that gay relationships had received much wider approval in the life of the Church in the Christian era than had previously been thought. The views of both Vasey and Boswell have been widely contested. But the debate is set to continue. In a media world that loves innovation and does not view fixed positions as newsworthy, gay apologists will continue to get most of the headlines. Their opponents will be presented as repetitious and hard faced.

The right to sexual delight

Already I can hear some of my gay acquaintances saying 'How can it be fair that a heterosexual person is entitled to sexual delight in the company of another, while Christianity offers nothing but celibacy for the gay person?' What is certain is that the Church itself has become a source of confusion. The imprecise wording of the 1998 Lambeth Conference resolution on gay relationships has muddied the waters and played into the hands of the radical gay apologists. A great many gay Christians contend that they are not helped by the radical gay rights movements. Likewise many reject the help of Christian leaders like Bishop Jack Spong of the USA who, they say, fail utterly to understand them or their aspirations. As well, by uncritically supporting programmes that purport to offer gays 'healing', Christian churches have sometimes done more harm than good. So if the Christian Church is to continue to rule out anything other than celibacy for gays, then it must do more to offer community and support to disciples of Jesus who have chosen celibacy.

I am certain there is much about the gay scene, and in gay sexual practices, that is enormously destructive. If Christian churches can become the loving communities of faith they say they aspire to be, they have much to offer the gay person. But the path will never be an easy one.

John Martin is Associate Editor of Triple Helix

readers' letters:

To strike or not to strike?

*Junior doctor **Richard Brighton** is one of the British Medical Association negotiators:*

I read the article 'To strike or not to strike?' with interest. As one of the negotiators for junior doctors, it is a subject that has been very close to my heart over the past few months. On a cursory look my heart sank as I saw the conclusion that John Martin felt that Christian health professionals should not go on strike. So I reread it more closely, and found myself agreeing with him!

The first thing that needs establishing is what is meant by the term 'strike'. I suspect that most people understand it to be a total withdrawal of all labour. I believe that the legal definition is for any withdrawal of labour. Semantics? The difference is important for the latter includes providing emergency only cover, whilst refusing to perform duties relating to elective patients.

The key issue is the balance between justice and compassion. The long hours and poor working conditions that most junior doctors work have a great impact on patients, the doctors themselves, and their families. This is a situation that has gone on for years and whilst there has been a reduction in hours on duty there has been a great increase in intensity of work, especially out of hours.

How far should we go in pushing for justice when there could be effects on patients? The initial steps have to be discussions with bodies such as the Department of Health, but when these fail, what then? Industrial action is never a first choice but there may be occasions when the benefits in the long term outweigh the effect in the short term. The form of industrial action is important - having the greatest gain for the least cost has to be a priority. The BMA Junior Doctors' Committee has ruled out total withdrawal of labour as an option, because we felt that the effect on emergency patients would be too great.

Industrial action was very close; the process had started and may still be necessary. It is not a decision that is made easily but solving this problem is important. In the next few weeks there will be the final outcome of how long it will be till the 48 hour week is introduced, when perhaps we can see doctors working more reasonable hours and getting at least one day a week of rest as God intended.

Postcoital contraception

*Birmingham GP **Greg Gardner** continues the debate about the status of the embryo:*

Mandi Fry and Hugh James have re-ignited a crucial discussion about the nature of the embryo (*Triple Helix* Autumn 1999). The gradualist school of thought which believes that unborn human life becomes more precious the older he or she becomes has one massive obstacle to overcome. Scripture teaches that the person whom Mary conceived in her womb was Jesus, not some kind of amorphous zygote or embryo or fetus but Jesus himself. There is no evidence that Jesus's human life started at any point other than the very beginning, ie fertilisation. If Jesus became like one of us at fertilisation, what does this say about our own humanity?

Mandi Fry is correct to point out the abortifacient nature of several contraceptives including the IUD and the progestogen-only pill. To this list others could be added, including - sometimes - the combined pill. Because of this dual action of various contraceptives there has been a sustained effort to redefine nearly every term in the thesaurus of human reproduction including 'pregnancy', 'conception', 'abortion' and 'person'. This manipulation of the truth is a deliberate attempt to alter the definition of life. At a conference about the IUD in 1964, one delegate said 'In a Moslem country like Pakistan, if it's considered that the IUD is an abortifacient, this would have a bearing on acceptance or rejection'. The reply from eugenicist Dr Christoper Tietze was, 'If a medical consensus develops and is maintained that pregnancy, and therefore life, begins at implantation, eventually our brethren from the other faculties will listen'.[1] In the following year, the American College of Obstetricians and Gynecologists put out a statement proclaiming 'Conception is the implantation of a fertilised ovum'.[2] There was no scientific evidence to support this change yet for political reasons, in order to enhance the acceptability of abortifacient contraceptives, goalposts had to be moved.

Some recent examples of terminology mutation have been those of 'emergency contraception', 'safe sex' and the neologism 'contragestive' invented by Etienne Baulieu in the hope that the term 'may defuse the abortion issue'.[3]

The death of truth is associated with the death of cultures. That is why it is important that attempts to change the definition of life, whether at the beginning or end, should be resisted.

References

1. Segal S, Ed. Proceedings of the Second International Conference, Intra-Uterine Contraception. *Excerpta Medica*, 2-3 October, 1964; 86:212
2. ACOG Terminology Bulletin, terms used in reference to the fetus. Chicago: American College of Obstetricians and Gynecologists, 1965
3. Baulieu E. Contragestion by the Progesterone Antagonist RU 486: a novel approach to human fertility control. *Contraception,* 1987; 36 (Suppl):1-5

Homoeopathy

*Peter May's Autumn 1999 review of Steven Ransom's Homoeopathy - What Are We Swallowing? brings a robust response from Lincolnshire GP **Judith Gosney**:*

I was astonished and offended by the review by Peter May

about an obviously one-sided and biased book on homoeopathy. Surely I cannot be the only Christian doctor who has used homoeopathy widely in general practice and found it invaluable where conventional medicine has nothing to offer?

The assertion that 'for financial gain he kept selling this remedy and refused to divulge its secrets', as though this were in some way reprehensible, is patently absurd. How many modern pharmaceutical companies give their newest drug away free and send details of its synthesis to their rivals? Belladonna in dilution is far from a 'useless substance' as I have proved to my satisfaction over many years and it is a delight to hear patients request homoeopathic treatment again because 'it worked so well last time'.

I wonder how many modern physicians take total responsibility if a patient dies despite their ministrations, and how many begin to presume the patient to be neurotic if they do not improve? Sarcastic condemnation about 'crackpot theories . . . theoretically absurd . . . intrinsic nonsense' which nevertheless seems to be 'sweeping all before it' seems rather contradictory. Just because we cannot show how something works doesn't negate its power.

Can Dr May show me a well constructed trial to prove the present existence of God, the efficacy of prayer, the power of faith? As Christians we take these things on trust - as I took homoeopathy before I started to use it and was astonished at its efficacy.

I am afraid the scathing arrogance of opinion must be off-putting for many readers - not least non-Christians whom we may hope to attract. As I read the journal I am reminded more and more of a 'holy huddle' who condemn without knowledge and appear to consider themselves better than others who do not share their opinions absolutely. Very dis-spiriting.

For a more balanced overview of homoeopathy see the British Medical Journal series ABC of Complementary Medicine (23rd October 1999 page 115ff) - the writers are unbiased. If Dr May lasts long enough he may live to see homoeopathy - like aseptic techniques - eventually proven!

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.

Write to:
Triple Helix
157 Waterloo Road
London SE1 8XN
Fax: 020 7620 2453
e-mail: admin@cmf.org.uk

reviews:

The Thorn in the Flesh

R T Kendall. Hodder & Stoughton, London. 1999. 228pp. £6.99 Pb. ISBN 0 340 74546 0

Every Christian working in healthcare would find this book a valuable resource. Dr Kendall has taken the sermons he preached at Westminster Chapel in 1998 on 2 Corinthians 12:7 and focused on eleven problems facing contemporary society. As individuals and in family and public life we are challenged to make sense of difficult personal relationships and events which appear out of our control. At the centre of how we cope is our worldview, and the author presents the Christian biblical viewpoint expressed so well by Paul in his letter:

'To keep me from becoming conceited because of these surpassingly great revelations, there was given me a thorn in my flesh, a messenger of Satan, to torment me' (NIV).

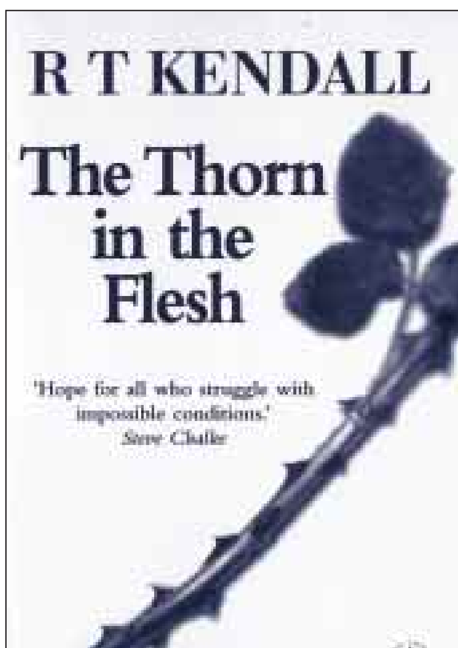
This book considers the question 'Why me?' Secular society has devised educational and psychological techniques to cope with adversity and it is not surprising to realise that many of these are based on biblical principles, even if these are unrecognised, for 'all good things come from above' (James 1: 17).

In introducing the subject Dr Kendall refers to his previous book *The Anointing: Yesterday, Today, Tomorrow* (Hodder and Stoughton 1998) in which he showed that every person has an anointing. 'God may want to increase our anointing . . . he may choose to do this by way of a "thorn in the flesh". This will get our attention and is designed to keep us humble' (p1). So the reader is invited to share the assurance that God has not finished with us yet and he is refining us for a greater anointing for his glory.

To qualify for this special form of chastening we need to have a conviction of sin which often comes through the Holy Spirit applying the preached word. Then we will have our reward at the Judgment Seat of God which Paul himself so sought after (1 Corinthians 9:24-27). The paradox of the 'thorn in the flesh' is that Satan is involved in bringing our affliction (Job and Judas Iscariot) but God takes the full responsibility for its outreach. We must

not try and remove it ourselves - it is for our good - the next best thing that happens to us after our conversion and anointing.

To the reader who is searching for insight into life's meaning, each chapter brings greater understanding. The relevance of the chapter is made clearer as Dr Kendall develops the application for many scenarios, and no one need feel left out. Jesus, who was himself the loneliest person when on the cross, may call the one who feels so lonely to be an intercessor. Unhappy employment may be a means God uses to make us more dependent on him and to crush our pride. We learn when we have an enemy how to forgive, how not to grieve the Holy Spirit and how to refuse to vindicate ourselves. A handicap or disability or any trial may lead us to self pity, but God uses these 'thorns' to drive us closer to himself.



In making a choice where we live we may 'pitch our tent near Sodom' as Lot did, and land up in unhappy living conditions. But like Moses we get our compensation in 'the joy of the Lord', remembering that the Kingdom of God is within. For someone with a sexual problem there may be temptation but when the weakness is confessed '[God] is faithful and just and will forgive us our sins' (1 John 1:9). Also with an unhappy marriage God is jealous and wants our attention. We forfeit our reward if we harbour bitterness. We need to stop pointing the finger and one day we may realise the thorn is part of a rose, beautiful and fragrant.

A chronic illness may be present to manifest God's glory in healing or in some plan God has to advance his kingdom. In submission we develop spirituality without self-righteousness. A personality problem is often the root of theological controversy. Even Paul and Barnabas fell out, and James points to the underlying problem - the tongue. We grieve the Holy Spirit when we are a thorn in the flesh to another by being overly righteous, overly scrupulous or overly submissive.

In the chapter on money matters the biblical injunction to tithe is made the basis of having our needs met, and when work is not available it is all the more important to thank God for the essential things we do have. In conclusion Dr Kendall quotes the saying of a ninety year old lady: 'I can hardly tell the difference between a blessing and a trial'.

The pastoral style of writing encourages the reader. The author gets alongside, empathising with the feeling, be it loneliness, a chronic disability or illness, or a personality problem. The reason for the 'thorn' is developed throughout the book with repetition of God's primary aim that we become intimate with him, but no facet of the meaning is left unexplored. The author shares his own walk with God and his personal experiences and the whole book is firmly based on scripture. The Bible is frequently quoted in full so that the meaning is not lost, and the book can be read anywhere. There are useful notes on Chapters 9 (chronic illness) and 11 (money matters) at the end of the book, but the book lacks an index. However, students will find much material for further study and are encouraged to think for themselves.

This review has attempted to distil some of the wisdom and comfort which is shared in the pages of this book, but the personal touch can only be fully appreciated when it is read. It could save many a Christian from falling into unnecessary trials and it encourages our praying that we be not led into temptation. The messages contained in these pages can be used in everyday clinical practice by the healthcare professional, lightening the burden for Christian and non-Christian alike. There might even be some who will come to a saving knowledge of Jesus Christ, for God can use many means to bring his chosen ones into the Kingdom of Heaven.

Anita Davies
(Physician, London)

Use and Misuse - a Christian Perspective on Drugs

Ollie Batchelor. Inter-Varsity Press, Leicester. 1999. 175pp. £5.99 Pb. ISBN 0 85111 599 3

'Drug use is everybody's problem.' So begins the introduction, and in the remainder of the book Ollie Batchelor proceeds to demonstrate that 'everybody' includes Christians - and the church.

He builds his case carefully, beginning with a broad historical overview of drug use and legislation, showing how attitudes towards specific drugs have changed over time. Included in his definition of 'drugs' are the legally available and socially

acceptable alcohol and tobacco. Part of his groundwork includes the clarification of drug terminology and the dispelling of certain misconceptions about drug use, as well as a description of various commonly used psychoactive drugs and their legal classification.

He helps the Christian reader to understand the various reasons why people use drugs because this is vital to any effort to contribute positively to the drugs issue. Although he acknowledges that pleasure is probably the greatest single reason why people use drugs, for many there is also a spiritual dimension, a hunger for 'something more'.

Having laid this foundation, the author proceeds to build a framework of biblical principles which he believes should inform the Christian's own use of drugs, devoting a whole chapter to the sometimes controversial issue of alcohol. He manages to avoid being either legalistic or licentious and emphasises personal responsibility when making choices.

Ollie Batchelor then turns his attention to the church, beginning with a summary of past church involvement in drugs issues (mainly alcohol) and paying tribute to present achievements in the field. The remainder of the book points the way forward for the church, both in principle and in practice.

This is a truly excellent book - easy to read and very informative. It issues a challenge to the church, and then helps the church to meet that challenge.

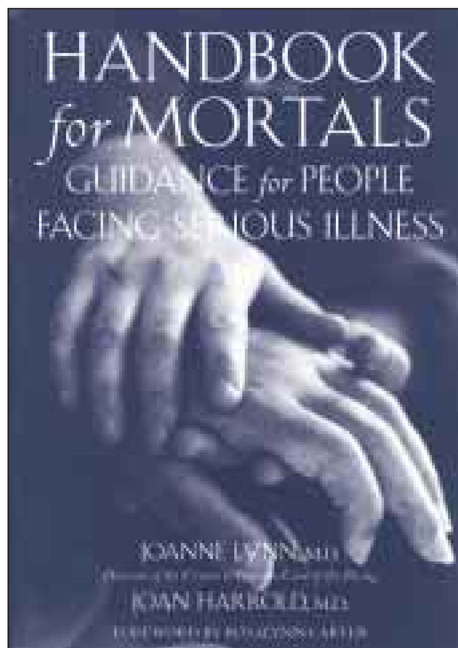
Marolin Watson (works with Hope UK, a national Christian drug and alcohol education charity based in London)

Handbook for Mortals - Guidance for People Facing Serious Illness

Joanne Lynn and Joan Harrold. Oxford University Press, New York and Oxford. 1999. 240pp. £14.99 Hb. ISBN 0 19 511662 3

In this book there are many helpful comments and suggestions to help people facing serious illness. This perhaps is its greatest strength. I cannot think of many books for the patient but legion are the titles written for the healthcare professional.

The opening chapter is entitled 'Living with serious illness'. So often individuals feel that life has come to an end once the diagnosis of a serious illness is made and all they can do is sit around focusing on their own problems awaiting the inevitable. Somehow the message needs to be got across that there is still a great deal of living to do. You can live an active life albeit within the limitations of disease and enjoy a great deal of satisfaction. I remember a patient who upon discharge from the hospice boarded a plane bound for Spain and enjoyed four weeks' holiday in the sun. Others have achieved important personal milestones.



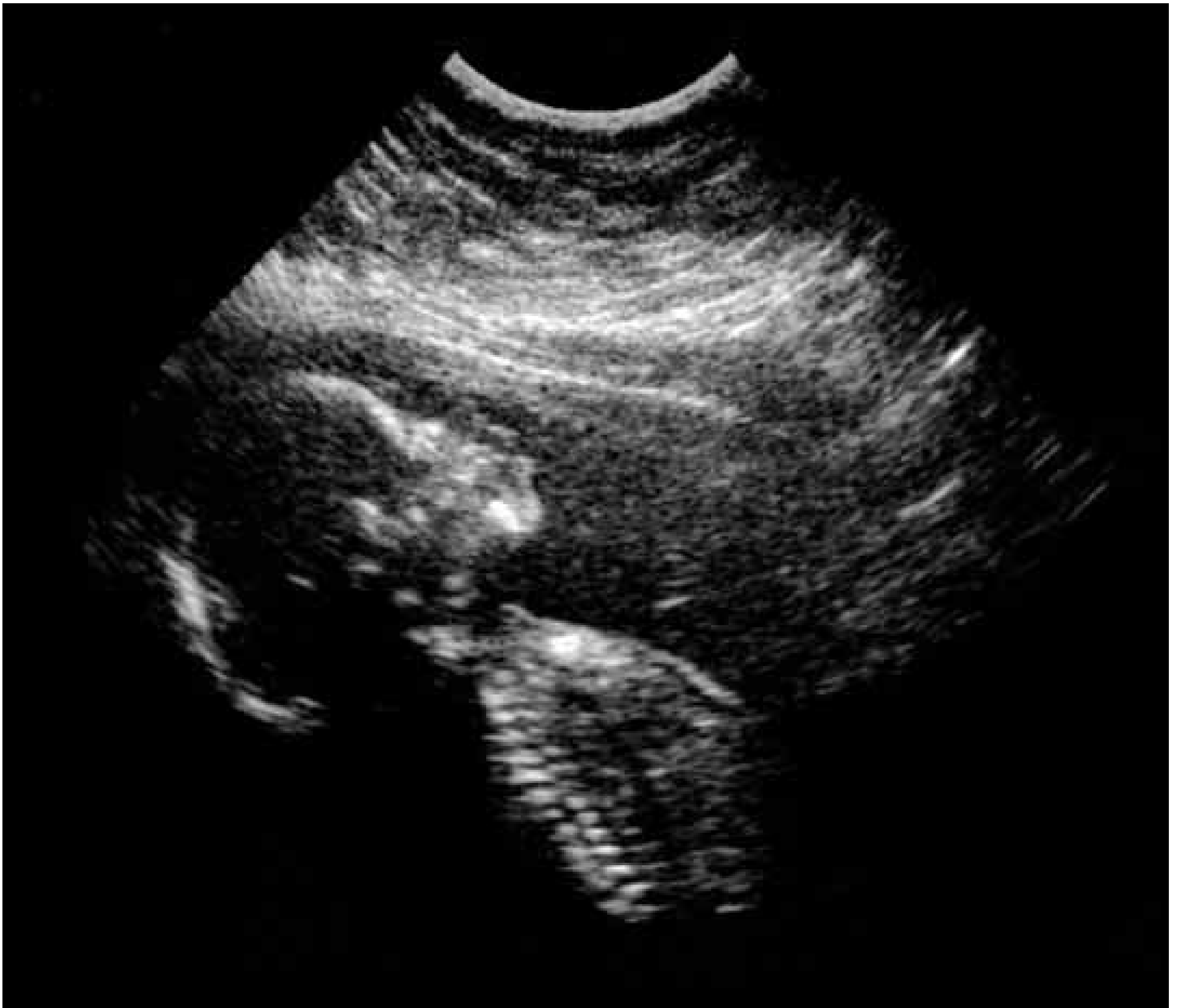
There are also useful sections on setting realistic goals, the importance of looking after yourself, finding support by asking questions and not being a passive patient, talking with others, and family dynamics. There is a useful chapter on controlling pain, which avoids the use of technical language and may be helpful for people facing the prospect of taking drugs they cannot pronounce and worried about side effects.

A chapter about planning ahead will help people realise they still have choices regarding treatment. We are becoming more patient-centred in treatment plans but many feel intimidated by the highly technical world of the large modern hospital. I can think of some of our patients who would benefit from the chapter on 'managing other symptoms'. This section looks at breathlessness, nausea and vomiting, bedsores, and depression. There is simple advice which will help individuals find relief.

The most important feature of this book is the help it provides in planning for the future and remaining in control of treatment and life. There are many books on the topic of dying, some autobiographical, others medically orientated, but few offering help and advice to the person affected by serious illness. The size of the book may be somewhat daunting to a frail individual.

My negativity about the book has two parts. The first is size, over 200 pages. I do not know of many seriously ill patients who could cope with something this large. Secondly, and here lies my major concern about this book, it is written for a North American audience. Many references are not applicable to the UK. For example, in this country hospice care is free to the patient and may last a year or two. In North America health insurance policies seem to provide for six months' care (p53). Local authority structures are also very different. People will lose interest if the book fails to address their need. Several photographs should be removed from a second edition as they are simply awful (pp 80, 87, 111, 123, 192 especially). Unless you want to locate a Website address the 20 pages of organisations will be of little use. Changes need to be made for this book to benefit those living on this side of the pond!

Stephen Henwood (Chaplain, St Francis Hospice, Havering atte Bower, Essex)



You knit me together in
my mother’s womb...
I am fearfully and
wonderfully made