TRIPLE HELIX

Winter 2001

For today's Christian doctor

NEAR DEATH EXPERIENCES
Can we learn anything from them?

VIRGINITY
Still in fashion?

THE HUMAN RIGHTS ACT AND PVS

ABORTION
The cost of conscientious objection

CANNABIS
Should it be legalised?

EFFECTIVE PARENTING

UGANDA REVISITED

EUTYCHUS

FEELING DISAPPOINTED?

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EDITORIALS

Virginity

Government's rediscovery of its value is welcome

It's official! '*£60m MESSAGE: VIRGINS ARE OK*' proclaimed the *Evening Standard* recently, reporting on the Government's latest advertising offensive to try and reduce the number of teenage pregnancies in Britain (which currently exceeds 90,000 per annum).

'There is nothing embarrassing about being a virgin' one sixteen year-old claimed in the *Daily Telegraph*. However the Department of Health seemed a little more embarrassed about it than the headlines initially implied. The message that 'It's cool to be a virgin' was thought to be too unrealistic to lead the campaign and the more ambivalent slogan 'Sex, are you thinking enough about it?' was finally adopted instead.

Ambivalence often seems to sum up the general establishment attitude toward virginity. Delaying the onset of sexual intercourse is widely seen as a key objective for sex education programmes and is often used in research as an outcome measure of their effectiveness. The July 2000 DfEE guidelines on sex education emphasise its importance. Yet some major providers of sex education see it as a lost cause. Several leading sex educators have expressed to me their incredulity about encouraging abstinence. Neither 'abstinence' nor 'virgin' appear in the glossary of the FPA workbook for first schools!

The press also betrayed their cynicism in much of their coverage. *The Sun* in pronouncing that Katy Hill 'the super-cool star of *Live and Kicking* reveals today that she stayed a virgin until her wedding night' could not resist adding 'after making her boyfriend wait 13 years for sex'. The idea that any couple could freely and joyously agree together not to have sex before marriage is one that passes Fleet Street's understanding.

Sadly virginity, fidelity and indeed any concept of the importance of sexual purity seem to pass many Christians' understanding too. In writing about the pragmatic arguments for encouraging abstinence,[1,2] I have expected and received much attack. However the opposition I have encountered from Christians has surprised me. When in the scriptures Paul writes 'I am jealous for you with a godly jealousy. I promised you to one husband, to Christ, so that I might present you as a pure virgin to him',[3] he is surely drawing an analogy between our sexual union and the exclusive intimacy God desires with his people. This is a thread that runs through from Genesis to Revelation.[4] Both content and context of our sex-lives have the most profound implications about the nature of our relationship to Christ.[5]

The Government's rediscovery of the value of virginity is welcome. Christians should have the strongest motivation to help teenagers resist pressure to become sexually active. We have the spiritual dimensions of sex revealed to us and the power of the Holy Spirit within us to enable us to 'flee sexual immorality'[5] and honour God with our bodies.

Trevor Stammers

Tutor in General Practice, St George's Hospital Medical School and regular author and broadcaster on sexual health.

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2 Stammers T. The case for virginity. *BMJ* (In press)

3 2 Corinthians 11:2

4 Genesis 1:27-28; Isaiah 57:7,8; 62:5; Jeremiah 2:2, 23-25; Ephesians 5:25-32; 1 Thessalonians 4:3-8; Revelation 21:2

5 1 Corinthians 6:13-20

The Human Rights Act and PVS

Not a blind bit of difference

Photo: John Worrell

The Human Rights Act 1998 came into force in England, Wales and Northern Ireland on 2 October 2000, having had effect in Scotland before. Article 2 states: 'Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally...' and then makes well-recognised exceptions for capital punishment and self defence. This right is the most fundamental of all, and ethicists were waiting to see its impact on medical law. We did not have to wait long.

On 5 October two cases of women in permanent vegetative state came before Dame Butler-Sloss, president of the High Court family division. The question was whether tube-feeding could still lawfully be withdrawn, as it has been occasionally since the landmark verdicts on Tony Bland[1] which controversially established that treatment that confers no benefit on a patient, including artificial nutrition and hydration, may be stopped. Would the new Human Rights Act affect this?

A mere day later, after evidence and legal submissions (and significantly the Official Solicitor did not oppose the applications) the declaration came that artificial feeding was not in the patients' best interests and could be withdrawn.[2] The 'Right to Life' law has thus made not a blind bit of difference.

However, the two patients remind us every case is different. Pro-life observers in court said that in Mrs H the surgery needed to replace her blocked tube would indeed have been a disproportionate burden, and they therefore did not think there was any intention to kill. Mrs M was typical of court cases post-Bland, but in the eight years since that verdict, only about 20 cases of PVS have come before the British courts out of the several thousand who have entered PVS and left it by natural death. The intuitions of 99% of professional and family carers are that tube-feeding in PVS should be continued, and so far there have been few deaths due to withdrawing food and fluid.

'Hard cases make bad law' and CMF members may disagree about the management of PVS, but this verdict at least reminds us of the clear and present danger of backdoor euthanasia. The risk is that if we end patients' lives intentionally by deliberate omissions of basic care, we will come to end them by deliberate acts of commission.

Andrew Fergusson

Head of Policy at the Centre for Bioethics and Public Policy

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Gene screening for insurance

Both necessary and reasonable

Gene testing is set to become routine for all large insurance policy applications. Lessons learned from HIV-related fraud suggest it as the way forward however undesirable the risks of creating a genetic underclass. Both the Genetics Advisory Commission and the Association of British Insurers support gene test results being given to insurance companies (*BMJ* 2000; 321:977). This has become both necessary and reasonable.

We have been here before with HIV. Insurance companies were defenceless against people who had secret positive HIV test results and then took out huge policies, while their GPs gave them a clean bill of health. After a number of high profile fraud cases most companies insisted that everyone taking out large policies should be tested. The alternative would be a jump in premiums.

The equivalent of a private HIV test is already upon us for gene screening, using swabs of saliva. Expect gene testing to be widely available by e-mail order within three years.

We cannot have a situation where applicants know they are a terrible risk and the insurance company does not. It is vital that applicants are asked to disclose any information they possess, including gene test results, which might significantly alter their risk rating. But, as we have seen with HIV, without proper testing this requirement alone will not protect against active deception.

The only alternative will be for insurance companies to start excluding illnesses which can be predicted easily using gene tests. That is what happened with HIV where some companies decided not to go down the testing route. But every day that list of gene exclusions is likely to grow, until testing becomes the more palatable option.

Urgent thought will need to be given to the plight of growing numbers of people who then find themselves unable to get life, health or mortgage cover. Christian doctors should respond by being informed, being truthful in documentation, acting as advocates for patients and encouraging the church to care and provide for those marginalised by the system.

Patrick Dixon
Director of Global Change

RU-486

Deception and corruption we haven't heard the last of

The US Food and Drugs Administration has recently approved the use of Mifepristone (RU-486) to procure abortions up to 49 days gestation (*BMJ* 2000; 321;851). RU-486 was developed by the French drug company Roussel Uclaf, a subsidiary of Hoechst. Hoechst was itself derived from IG Farben, the chemical giant who made the stabiliser for Zyklon B gas used to kill millions of Jews during the holocaust.

In response to boycotts of Hoechst products by the American pro-life community, Roussel announced in 1994 that it was giving up its patent rights to RU-486 and would cease manufacture even though pressurised by the FDA to apply for a product licence. The FDA broke its own rules repeatedly and facilitated transfer of the patent rights to the strongly anti-natalist Population Council *(www.nrlc.org)*.

RU-486 is not very effective unless used with prostaglandins or analogues such as Misoprostol. Searle Laboratories, the manufacturers of Misoprostol, have objected to its use as an abortifacient and in their literature they advise against its use in pregnancy. There have also been isolated reports of possible teratogenicity. In a series of 2121 women given the Mifepristone/Misoprostol regime, 106 failed to attend follow up (*N Eng J Med* 1998; 338 (18): 1241-7). It is possible that some of these may have had continuing pregnancies. The population control lobby like Misoprostol because it doesn't have to be refrigerated, a major advantage (to them) in the developing world.

The Population Council could not find a source for RU-486. Recent reports mention a contract with the Hua Lian company in Shanghai. This is a source of much of the Mifepristone used in China where coerced abortion is widespread (*www.nrlc.org*). Some of the other drugs made at this plant were found to be contaminated with the cytotoxic agent Fluorouracil. Despite this and other serious issues, the FDA rescinded earlier advice on safety and granted the product licence.

In the UK, RU-486 is being promoted by the RCOG in their abortion 'guidelines' but hasn't found favour with the private sector. It is not very profitable because of the need for three visits, placing it in a different category from traditional assembly line abortion. The history of this drug is a long tale of deception and corruption on several continents. We haven't heard the last of it.

Greg Gardner
General Practitioner in Birmingham

European Employment Directive

Erodes Christian liberties

The European Employment Directive, proposed under Article 13 of the Treaty of Amsterdam, was signed on 17 October 2000. The Directive prohibits any discrimination on the grounds of a person's religion or belief, disability, age, sexual orientation or racial or ethnic origin. The proposals are wide ranging in their application and deal with issues including employment, access to promotion and training.

The original draft of the Directive protected only 'occupational activities' which 'pursue directly and essentially the aim of ideological guidance in the field of religion or belief...' (clause 4.2). Under this wording a church could have insisted its pastor was a Christian, but this would not have applied to other posts such as secretary. There were also fears that Christian GP practices and hospices would have had difficulty employing only Christians, because most of their staff are not primarily involved in giving 'ideological guidance'. However, the Government responded to the protests of concerned Christians (10,500 letters were received), and reached a compromise that should now permit Christian GP surgeries and hospices to employ people who share the same ethos.

This concession is welcome but we must still be vigilant to ensure that strong protections are retained as the Directive is incorporated into British law over the next few years. The Directive remains ambiguous over the issue of 'sexual orientation'. If a practising homosexual claiming to be a Christian was refused employment, he could claim discrimination on the grounds of his 'sexual orientation'. Could a secular court be expected to understand that Christian faith involves lifestyle as well as belief?

There is uncertainty, too, as to whom the Directive really covers; whereas it may be possible for Christian GP practices and hospices to employ Christian doctors, what about nurses, receptionists, and ancillary staff?

The purpose of the European Employment Directive was to ensure freedoms, but it erodes the religious liberties that this country has enjoyed for centuries. Christian organisations should be free to employ people whose belief and lifestyle commends the Christian gospel.

Seyi Hotonu
Researcher at the Christian Institute

Abortion and Conscientious Objection

The abortion and conscientious objection debate was re-ignited this March when a CMF member was denied a general practice rotation because he refused to clerk patients for elective abortions. When asked, Dr Everett Julyan told the interview panel that he would neither prepare patients for nor perform abortions because of his beliefs. He said that two panel members had said later that he had not been appointed *solely* because of his views on abortion.

North Glasgow University Hospitals NHS Trust has admitted that 'inappropriate questions may have been asked'. Furthermore they stated: 'There is no policy to stop candidates with conscientious objections from working in our department.' Still, given the large number of abortions performed there, they felt it 'wholly reasonable' to ask a doctor's views.[1]

Health is a devolved issue in Scotland but abortion policy is reserved to Westminster, mainly as the government fear that changes to the current legislation could lead to women travelling across the border to seek abortions if the laws were different in England and Scotland. In 1994 the NHS Executive issued guidance to all English and Welsh hospital trusts, instructing them not to question candidates about their personal views on abortion. However, for reasons that are still unclear, similar Scottish guidelines were not issued.

The Abortion Act 1967 carries a conscientious objection clause, allowing doctors to refuse to participate in terminations but obliging them to provide emergency treatment when a woman's life may be jeopardised. However, the BMA's advice concludes that doctors who feel unable to participate in abortions still have an ethical duty to refer patients to another colleague and that 'preliminary procedures such as clerking in the patient' are 'incidental to the termination' and are to be considered outside the scope of the clause.[2] This suggests that while doctors are not legally required to authorise or perform abortions, they are obliged to be involved in pre-operative care and referral, regardless of their personal beliefs. However, these recommendations have never been tested in court. They are based mainly on the outcomes of two legal precedents, one of which was the Janaway case, concerning a doctor's secretary who refused to type a referral letter for an abortion, claiming the protection of the conscience clause. In his summing up of the case, Lord Keith said, 'The regulations do not appear to contemplate that the signing of the certificate would form part of the treatment for the termination of pregnancy'.[3]

It is increasingly difficult for Christian doctors to enter careers in certain specialties and there is substantial evidence of discrimination. A CMF survey of 1405 doctors revealed that 14% of doctors felt they had been discriminated against because of their abortion views. Four thought they had been refused jobs whilst five members had had to change jobs or even specialties.[4] However, Dr Julyan is believed to be the first to be told that he had been discriminated against. Having been approached by a *Daily Mail* reporter, he eventually agreed to be interviewed in the hope of preventing future discrimination against other candidates.

> IT IS INEVITABLE THAT MANY OF US WILL FACE DISCRIMINATION AND PERHAPS EVEN DISMISSAL

Gordon MacDonald from the Christian charity *CARE* took Dr Julyan's case to the Scottish Executive and also called for definitive instructions for Scottish Trusts. In response an Executive spokesperson said, 'We are not aware of the specifics of this case but we will look into anything that is brought to our attention.' They added that the Executive had no plans to issue any further guidance. Opposition politicians and pro-life groups received these statements angrily, also calling for devolution of abortion policy.[5] A spokesperson for the Conservative party said, 'It is quite unfair that a young doctor's prospects should be put at risk because of his ethical and moral judgements. There should be no discrimination in this field'.[6] In a turn around, the Scottish Executive is now consulting the medical profession on whether guidelines similar to those in England and Wales should be issued in Scotland.[7]

Given our society's increasing acceptance of abortion and corresponding decline in morals, it is inevitable that many of us will face discrimination and perhaps even dismissal or criminal conviction because of our personal beliefs. Whatever the cost, we must hold onto our convictions and biblical principles. God puts human authorities in place and expects us to obey them,[8] but our obedience to him must take precedence. If we believe that abortion is unacceptable, we must obey God first, regardless of what rules and regulations say. Even if we do not take part in the procedure, filling out authorisation forms or clerking patients surely gives tacit approval to the abortion process. To disobey God for fear of losing career, reputation or respect is to make idols of these things.[9]

Helen Barratt is News Editor for Nucleus

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7 Write with your views: Ms Susan Deacon, Minister of Health, The Scottish Executive, St Andrew's House, Regent Road, Edinburgh EH1 3DG
8 Romans 13:1-2
9 Deuteronomy 5:7; 1 John 5:21

Fergus Law enters the debate on the benefits and dangers of cannabis

Should cannabis be legalised?

Cannabis is the world's most widely used illegal drug. British school children have the highest (around 40 percent) and adults the second highest use compared with the rest of Europe.[1] About one in five 16-29 year olds have used it in the last year, one in eight within the last month. The majority of young people believe it is safe and should be legalised or at least decriminalised. Only a third of adults believe cannabis to be harmful. The pro-cannabis lobby has attracted massive support from the public, media and even political parties such as the Liberal Democrats. Successive governments have however rejected such pleas. Recently, the Conservative Party's shadow home secretary announced their 'zero tolerance' policy for cannabis possession; and eight members of the shadow cabinet immediately confessed to having used it!

Although much is known about cannabis and its effects, arguments for and against its use are complex and cannot be resolved because we lack an adequate knowledge base. Many organisations have attempted to summarise the evidence impartially.[2,3,4,5,6] Given this level of interest, it is clearly important for Christians to know how to respond in order to be salt and light to the world.

Biological basis

Cannabis is derived from the hemp plant *Cannabis Sativa*. Used since antiquity, it was around in Jesus' day though not mentioned in the Bible. It contains over 400 chemical compounds (several thousand when smoked) including more than 60 cannabinoids - compounds unique to this plant genus. Cannabinoids interact with cannabis receptors in the body: like opiates, they substitute for endogenous compounds (eg anandamide) that interact with these receptors. Of all cannabinoids delta-9-tetrahydrocannabinol (THC) has the greatest effects on the brain.

The law

It is illegal to grow, possess, produce, smoke or supply cannabis to another person; allowing your premises to be used for these purposes is also against the law. Cannabis and most cannabinoids are both Schedule 1 (absolutely prohibited from medical use) and Class B (attracting prison terms of up to five years for possession or 14 years for dealing). This consumes a lot of police time, accounting for three-quarters of all drug offences and seizures. As the police frequently use their discretion, a wide gap has opened up between law formulation and practice. The Police Foundation recently recommended that cannabis be reclassified as Schedule 2 (allowing medical use) and Class C (reducing the penalties involved). Indeed they stated: 'The evidence strongly indicates that the current law and its operation creates more harm than the drug itself'.[7]

Cannabinoids as medicines

We need to know if cannabis's potential benefits outweigh its risks. How does it compare with the alternative treatments available? The recent BMA review concluded: '…cannabis itself is unsuitable for medical use, (but) individual cannabinoids have a therapeutic potential in a number of medical conditions (see table) in which present drugs or other treatments are not fully adequate… present evidence indicates that they are remarkably safe drugs with a side-effect profile superior to many drugs used for the same indications'. They further stated that such therapeutic use should be confined to cannabinoids given as a tincture, oil or aerosol.[8] While two orally psychoactive cannabinoids (nabilone and dronabinol) can be prescribed legally in the UK, slow onsets of action and plasma level variability limit their therapeutic roles.

Evidence for effectiveness[2]

Reasonable evidence
- Analgesic
- Antiemetic
- Appetite stimulant
- Muscle relaxant

Evidence inadequate or not promising
- Anticonvulsant
- Bronchodilator
- Glaucoma
- Hypertension
- Mood disorders
- Opiate and alcohol withdrawal
- Stroke & neurodegenerative disorders

Non-medical use of cannabis

There are three main types (but many subtypes) of cannabis: herbal (marijuana or grass), hash (resin) and the much rarer oil. Cannabis has over 200 slang names including blow, dope, draw, ganja, grass, hash, herb, pot, puff, skunk, wacky backy and weed etc. The amount of THC in cannabis varies considerably even for specific sub-types. A typical joint (reefer, spliff, toke) would contain a half to one gram of cannabis plant material (of the size of one to two barley grains) that may contain between five and 150 mg THC (one to 15 percent purity). A 'teenth' (sixteenth ounce) is sufficient for five joints and a single one of these could be enough for two or three people. Regular users typically smoke one or two joints several times a week (an 'eighth' ounce weekly) but heavy users smoke five or more joints a day. Typically it is mixed with tobacco when smoked; a greater effect if obtained when smoked in a pipe (called a bong, hookah or hubbly bubbly) where the smoke is cooled but not detoxified as it passes through water. It may also be eaten in 'space cakes' or cookies or drunk as tea (bhang). Its cost ranges from five to 30 pounds per eighth ounce, depending on sub-type and quality. It has been suggested that cannabis is a gateway to other hard drugs; however, evidence suggests that the major predictors of progression to hard drugs are not cannabis use alone, but heavy use in association with psychiatric disorders or a family history of psychopathy (including alcoholism).[9]

Major obvious effects of cannabis

The effects of cannabis depend on the amount and mode of use and the user's expectations and mood. When smoked the effects begin in a few minutes and last up to one hour with low doses or two to three hours with high doses. The most obvious effects of being 'stoned' are being relaxed, talkative and laughing easily (giggly and silly in naive users), followed by 'sleepiness' (folloed by sleepiness). Users may experience 'the munchies' (hunger) and heightened sensory perception (eg colours or music). Sometimes they have difficulty in thinking, problem solving, walking or

'WE NEED TO SUPPORT STRATEGIES THAT GIVE PATIENTS WHO WILL BENEFIT ACCESS TO CANNABIS'S THERAPEUTIC PROPERTIES, WHILST AT THE SAME TIME DISPELLING MYTHS, INCREASING AWARENESS OF ITS HARMFUL EFFECTS AND ACTIVELY DISCOURAGING ITS HARMFUL USE.'

remembering the immediate past. Some users also become anxious, suspicious or paranoid and panic attacks can be precipitated. At high doses hallucinations may occur. Chronic use leads to a prolongation of these effects, often in association with low energy and poor motivation, work or educational performance. Perhaps five to ten percent of regular users become addicted, finding it difficult to stop and experiencing a mild withdrawal syndrome when they do.

Comparison of cannabis with alcohol and cigarette smoking

Both alcohol and cannabis are often used for their intoxicating and euphorant effects. Both produce many similar effects on the brain although those due to cannabis are typically milder. Admittedly, chronic heavy cannabis use does not cause the range of problems that alcohol does (eg brain damage and liver cirrhosis). With the exception of nicotine and cannabinoids, cigarette and cannabis smoke contain the same toxic constituents. However, cannabis smoke contains a substantially higher proportion of particulate matter; more carcinogens and tar are inhaled longer and more deeply, causing increased daily cough, phlegm and wheezing, in addition to chronic respiratory disease such as chronic bronchitis. Tobacco smoking causes cancers and has toxic effects on the heart; as it is so similar, cannabis smoke probably also causes these. If the two are smoked together, the rate of damage is further accelerated.[10]

Conclusion

Cannabis is not a harmless drug. This is not disputed. Experts are also of the opinion that it is less harmful than the other main illicit drugs. 'When cannabis is systematically compared with other drugs against the main criteria of harm (mortality, morbidity, toxicity, addictiveness and relationship with crime), it is less harmful to the individual and society than any of the other major illicit drugs or than alcohol and tobacco.'[11] Overall these reports agree that cannabis or cannabinoids should be legalised for medical use and that there are strong arguments to reduce the penalties associated with its use. A recent internet survey of nearly 1,000 doctors found 54 percent thought the law on cannabis was too strict and only about 12 percent thought it was not strict enough.[12]

God gave us reward systems in our brains so that we could enjoy the good things in life. Drugs of abuse interact with these natural reward systems and addiction is a sign that they have been 'hijacked', resulting in reduced control over their use. As Christians we serve only one master and should seek help if another begins to gain control. We choose not to support the distribution of drugs by potentially violent criminal gangs and oppose the glamourisation of any drug of addiction. We are aware that our body is the temple of the Holy Spirit, to be kept pure and holy. The Bible advises against intoxication with alcohol[13] and no doubt the same should apply to cannabis. Furthermore, we must not do anything that might make our brother stumble, in order to reflect more fully the glory of Christ. Overall we need to support strategies which ensure that those patients who will benefit from cannabis's therapeutic properties can have access to it, whilst at the same time dispelling myths, increasing awareness of its harmful effects and actively discouraging its harmful use.

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KEY POINTS

Cannabis and cannabinoids do have therapeutic potential in a number of medical conditions for which other treatments are not fully adequate; but cannabis is not a harmless drug. It produces disinhibition, cognitive difficulties, emotional disturbances, poor motivation and (sometimes) addiction. Cannabis smoke also contains carcinogens, particulate matter and tar suggesting that in regular users it will produce a similar spectrum of respiratory, circulatory and neoplastic diseases to tobacco smoke. Christian doctors need to speak the truth about cannabis's adverse effects, discourage its harmful use and support legislation which protects the vulnerable from exploitation, whilst supporting the evidence-based therapeutic use of cannabinoids where appropriate.

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Mike Reynolds draws out four goals for the Christian doctor from Jesus' healing of the cripple in John 5

Jesus on ward

After two years as CMF regional staffworker, I returned to full-time medicine as a specialist registrar. Not only did my working practice and time commitments change but I had new responsibilities and pressures. I began to struggle again with many of the issues I had warned students about. Coping with a patient's near death due to my possible error and giving a student talk on 'dealing with exam stress' seemed miles apart.

Many Christian doctors lose the enthusiasm their faith once had. It's easy to find ourselves just struggling to keep afloat. Faith may have little impact on work and the lives of those around. Career plans seem of utmost importance, determining future plans. Medicine and money become idols. Fiddling research (but losing integrity) is tempting. People become pathologies. Tiredness and stress lead to cynicism. We complain about our lifestyles and start to see medicine merely as a job rather than a privilege to serve God by serving others. Our arrogance separates us from other professionals and we carry this sense of elitism into our churches and spiritual lives. Spiritual schizophrenia develops: we have a fragmented mind with our faith becoming separated from our day-to-day living.[1] We struggle with peer pressure and easily compromise our witness. Time constraints become complicated by administration, planning, revalidation and finally patients. We lose our perspective on what it means to be like Christ on the wards.

Let's return to first century Jerusalem to see how Jesus dealt with pressure. He too had many demands on his time but was able to keep them in focus. We need to bring a Christ-like perspective to our practice of medicine; to ask 'What would Jesus do?'

Jesus was compassionate

Read John 5:1-18 and imagine the scene. It is the Sabbath and Jerusalem is full of pilgrims from all over Israel who have travelled for one of the three main festivals. Near the Sheep Gate is a shady area with covered colonnades and a pool. Many blind and paralysed people are gathered, sheltering from the heat of the day and hoping that they will be healed of their infirmities. In the midst of the hustle and bustle, Jesus comes along and singles out an individual. He pauses and spends time with just *one* person. He learns about him, his condition and suffering. He is not cynical or arrogant in his approach but shows compassion, dealing with this man as if there was no one else around.

Jesus approached people as individuals at their point of need. Additionally, by the skilful use of questions, he was able to draw out their wants, fears and hopes. Even in the busyness of the day, he made time for them.

In the earlier chapters of John, we see Jesus making time for a variety of other people. In the middle of the night he talks with Nicodemus, a religious leader. After a long journey he makes time for a Samaritan woman who has come to draw water at the well. What were the consequences of these actions? Nicodemus is listed as an early believer and the Samaritan woman also comes to faith, as do many other Samaritans.[2] In our task-orientated world let us not lose sight of individuals and relationships. At the end of a long clinic or post-take ward round, we still need to view each individual as Christ does, someone created in his image.[3]

Jesus was charismatic

Jesus was charismatic in the sense that he used his gifts. He saw the need of the paralysed man and healed him. He didn't leave him with platitudes but dealt with the problem. Notice also how Jesus then slipped away into the crowd. What might have happened to us in such a situation? Would we have ended up speaking at healing seminars and running retreats?

Jesus wasn't arrogant about his gifts. Neither should we be. We are privileged to have medical training but we must use these gifts humbly, to the best of our ability. We must take care to keep our skills and knowledge up to date and be humble enough to except correction and change.

Jesus was evangelical

Francis of Assisi is often quoted as saying, 'I share my faith with everyone I meet and occasionally I use words'. Nothing neutralises our witness more quickly than an ungodly life. However, we can use this as an excuse for keeping silent about Jesus Christ. Jesus didn't just do good works with his hands when he healed the paralysed man: he found that man again and told him to stop sinning because he needed to repent. We simply can't hide behind our good deeds, holding back the unpalatable truth that something worse may happen. Jesus did good works but he also preached the gospel. He was not afraid to talk of hell.

rounds

Standing against the 21st century's opposition to the Christian faith, we must proclaim the gospel.

Of course, proclaiming this gospel to rebellious mankind can seem foolish. The difficulty and the size of the task can overwhelm us. Thankfully, God has given us only three things to do. Firstly, we should preach the gospel as clearly as possible, answering all questions as sincerely as possible.[4] Secondly, we should pray for each individual who hears the gospel.[5] Lastly, by the grace of God through faith in the finished work of Christ, we should live a life that in some way commends the gospel we preach. Once we have done these things with compassion, some individuals will respond. Does our behaviour win people for Christ?

Some doctors argue that we have no time to share the gospel or that we should not abuse our doctor-patient relationship by doing so. However, the General Medical Council has ruled that doctors are free to share their faith with patients provided they do it in an appropriate and sensitive way.[6] We should pray for, and take, these opportunities. It is good to get into the habit of slipping a question such as, 'Do you have a faith that helps you at times like this?' into the social history. It probably won't be appropriate to probe more deeply there and then but the patient's answer may well reveal something that we can pick up on later. Neutral questions such as, 'Do you have spiritual resources you can call on?' or 'Are you interested in spiritual things?' are open-ended enough for us to introduce the subject without being pushy or offensive.[7]

Jesus was persecuted

The Jews persecuted Jesus for two reasons. First, he healed a man on the Sabbath, and told him to pick up his mat and walk. This went against the Jewish understanding of Sabbath law, but was in harmony with God's plan for the Sabbath. As God did not stop his deeds of compassion on the Sabbath, neither did Jesus. In our society we also need to stand against the prevailing thoughts, attitudes and ethics that are contrary to the character and revealed word of God. A biblical insight into current ethical problems will enable us to stand out for Christ when we are put into the spotlight. It can also be an opportunity to present the gospel message to our friends and colleagues. The boundaries of medicine are changing at a great rate and new ethical issues can arise with little warning. In order to be able to respond quickly with godly wisdom, we should prepare ourselves with regular Bible study; applying God's word to the issues of the day.

Second, Jesus was persecuted because he called God his Father, thus declaring himself equal to God; he also taught that salvation came through him only.[8] We too will face persecution when we say, 'Salvation is found in no-one else, for there is no other name under heaven given to men by which we must be saved'.[9] When we stand against the materialistic, relativistic and atheistic world around us, we are following in Christ's footsteps. We are following Jesus' model.

LIKE JESUS WE NEED TO PRAY EACH MORNING, 'LORD, SHOW ME WHO I CAN PAUSE WITH TODAY'

Final exhortations

Let us guard against idolatry, cynicism, arrogance and spiritual schizophrenia and seek to follow Jesus' model. We need compassion to see people as Jesus sees them. We need to be charismatic, using our gifts and abilities to serve God and others. We need to be evangelical, proclaiming the gospel to a dying world; and we need to expect persecution for proclaiming and living Christian values.

Finally, like Jesus at the pool of Bethesda, we need to pray each morning, 'Lord, show me who I can pause with today'.

Mike Reynolds is a Specialist Registrar in Gastroenterolgy in London, formerly CMF regional staffworker.

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KEY POINTS

Jesus' healing of the invalid at the pool of Bethesda in John 5:1-18 provides a comprehensive and balanced model for the Christian doctor. Jesus was compassionate, making time to meet the man as an individual at this point of need. He was charismatic, in that he used his gifts of healing humbly and to the best of his ability. He was also evangelical in calling the man to repentance and faith. And he was persecuted when he demonstrated love rather than legalism and claimed a special relationship with God the Father. In God's strength we need to follow his example and each day ask God whom we should pause with.

Seize the day

A friend of mine once told me that when he got married he had four theories of child-rearing and no children. 'Now I have four children and no theories,' he says with a rueful smile. One thing is certain in a changing world: many of the old formulas about living don't any longer hold water. On the other hand there are timeless principles that really do work.

THE REAL CRAVING OF CHILDREN IN ANY GENERATION IS A FATHER'S (OR MOTHER'S) PRESENCE

1 Carpe diem

In *The Dead Poets Society* Robin Williams plays a teacher struggling to achieve some sort of rapport with his pupils. One day he and his pupils walk down a corridor lined with old photographs of past students of the school. Dozens of young people, captured on celluloid, stare out of the frames; faces full of potential, lives at the start of their journey. But many are now dead, ravaged by wars in Germany, France, Korea and Vietnam.

The normally boisterous pupils are silent as they gaze back in time at the faces of previous generations, and their teacher whispers in their ears the Latin phase 'Carpe diem - Seize the day'. It means simply that none of our tomorrows are guaranteed and we need to make the most of every opportunity today.

The Carpe Diem principle is nowhere truer that in relations with our children. And this is because the door of childhood closes so fast and finally. One of the reasons we don't spend quality time with our children is that, when they are small, we believe there will always be a tomorrow.

Gather ye rosebuds while you may,
Old time is still a flying,
And that same flower that smiles today,
Tomorrow will be dying.
Robert Herrick

2 Start with the nappies

One of the best ways for a father to communicate with a new daughter is by changing her nappy. This may lead to giving her a bath. Hold her in your arms as often as possible: you may get good at it and even begin to like it. Nursing research shows that touch can be healing. Talk to her as if she can understand every word you say. You may find that these tasks become habituating. These habits will also communicate to other members of your family who may ask for special time too.

3 Show and tell

Tell your children every day that you love them. Seven percent of communication comes through the spoken word, the rest is made up of tone and gesture et cetera. So even small children can read our confused and less than honest communication. We need to show the love we are professing. Communication by showing takes a little extra time. But maybe the measure of our love is this little extra time. We need to get below the surface with children. Your 14 year-old son may say, 'Now I'm a teenager forget about hugging me!' Underneath he may still wish you would.

4 Build lifelong hobbies

Start a hobby or leisure activity with your child that is not dependent on your physical fitness. You may do it together for the rest of your life. If at first you don't succeed, take the time to keep trying. This is a message that will communicate.

5 Have fun

Life is serious. There is pain and sorrow on every hand. There are bills to pay, and examinations to pass, there is healthy eating to attend to, and discipline to be imparted. All that is true, but

childhood needs to be a time for laughter. We somehow have to raise children who can cope with the serious issues of life and yet can remember years of laughter. That may involve *us* in learning to laugh again.

When my children were small they used to love having what we called a 'family night'. They would drag their mattresses into our bedroom and sleep on the floor. But once in a while we would have a 'super family night'. That involved us all sleeping on the lounge floor together. There are no logical reasons why four people with perfectly good beds should want to do that; except that it's fun.

I was once speaking at a conference and described this in a little more detail. I said, 'It's wonderful. We all lie there in the dark, with the fire on, listening to story tapes and eating too much chocolate.' When I finished speaking I knew I was in trouble. I'd done enough public speaking to be able to recognise that look at 100 yards. She cornered me and said: 'Do you think it's wise to encourage children to eat chocolate just before they go to bed? Their teeth will rot.' That's a killjoy in action. They smell a little fun and swoop. I wearily explained, 'Yes, they did clean their teeth afterwards…'. But children love those who have time not only to teach them, but to have fun with them.

6 Develop traditions

Develop family traditions **together**. This could be as simple as cooking hamburgers every Saturday night. You can build traditions around all sorts of events: Christmas, birthdays, even visits to Granny. Your children will look forward to them and remember them when they're grown up.

7 Let them hear what you think

In the film *True Lies*, Arnold Schwarzenneger has a teenage daughter who he finds hard to control. One of this colleagues from work explains why he may be finding it so difficult. 'You're not her parents any more. Her parents are Axl Rose [the lead singer in the heavy metal rock group Guns and Roses] and Madonna. Don't think that the five minutes you spend with her can compete with that kind of bombardment.'

If we want our children to accept our values, we have to pass them on. Those values could be spiritual; if I want my children to believe, I need to take time to explain the Christian faith. They may be sexual; if so I need the courage to talk to them openly about both the wonder and dangers of sex. If I have things that I believe are right or wrong, I have to let them know what these are. They may reject these values, but if they matter to me, I dare not leave it just to others to teach them.

8 I love you - anyway

The key to a child's heart is to let them know we love them regardless. There is no more powerful force on the face of the earth for building strong relationships than unconditional love. I learnt that lesson the hard way. I remember my daughter coming home from school. She came running in, yelling, 'Dad, I got 95% in maths.' I had two questions for that little girl. 'What happened to the 5%?' and 'Where did you come in the class?' I'm not proud of that memory. Katie has a whole life in front of her filled with those who want her when she succeeds. I want to motivate her to be the best she can be, but more than that, I want her to know that my love for her is not based on success but on the fact that I'm her father.

9 Be wise about when to go into battle

People in the military will tell you that occasionally it's vital to pick fights. The constant question needs to be, 'Is this a situation that's worth doing battle over?' If not, we risk being backed into a corner with no way out, for no good reason.

One father I know described a battle he wished he'd never entered.

My daughter came home one evening with bright orange hair. I hit the roof. My first thought was, 'What will people think of us?' I told her that she would never look like that under my roof, and to get it changed. She refused and I was left with either backing down or making her leave. As it was we didn't speak for a month. We're fine together now, but I almost lost my daughter over some stupid hair dye.

10 Give them what I do have

Dr James Dobson has said: 'We are so busy giving our children what we didn't have, that we don't have time to give them what we did have'. Your nine year-old son will forget the television you bought for his bedroom. True, it will always seem kind to him. It will never say, 'Later'. It will always say sit down with me now. It will, in the isolation of his room, go about the business of educating him. It was expensive, but it will never be a memory he will cherish.

But he will never forget the night that you and he slept in the garden in an old tent somebody lent you. He will remember the sense of thrill as you both ate too many marshmallows, and how he felt when the battery in the torch failed and it was darker than he had ever known. And when he is old he'll still remember it.

And there it is – the greatest dilemma of being a parent in a society where love can easily be measured in presents whilst the real craving of children in any generation is a father's (or mother's) presence.

Rob Parsons is Director of Care for the Family. His latest book, The Sixty Minute Mother, is published by Hodder & Stoughton, £6.99.

Rob Parsons suggests ten principles about parenting that Christian doctors should both practise and preach

The door of childhood closes fast and finally so we need to 'seize the day' now to build strong relationships with our children. There are timeless principles of child-rearing that really work: developing family traditions, starting joint leisure activities, enjoying fun and laughter together and constantly demonstrating our love in both word and action. If we want our children to share our values we have to pass them on, both verbally and by example. Conflict is inevitable but we need to pick our fights wisely, and whatever happens, let them know that we love them regardless. Overall, the greatest craving of children in any generation is a father's or mother's presence.

Janet Goodall returns to the pearl of Africa after nearly three decades

In 1972, as my hospital contract with the Uganda Government was ending, Idi Amin announced that British people in my position must leave within two weeks. My flight was already booked for that day and I flew out, heading for North Staffordshire, but saddened by what was happening to people I'd come to love. Great trials have hit Uganda since then, not least being the AIDS endemic and, more recently, the massive cult murders and suicides.

Uganda revisited

A few months ago an invitation came to go back to Uganda to give a few talks about the needs of dying and bereaved children, and I've recently returned from that three week visit, made with another medical friend. We found it a sobering, challenging and yet inspiring experience.

President Museveni has made a huge difference to the economic and social stability of the country and publicly expresses sympathy with the Christian faith and witness of his wife. His efforts have helped to release Uganda from payment of its national debt to Britain, following the Jubilee 2000 campaign. Unlike many other African countries, the leaders have been honest enough to face the truth about AIDS and to produce a fall in its incidence, that is except amongst teenage girls. Nevertheless it still remains a terrible scourge and we scarcely met a family who had not lost someone through it. I met many affected children, so teaching about their needs was much needed.

Perhaps the most memorable audience was of hundreds of African grannies, carers, counsellors and children in a packed village schoolroom, convened by World Vision. Without warning, I was asked to 'explain to them about helping grieving children' - through an interpreter, without visual aids and with no idea of the level of understanding of the listeners! I'd been told that the prevailing attitude seems to be that children, whether sick or sorrowing, do cry a lot - so what? Amongst the crowd was the shining, attentive face of an AIDS counsellor, so I hope he got the message, even if no one else did that day.

The Ugandan policy is to keep orphans within their own communities and not in orphanages, though in practice this means that children as young as six to twelve years old can be 'head of the household'. Global Care is a Coventry-based charity which has several projects for helping orphans in Uganda, as well as elsewhere in the world. I was able to visit two of these projects, one at Mbale, near the Kenyan border, and the other at Rukingiri, near the borders of Congo and Ruanda and also close to the scene of hundreds of cult deaths.

I've never before visited such poor homes. Many are basically mud huts, without electricity or water supplies and with leaking thatched roofs. Cooking is done over a charcoal burner, the staple diet being green bananas ('matoke') and rice. Clean water from boreholes has to be bought, then carried (sometimes for miles and by children) in two-gallon plastic containers.

For a large household this expense can be too

costly, so contaminated water is then used instead. There are no child allowances or widows' pensions, so survival depends on home-grown produce and any income on selling either some of that, or home-made charcoal or, sometimes, hand-woven basketry.

As 30% of the workforce has been wiped out by AIDS, there are frequently no able-bodied close relatives left, so grannies, who might have thought the time had come to put their feet up, instead have to dig and delve in the banana groves (again with the help of the children) to grow a few beans to add to the matoke. Malnutrition and infections are also endemic, especially for those who are HIV positive. I met elderly Erivida, whose eight children and their partners had each in turn died, leaving her in her small hut with six young grandchildren. Another, in her seventies, was caring for twelve.

The other major concern is education. Primary schools were only recently declared free for all, without first counting heads, so that schoolteachers are often swamped with classes of up to 500 children. Private education has accordingly taken off for wealthier families, but even then we saw classes of around 80. Senior school fees are about £750 a year, with uniforms, exercise books, pencils and paper to be found as well. We were shown the school reports of several very bright children, with pleas for contributions. Uganda has already lost a huge number of young parents and now risks the emergence of a poorly educated generation, made up of their surviving children.

The churches are equally packed, congregations of 1,000 being the norm, yet without enough pastors and teachers, hence the risk of false cults creeping in. Many are converted but, with notable exceptions, not so many learn and practise discipleship. One of the exceptions was Stephen Asubu, Global Care's man in Uganda. I went with him to see a child in Mbale, living in one room with her destitute mother and four siblings. Farah's education and a meal a day come through Alice, a Staffordshire child, who can't change the world but is making a world of difference to Farah.

What about those grandmothers, who are themselves grieving, as well as burdened with unsought cares? This is where most inspiration and challenge came home to us. Erivida, like many others we met, is a Christian, and as she signed to us how hard she has to work and how hungry she gets, her face suddenly brightened as she looked up, hands raised, and said (we were told), 'Praise God. The Lord in heaven, he knows. God is great. God is good.'

This old lady was not the only one we heard expressing praise in the midst of pain. I was reminded of Paul's letter to the Corinthians, where he speaks of 'troubles, hardships and distresses... hard work, sleepless nights and hunger... known, yet regarded as unknown; dying and yet we live on; sorrowful yet always rejoicing; poor yet making many rich; having nothing and yet possessing everything.'(2 Corinthians 6:4-10)

If I had so much taken away, would I, too, keep trusting and praising like that? And how about you?

Janet Goodall is a retired Consultant Paediatrician in Staffordshire.

KEY POINTS

Under good leadership Uganda is doing better than most African countries in combatting the scourges of national debt and AIDS. But AIDS has still killed 30% of the workforce and the associated poverty, malnutrition and infection still produce an overwhelming burden, especially for orphaned children. Education is increasingly becoming the privilege of the rich only. Churches, although packed, lack pastors and teachers meaning that cults are creeping in and real discipleship is failing to keep pace with conversion rates. Despite this, the joyful faith seen in individuals in the face of pain and suffering is an incredible inspiration and challenge to us in the affluent, and indifferent, West.

EUTYCHUS

Conjoined twins separated

The Maltese conjoined twins Jodie and Mary (*Triple Helix* 2000; Autumn:3) were separated in a 20 hour operation in Manchester on 6-7 November, resulting in the death of the weaker twin Mary. The Court of Appeal judges had previously ruled that Mary's life could be killed 'in defence of Jodie' during the procedure because she was an 'unjust aggressor' threatening Jodie's life. A commentary of the case by Professor John Wyatt, chairman of the CMF Study Group, has been published in the CMF Student Journal (*Nucleus* 2001; January:2-4) and is available on the CMF website at *www.cmf.org.uk/pubs/nucleus/nucjan00/twins.htm*. Alternatively email us at *pubs@cmf.org.uk*.

Euthanasia in the Netherlands

The Netherlands officially legalised euthanasia on 28 November, although it has been legally sanctioned for some years. In 1995, physicians in the Netherlands received 9,700 explicit requests for euthanasia or physician assisted suicide, of which 37% were granted and carried out. A recent survey of Dutch physicians has shown that, of those 'assisted', the most common reasons given for the request were 'loss of dignity' (56%) and 'unbearable or hopeless suffering' (74%). In a third of cases life was estimated to have been shortened by more than a month. (*BMJ* 2000; 321:865, 7 October)

Acupuncture report challenged

The British Medical Association's recent endorsement of acupuncture (*Triple Helix* 2000; Autumn:16) has come under stinging attack in the correspondence columns of the *British Medical Journal*. The BMA's conclusion that acupuncture was effective for back pain, dental pain and migraine is said to be based on studies that were inconclusive, inadequately randomised or not blind. The authors of the BMA report are accused of bowing to the pressure of public opinion and changing their stance in the absence of scientific evidence. This, say the challengers, is harmful both to the public's health and the economy of the NHS. (*BMJ* 2000; 321:1220-1221, 11 November). The biblical injunction to 'enquire, probe and investigate thoroughly' (Deuteronomy 13:14ff) must surely be relevant here.

Blatant patent discrimination

95% of people infected with HIV worldwide live in the world's poorest countries, but patent protections on treatments mean that the annual cost to treat a patient with AIDS is up to 100 times the gross national product per capita. (*BMJ* 2000; 321:833, 30 September). At the AIDS 2000 Summer conference in Durban, Jeffrey Sachs, director of the Center for International Development at Harvard, clashed with the world's global agencies over funding. 'It will take ten years to negotiate the conditions of the (World Bank's $500m) grant with the 40 recipient countries, and by then half the sum is used up by salaries for the World Bank consultants', he said. The North has the drugs but few patients; the South has the patients and no drugs. (*BMJ* 2000; 321:1357, 25 November)

Apocalypse now?

Three *BMJ* editorials point out the link between Britain's recent floods, fuel price protests and the crumbling rail network. The floods are a symptom of global warming, which in turn is a consequence of exhaust emissions of greenhouse gases. Rises in fuel prices might encourage more to use public transport, or to walk (*BMJ* 321: 1168, 11 November). Eutychus has opted for the more eco-friendly approach of typing his column at home after a frustrating month of commuting delays. The link between human behaviour and natural disasters has, of course, been pointed out before (Ezekiel 14:12-23).

Pre-implantation Diagnosis

Three recent high-profile cases of pre-implantation diagnosis (PGD) have highlighted concerns about embryos being used as a means to an end. They include: Colorado infant Molly Nash (whose Fanconi anaemia was treated with a stem cell transplant from the umbilical cord of her specially 'created' sibling Adam); a Spanish haemophilia case where only male non-carriers of the gene were implanted; and the Masterton case (in which a British couple were denied permission to produce a female baby by PGD to replace a daughter who died following burns).

Research funding inequality

Of the £37bn spent annually worldwide on health research, only 10% goes for the diseases affecting 90% of the world's people, according to estimates from the World Health Organisation. Between 1975 and 1997, of the 1233 new medicines patented, only 1% were for tropical diseases. (*BMJ* 2000; 321:787, 30 September)

Hope for refugee doctors

Up to 2,000 doctors with refugee status in the United Kingdom will be offered appropriate training and opportunities to work for the NHS under a scheme announced in early November. Refugee doctors are keen to work, but the obstacles they face are currently overwhelming. The scheme could help make up some of the extra 7,500 NHS doctors that the government plans to have in place by 2004. *The Report of the Working Group on Refugee Doctors and Dentists* can be found at *www.doh.gov.uk/medicaltrainingintheuk/index.htm.* (*BMJ* 2000; 321:1178, 11 November). The alien gets special mention in scripture. (Exodus 22:21; Leviticus 24:22; Psalm 146:9)

Training abroad for paediatricians?

Christian doctors who have worked in developing countries have long recognised the rich opportunities for medical training such experience offers. Now, a joint venture between the Royal College of Paediatrics and Child Health and VSO (Voluntary Service Overseas) will give specialist registrars a broader specialist training with a year in the Gambia. Could Christian doctors be instrumental in encouraging *other* royal colleges to adopt this model as a means to providing better care and training for those in the developing world? (*www.vso.org.uk*; *BMJ Classified* 2000; p3, 28 October)

OPPORTUNITIES ABROAD

Specific Vacancies by Country

A longer list of Opportunities is published in *Saving Health* and is available from MMA HealthServe, First Floor, 106-110 Watney Street, London E1W 2QR. Tel: 020 7790 1336. Email: info@mmahealthserve.org.uk. Website: www.mmahealthserve.org.uk.

AFRICA

Kenya

Chogoria Hospital urgently needs a **medical officer-in-charge** and a **general surgeon**. This 306 bed hospital, serving a population of half a million, is situated on the eastern slopes of Mount Kenya, almost on the equator at 5,000 feet and 150 miles north-east of Nairobi. With a staff of 471 the hospital is the centre for a community healthcare system with 31 rural dispensaries, has a registered nurse training school with 100 students and shares in the national pre-registration training of doctors. It is about to take part in an Africa-wide scheme for the training of general practitioners.

Information from Miss Sheila Ballantyne, Assistant Secretary (Personnel), Church of Scotland Board of World Mission, 121 George Street, Edinburgh EH2 4YN. Tel: + 44 (0) 131-225 5722.

Uganda

Rushere Hospital is looking for a **doctor** to start around Easter 2001 and to give at least a couple of years to its development as a 'Christian based Interdenominational Hospital that serves everyone'. Either a single person or a couple would be welcome. Housing is available. Other staff are also being sought. Forty schools and seven clinics fall under the responsibility of the hospital. There are plans for erection of hospital blocks, land has been levelled, and rows of exotic flowering trees have been planted. Presently there are three senior staff houses, a hospital block and a few nurses' quarters.

The hospital was started some ten years ago and it is seeking to re-establish its Christian basis having lost its way with the growth of secularisation. A Christian constitution is being written and electricity has been installed in all the buildings as well as water from the boreholes. Income generating projects are being developed and a shop has been opened.

The director asks for prayer for the enormous work ahead, that Jesus will be glorified through the work of the hospital and its outreach into the community. Pray that many will find healing and wholeness.

Information from CMF or MMA or Joan Hall at Box 256, Kampala, Uganda. Email: rusherehospital@hotmail.com

West Africa

Public Health professional with training in nutrition to join a Christian team in an established programme of feeding centres for about 14,000 mothers and their malnourished children.

For further details email Andrew Dimmock at andrew.dimmock@ccmail.lfa.com or Hilary Steele at mmahilary@mmahealthserve.org.uk

Zimbabwe

Child Health lectureship in the Dept of Paediatrics and Child Health (as advertised in AFRO-NETS, 24/10/2000).

Contact Senior Assistant Bursar (Academic Staff), University of Zimbabwe, P O Box 167, Mt Pleasant, Harare, Zimbabwe. Fax: +263 940 333407/335249. Telegrams:University, Telex: 26580 UNIVZ ZW or email Dr Rose Kambarami at rkambarami@healthnet.zw

RESOURCES

Doctors' Dilemmas

At the request of an increasing number of resource-poor countries, a small group of CMF doctors runs refresher courses for General Practitioners in the UK and courses to promote General Practice abroad.

If you are a GP or specialist with an interest in family practice and desire further information, contact Dr John Geater or Dr John Caroe. Email: j.geater@which.net or caroe@btinternet.com

Mission Technical Training

This agency offers full technical training for overseas mission workers for Land Rover, Bedford, Lister. Courses can also be tailored to your own requirements.

Contact John Barker, 'Kagando', 121 Sandygate Mill, Kingsteignton, S Devon TQ12 3PG. Tel: 0626 62380.

Medair Seminars 2001

Medair works in Northern Kenya where there is severe famine; in Kosovo building new houses for displaced families; in Southern Sudan where an increase in hostilities has forced some personnel to leave (though two teams remain); and in Afghanistan where new Taliban regulations have increased procedural difficulties.

Its seminars are designed for those planning to work in such situations:

- 2-11 February in Sevenoaks, UK
- 8-17 in Heidebeek, Netherlands
- October/November in Ballaigues, Switzerland

The number of bookings is increasing rapidly especially for the UK.

Contact Medair, 9 Wheat Close, Nottingham NG8 4GL. Tel: 07932 006 946. Email: info@madair.org.uk

New Journal on Repair and Reconstruction

The *Journal for Injury, Deformity and Disease* (Volume 1, Issue No 1, 2000) is published by a new Christian Charity, the International Community Trust for Health and Education Services (ICTHES). The journal is produced in association with British plastic surgeons and was very well received by 180 plastic surgeons at the first Pan African Conference in Ghana in March 2000. Mission and volunteer organisations are invited to send names and addresses of healthcare personnel who might benefit from receiving the journal regularly (presently twice a year). The journal is sent out free but gifts to the organisation are welcome. The first two issues are on burn injury.

Contact Dr Murray McGavin, ICTHES, 106/110 Watney Street, London E1W 2BR. (Dr McGavin also produces a similar journal *Community Eye Health*).

Mission Supplies

This organisation helps with the purchase of supplies and equipment and freighting free of VAT of mosquito nets, water filters, solar equipment, computers etc.

Contact Gerry Slessenger, Mission Supplies Limited, Mission House, 22 South Drive, Cheam, Surrey SM2 7PN. Tel: +44 (0) 20 8643 0205. Fax: +44 (0) 20 8770 7407. Email: gerry@missionsupplies.co.uk. For freighting call FreeFone 0880 018 3370. Email: juliet@bifs.net

Alex Bunn asks if there is light at the end of the tunnel.

Near death experiences

Rene's van aquaplaned out of control, smashing her skull on an industrial power pole…

'I was moving headfirst through a dark maelstrom of what looked like black boiling clouds. I felt that I was being beckoned to the sides. That frightened me. Ahead was a tiny dot of bright light that steadily grew and brightened as I drew nearer. I became aware that I must be dead…I rushed greedily forward towards this light.

I arrived with an explosion of glorious light into a room with insubstantial walls. I was standing before a man in about his thirties, about six feet tall, reddish brown shoulder length hair and an incredibly neat short beard and moustache. He wore a simple white robe. Light seemed to emanate from him. I felt he had great age and wisdom. He welcomed me with great love, tranquillity, peace (indescribable), no words. I felt as if "I could sit at your feet forever, and be content". This struck me as a strange thing to think, say or feel. The fabric of his robe fascinated me. I tried to figure out how light could be woven!'[1]

IN FILMS SUCH AS FLATLINERS, RECENT TELEGRAPH ARTICLES AND THE JOURNAL OF NEAR DEATH STUDIES, A QUESTION IS BEING ASKED: 'COULD NDES BE GLIMPSES OF HEAVEN?'

What is a 'Near Death Experience'?

'Near Death Experiences' (NDEs) appear to offer objective insights into life after death. The media interest reflects a widespread belief that they constitute scientific evidence for an afterlife. In films such as *Flatliners*, recent *Telegraph* articles and the *Journal of Near Death Studies*, a question is being asked: 'Could NDEs be glimpses of heaven?'Dr Peter Fenwick, consultant neuropsychiatrist at the Maudsley Hospital, presides over the International Association for Near-Death Studies. In response to a 1987 QED documentary, he collated a database of over 300 NDE accounts. Common features include:

- feelings of overwhelming peace, joy and absence of pain
- an out of body experience, where the person comes to rest at a vantage point, frequently near the ceiling
- passing along a dark tunnel towards a pinpoint of light
- brilliant light drawing the person towards it
- a being of light: an indescribable experience, characterised by warmth and overpowering love
- life review with weighing up of past actions
- appearance of (usually dead) relatives or significant others
- point of no return, an impassable barrier
- wanting to stay but having to return to unfinished business or family needs

How common are NDEs?

The first *prospective* NDE study recently made headlines: six percent of cardiac arrest survivors on a coronary unit described a classical NDE and three percent more had experienced some of the above features.[2] Unfortunately, none were able to identify objects placed above eye level so as to confirm a literal out of body experience! In *retrospective* studies, up to 33% had had an NDE.[3,4,5] Statistically, we have all looked after such patients.

Is there an organic explanation?

1. Are they drug induced?

In theory, drugs given during anaesthesia or as part of a resuscitation attempt could disorder brain function and produce elements of an NDE. However, only 14% of patients on Dr Fenwick's database had been given drugs at the time of their experience.

2. Are they endorphin-mediated?

The body's own pain-killing chemicals could induce a sense of euphoria. Still, only a fraction of people who undergo extreme stress, such as athletes, experience an NDE. There is a surge of endorphins following grand mal seizures but the effect is anything but euphoric and coherent visions are not reported.

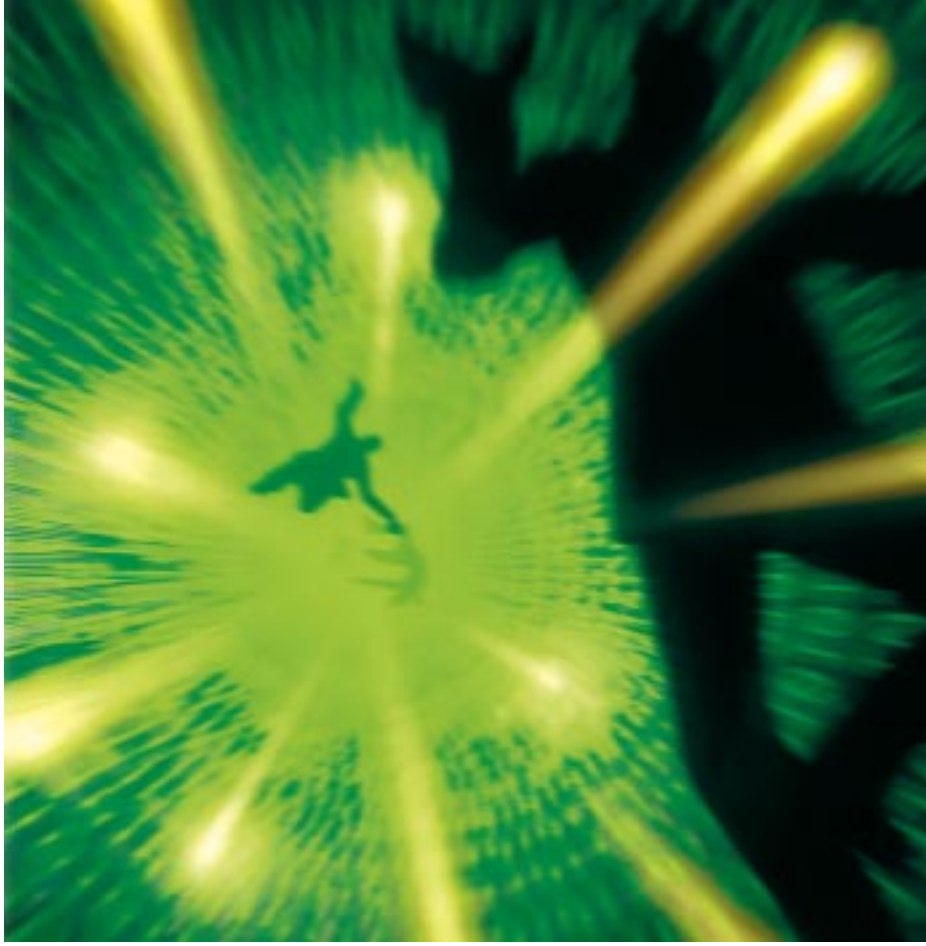
3. Are they a result of cerebral hypoxia?

This elegant theory is based on the fact that most visual system neurones are devoted to the centre of the visual field. Hypoxia might cause random firing of neurones, resulting in a central dot of light that spreads out to the peripheries. Subjectively this would look like movement down a tunnel of light.

However, doctors may recall a student respiratory physiology experiment where subjects are attached to re-breathing circuits, become hypoxic and blackout in a similar way to fighter pilots in training; neither students nor pilots report NDEs.

Another anomaly relates to memory. Experience with head injury patients has taught that the more

GOD CAN SPEAK THROUGH DREAMS, VISIONS AND VISITATIONS BUT THE BIBLE WARNS OF THE DANGERS OF RELYING ON THIS FORM OF REVELATION; SPIRITS NEED TO BE TESTED.



significant the brain injury, the greater the amnesia. The temporal lobe is acutely sensitive to hypoxia so there should be no memory of such a hypoxic event. Moreover, we know that the EEG during cardiac arrest is flat.

So, what then is the substrate of these experiences? Is consciousness independent of brain activity? Fenwick claims that it is the clarity of the NDE, a self-perspective seldom afforded the normal conscious mind which appears to confound the definition of the dying brain.[6] He points to the detailed panoramic life-review; people not only receive flashbacks of thought and action but also a realisation of how these have affected others around them. He does not believe that neurophysiology can explain these experiences but does concede that neural events could occur as consciousness returns and the recall projected back to unconscious period. Co-researcher Sam Parnia is even more convinced:

'I started off as a sceptic but, having weighed up all the evidence, I now think that there is something going on. Essentially, it comes back to the question of whether the mind or consciousness is produced from the brain. If we can prove that the mind is produced by the brain, I don't think there is anything after we die because essentially we are conscious beings. If, on the contrary, the brain is like an intermediary which manifests the mind, like a television will act as an intermediary to manifest waves in the air into a picture or a sound, we can show that the mind is still there after the brain is dead. And that is what I think these near-death experiences indicate.'[7]

4. Are they hallucinations?

NDEs are visions that subjects believe to be real. Whether they have a basis in external reality is debatable. Unlike NDEs, hallucinations are renowned for their subjective content that others cannot appreciate. However, despite some similarities, NDEs are quite varied and many are culturally laden.

5. Are they derived from upbringing or culture?

Children don't commonly contemplate death but they do have NDEs. Many accounts come from children less than seven with underdeveloped abstract thinking. Without preconceived notions, their NDEs are unlikely to be a product of wish-fulfilment. One man recalls surviving pneumonia as a five year old:

'I saw the doctor put the sheet over my body as I too was rising over my own body. I clearly saw angels around the window, then I sort of drifted into my body...You don't talk about these things as folks will think you are some kind of nut. Only my close family knows about this.'[8]

Children have more overtly religious experiences: a more concrete Heaven with golden gates, angels and a Jesus figure, whereas adults generally experience such a figure when faith is already present. Are children more spiritually receptive or merely more impressionable?

What about NDEs in other cultures? An Indian survey revealed similar visions with life reviews and judgements but more frequent religious beings. However, the apparent reason for return from the brink of death was commonly an administrative error or case of mistaken identity rather then a mission to complete or obligations to loved ones.[9] This demonstrates the potential for cultural bias, a subjective interpretation of what must be an extraordinary experience. For example, what do we make of Rene's Christ-like vision? Was Jesus, an ethnic Jew, really a six foot man with reddish brown hair or is this image derived from romanticised Victorian art?

6. Are NDEs a supernatural phenomenon?

Some accounts do not relate to life-threatening circumstances. Some people can meditate and have these visions at will. This questions whether all these experiences can be put down to

KEY POINTS

Near death experiences are surprisingly common, have standardised features, and are difficult to explain on the basis of drugs, endogenous endorphins, hypoxia, hallucinations or in terms of upbringing or culture. Recent research has led support to the belief that consciousness out-survives the brain, prompting speculation about the existence of an afterlife. But, even if NDEs do provide knowledge about the supernatural, Christians need to measure their content against the teaching and 'real death' experience of Jesus Christ to ensure they are not being deceived. Unlike personal experience, Jesus' words are fully trustworthy, and we need to advise patients and colleagues accordingly.

physiology. Indeed, there is no satisfactory neurological explanation, so it is tempting to ascribe the scientifically inexplicable to the supernatural. However, irrespective of the mechanism, NDEs could be supernatural revelations.

What do NDEs tell us about the afterlife?

Taken at face value, NDE accounts suggest that consciousness survives physical death. They confirm belief in an ecstasy that awaits us, a divine presence that often bears striking similarity to biblical descriptions of Christ. They are consistent with theistic doctrine on these points, even speaking of some form of judgement. Moreover, less well publicised are numerous negative encounters with eternity:

'I found myself in a place surrounded by mist. I felt I was in hell. There was a big pit with vapour coming out and there were arms coming out trying to grab mine…I was terrified that these hands were going to claw hold of me and pull me into the pit with them.'

Another woman refused to elaborate, saying 'I had a hell-type experience twenty years ago, and it has haunted me ever since'. Hellish encounters are described by one to twelve percent of reports and this is probably an underestimate as survivors are reluctant to talk about them.[10]

False reassurance?

Most commentators are comforted by the stories they select. Fenwick's concluding quote conveys a survivor's optimism: 'One thing is for sure, and that is that death has no fears for me'.

Where does this leave us? How do we weigh up contradictory versions of the afterlife? There is only one certainty: they can't all be right!

For example, what do we make of accounts that contradict biblical revelation? Take Rene's life review, in which she was burdened by guilt but then felt 'the balance was in my favour, and I received great love'. She then received a commission: 'It is time to live according to your beliefs, whatever they may be, for the end times are upon us!'[11]

Her vision may be tantalising but does it give a reliable picture of God? The Jesus-like figure cannot be the historical Jesus of Nazareth. The real Jesus warned that our knowledge of and obedience to him in this life would determine who enters heaven.[12] Ultimately we will all bow before one reality, whatever we choose to believe before death.[13]

Are visions and revelations near truth experiences?

God does speak through dreams, visions and visitations[14] but the Bible warns of the dangers of relying on this form of revelation; spirits need to be tested:

'Every spirit that acknowledges that Jesus Christ has come in the flesh is from God, but every spirit that does not acknowledge Jesus is not from God. This is the spirit of the antichrist, which you have heard is coming and even now is already in the world.' [15]

This means that any message must be consistent with Jesus' 'in the flesh' teaching. His teaching is reliably recorded in the historical documents that make up the New Testament. Even if an angel preaches us a different message (for instance 'live according to your beliefs, whatever they may be') we are not to believe it.[16]

Alternative origins of revelation are someone's imagination[17] or a more sinister power.[18] We're warned that the devil himself can masquerade as an angel of light,[19] offering just enough truth to attract us. False prophets typically tell us the lies 'our itching ears want to hear'.[20] However comforting, false reassurance is like dressing a serious wound with a plaster: it only serves to compound our spiritual state.[21]

Sadly, our sincerity offers no protection from deception: 'The heart is deceitful above all things'.[22] Many people suppose that only those with a weak faith are sceptical. In contrast, Jesus warns the faithful of their vulnerability to false teaching. Instead, he commands us to be as shrewd as snakes and innocent as doves.[23]

So who are we to believe on the subject of life after death?

Jesus returned from a real death experience

All of the witnesses considered above stopped short of the threshold of death, only to wonder at what really lay beyond 'the final frontier'. They are inevitably ignorant of what will really happen when we die. In contrast to them, Jesus definitely died when he was executed two thousand years ago. The Roman guard demonstrated his death by piercing his thorax with a spear and showing that his blood and plasma had separated.[24] However, three days later, Jesus appeared once more, recognisable but different. His disciples thought he was a ghost or vision but Jesus assured them, 'Touch me and see: a ghost does not have flesh and bones as I have'.[25] He alone has the authority to tell us what lies beyond death because only he, fully God and fully man, has been there: 'No one has ever gone into heaven except the one who came from heaven - the Son of Man'.[26] We can trust his account of the way things are. Recorded in the Bible, his words have greater authority than any man's and must be the measure of all others.

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26 John 3:13

RevieWWWs with Cyberdoc

Cyberdoc reviews cannabis, virginity and near death experiences online - the words in bold correspond to links on Cyberdoc's website at *xtn.org/cyberdoc/cannabis*

Virginity

In the light of Trevor Stammer's editorial, searching the web for articles on being a virgin might be seen as a risky business. Always the intrepid web explorer, I ignored links to Richard Branson's company, pages about Mary's perpetual virginity (whatever that is) and sites displaying explicit pornography. 'Virgin sex' was one headline - which to me at least is a contradiction in terms.

Virginity in Vogue is an American campus-orientated page, boldly proclaiming the message that holding onto virginity until marriage is a good thing. The **Virginity FAQ**, written by Christians, is an excellent resource which cleverly avoids Christian arguments for virginity directly until almost the end of the page. Although a little lacking in format, it is well-reasoned and makes good reading. The **Family Research Council** site also has a good section of virginity-related articles and **Bible Sex Facts** is a collection of short pieces on every aspect of sex covering most issues succinctly. The **CMF Website** pages on sexuality are well worth a visit too.

Cannabis

I was amazed to discover a UK-based mail order site (where anyone can buy cannabis seed) which claimed that any responsibility for illegal propagation was the buyer's alone. A page offering information, kits enabling people to pass drug tests having consumed cannabis, fake cannabis plants (to surprise your boss) and even free seed samples astonished me even more. For ethical and legal reasons I have not advertised the links to these pages.

The Nectar of Delight gives a seemingly believable, although unreferenced, account of the history of cannabis. At least, there is no repetition of wild claims made elsewhere that Jesus and the Old Testament prophets consumed cannabis in order to experience ecstasy and hear from God. Sorry folks, but I could not bring myself to publish the web address of that particular page either! **Drugs and the Christian** is an altogether more helpful site that marshals biblical arguments well. Whilst not afraid to point out some of the medicinal uses of cannabis and give a detailed history of its pharmacology, it raises no doubt that it is opposed to Christians using the drug. **Drugs and Alcohol - the Truth** is a high-octane statistic-filled web article by Patrick Dixon which also gives links to many other drug related sites.

For a list of links to official sources of information on cannabis the page **Social Issues Drugs of Addiction** is also very useful.

Near Death Experiences

One of the major near death experience websites illustrates many of the worrying aspects of these phenomena for Christians. In **Guy's Story**, the author claims to have met Jesus but the outcome for him is sorrow at being alive and a divorce. Other pages on this site mention 'soul mates' and other concepts Christians would be uncomfortable with. Similarly worrying is the experience of **Dr George Ritchie**, which initially sounds typically Christian. But George sees disembodied spirits of people walking around on earth, something that is definitely not part of Christian belief. Sadly on the internet it is all too clear that many near death experiences are leading people into spiritualism and are being used to give substance to beliefs that are anti-Christian. **Religious Interpretations of Near-Death Experiences** is a thorough, well referenced examination of the subject and points out that many people who experience these phenomena become more open to Eastern religions. This last article is very helpful in explaining the universality of the experience, possible biological causes, and the role of religious beliefs in modifying the experience.

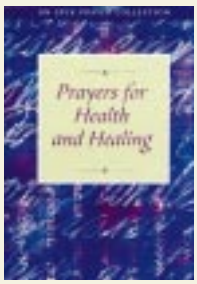
This article and links to previous Cyberdoc website reviews can be found at *xtn.org/cyberdoc/*

Cyberdoc is Adrian Warnock, SHO in Psychiatry and previous editor of Nucleus.

BOOKS

Prayers for Health and Healing

SPCK Prayer Collection
SPCK 2000
£12.99 Pb 120pp
ISBN 0 281 05273 5



Have you ever been prevented from praying with a patient through fear of sounding trite or appearing not to understand their pain and suffering? Or have you ever been asked as the 'health professional' in your church to contribute to a service? If you have, then you might have found that your years of medical training had not quite prepared you for this demanding role!

Well, never again need you fear being lost for words with this well-edited book of over 140 prayers for health and healing. It is divided into ten well-chosen sections. The first half of the book has general prayers for health and healing; the second half deals with illness categories such as chronic pain or illness in old age. These are all easily browsed through to find the prayer that suits both you and the occasion best.

There is an index of 80 different subjects ranging from babies to bereavement and stress to sleeplessness. There are also specific prayers for doctors, nurses and hospitals.

Prayers are in both old and new style and are suitable for use during church services or formal occasions, at the bedside and in the home. Looking up your favourite author isn't a problem either because there's an index of these too.

Overall I found this book helpful to read and easy to reference. It would make a good Christmas present for any doctor, nurse or church leader.

'Almighty God, who knowest our necessities before we ask, and our ignorance in asking: set free thy servants from all anxious thought for the morrow; give us contentment with thy good gifts; and confirm our faith that according as we seek thy kingdom, thou wilt not suffer us to lack any good thing; through Jesus Christ our Lord.' Augustine of Hippo

Michael Davey is a General Practitioner in Harrow and a former chairman of the CMF Junior Doctors' Committee

All the Hours God Sends?

Peter Curran
Inter-Varsity Press 2000
£7.99 Pb 216pp
ISBN 0 85111 656 6

It is a reflection of the way the health service has changed that this book, whose author has worked in the oil industry for many years, is entirely relevant to health professionals. Concepts such as work place stress, down sizing, maintaining motivation and seeking excellence are now all part of our day to day world. We all work in teams, and some of us lead teams. Yet, it is all too easy to fail to integrate the way we think and behave at work with the rest of our lives as Christians.

How often do we take time to think and talk with other Christians about the way in which the institutions we work for affect us, and about how we feel and act as an employee, employer or team member? Do we take enough time to think about what our job is doing to us and how we may be affecting others? If the answer is no, then this book is designed to help. The author's style is clear, and if management terms are used, they are explained. He combines a wide knowledge of industry and the pressures of work with a familiarity with scripture that enables him to use the Bible extensively to establish principles and to explore very modern dilemmas.

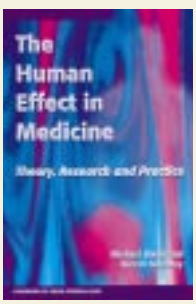
There will be times for all of us when the pressures at work feel overwhelming; when we get the balance between family, church and work wrong; when we are bored or frustrated or threatened by redundancy. All these areas are dealt with. The book can be read as a whole, but is designed so that each chapter stands alone, focusing on a specific area such as coping with change, or ambition and wealth. As with all good management documents, there is an action column at the end of each chapter, and these provide a challenge in themselves.

This book is valuable in several ways. It can help us as individuals to think through problems related to our work, and could provide rescue in a crisis. It would also make an excellent tool for a study group. I must get a copy for our practice library.

Rebecca Torry is a General Practitioner in London

The Human Effect in Medicine:
Theory, Research and Practice

Michael Dixon and Kieran Sweeney
Radcliffe Medical Press 2000
£17.95 Pb 157pp
ISBN 1 85775 369 0



The 'human effect' referred to in the title is, in effect, the placebo influence of the physician. The authors, both general practitioners, describe this effect particularly in the category of patient that makes up the bulk of general practice; those with chronic and incurable disease. Nevertheless, they state that a wide range of disease shows marked placebo response including, for example, peptic ulcer disease.

To maximise the 'human effect', the

authors emphasise the crucial importance of listening carefully to the patient, the actual words the doctor uses (especially his metaphors), the value of humour, and the need for continuity of care. The placebo effect is influenced by the attitude of both the doctor and the patient. The doctor's enthusiasm over a new remedy enhances its effect. The patient's expectations also have a positive influence. The colour and shape of pills is important, and while suppositories and injections have a greater effect than pills, a surgical operation has the most powerful effect of all.

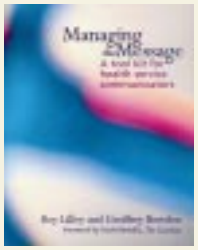
The authors urge doctors to move beyond the idea of the body as a machine. If doctors do, indeed, regard their patients in this way, then this book is timely. One cannot help feeling that what is advocated is really a return to the best practice of family doctors of an earlier generation. Perhaps the authors recognise this in saying, 'What is called for is less of a revolution and more of a revival'.

David Short is emeritus professor of clinical medicine in the University of Aberdeen, past chairman of the medical ethics committee of the University of Aberdeen and the Grampian Health Board, and Physician to the Queen in Scotland.

Managing the Message:

A tool kit for health service communicators

Roy Lilley and Geoffrey Bowden
Radcliffe Medical Press 2000
£19.95 Pb 148 pp
ISBN 1 85775 412 3



This is a brilliant book. Both authors have spent many years working at the interface of medicine and the media, and their experience overflows onto every page. This is an easy to read manual that not only teaches the reader how to communicate more effectively, but is also a wonderful example in itself of how to get the message across.

Written in bite-size chunks with plenty of white space, question boxes, illustrations and charts, it is a joy to dip into. The topics covered range from broad issues such how the media works and how to organise message management, right down to the specifics of how to use a notice board most effectively. (They suggest never leaving a notice on it for more than ten days and moving the board around the place!). Handling radio and TV interviews, managing the media when things go wrong, producing an annual report, advertising, making a promotional video and appointing a communications consultant are all considered in a lively jargon-free style.

The book is very funny and is brimming with memorable quotes and aphorisms. The Harvey Thomas quote, 'If they haven't heard it, you haven't said it' is there, for example, but Lilley and Bowden have plenty of their own: 'You can't look humble in a bow tie! It looks like you spend your life at a party, or behind a glass of gin!'or 'Pioneers get arrows in their backsides'. 'All organisations big and small have communication needs. For some, word of mouth is enough. For others not even the word of God can be heard above the din of day to day.'

Any doctor will benefit from even a 30-minute skim through this book and it is a must for those whose jobs involve regular local or national media contact. Many church leaders would benefit from it too. Jesus was a brilliant communicator who captured the complete attention of his listeners yet the church is often dull and unimaginative in comparison. The word of God might be clearly heard above the din of day to day life if Christian communicators took some tips from this book.

Trevor Stammers is a Tutor in General Practice, St George's Hospital Medical School and a regular author and broadcaster on sexual health.

The CMF Website on CD-ROM £3 (Special Offer)

The CMF website, first launched in July 1997, has so far attracted over 250,000 visitors searching for resources on medical ethics, evangelism and medical mission. It is now available on CD-ROM: over 30 back issues of Nucleus and 10 issues of Triple Helix together with ten years of CMF government submissions on ethics, the full set of CMF Files, a year's supply of daily devotions, the Confident Christianity evangelism training course, 'Cyberdoc' web reviews, a quarterly newsround of issues in medical ethics and much more. Everything is indexed by subject from a revised site index meaning that most specific queries can be answered within two or three mouse-clicks from the homepage. Over 200 external links take the browser directly to helpful Christian and medical sites on the internet.

This new resource enables access to a vast array of CMF literature and resources without having to search old journals, visit the office or wait for pages to download on the internet.

Letters

The Status of the Embryo

***Rev Chris Cook**, Professor of Psychiatry at University of Kent at Canterbury, remains unconvinced that embryos should be accorded the unequivocal status of 'human being'.*

Peter Saunders' HFEA submission on the status of the human embryo (*Triple Helix* 2000; Autumn:12-13) helpfully summarises some of the arguments in favour of a more conservative stance. However, I doubt that anyone is arguing that 'human embryos are not human beings worthy of respect because...' If the embryo is a human being, it is incontestably worthy of respect. If it is not a human being, it may still be worthy of respect because of its potential for development into such a being.

The crucial question is how we should define what it means to be a 'human being'. If humankind is made in the image of God, it would seem that the characteristics which are fundamentally human are unlikely to be biological in nature. It is, of course, a vexed question as to what the crucial characteristics of the *imago dei* actually are. However, the capacity for inter-personal relationship is surely an important consideration. To me, this seems closer to the concerns of scripture than a focus on biology.

If the high spontaneous abortion rate suggests that the majority of human beings have never entered into human/human or human/divine relationships (in the sense that we normally understand such relationships), and if they have never been capable of any kind of independent rational or volitional action in this world (however simple), what does this imply for our understanding of what it means to be human? Does it become possible to argue (***pace*** Augustine) that the majority of human beings have never sinned? How would we then re-evaluate the work of Christ in this context?

I agree that the value of human life is not defined by 'normality' of body or mind. However, I do not believe that the status of the human embryo should be defined by its normality. The soul is not eternal, and presumably does not precede the existence of the embryo. However, why should it 'logically' follow that the soul exists from the point of conception? Such arguments do not help us to define the status of the human embryo - they follow on from a predetermined position on that question.

I think that we should be grateful to Dr Saunders for stimulating our thinking in this difficult area of ethics, philosophy and theology. However, I remain to be convinced that the embryo should be accorded the unequivocal status of 'human being' (whether or not qualified by phrases such as 'in an early stage of development').

*Cheshire GP and Anglican Synod member **Sheila Grieve** feels that Peter Saunders' views are unrepresentative.*

The Autumn issue of *Triple Helix* causes me some uneasiness; in particular the submission by Peter Saunders to the HFEA, presumably on behalf of the membership. This certainly does not represent my views, and I question whether it represents the views of the majority of CMF members. In the 1996 survey of members' views about the status of the embryo, only 36% of the total doctor sample believed life had full value from the moment of fertilisation and only 20% of the total sample would not prescribe methods of contraception which might work by preventing implantation. These figures suggest that the majority would not be happy with the absolutist view and intemperate language of Dr Saunders' submission. Did Dr Saunders claim to be making the submission on behalf of CMF membership when he said 'with the HFEA Act the devil is not in the detail, but in the very foundation'?

*CMF General Secretary **Peter Saunders** replies.*

Those who see the embryo only as a potential human being usually don't make clinical decisions in its favour when it comes to the crunch. Chris Cook employs two of the common arguments used to justify a more liberal stance; namely that embryos' (alleged) high mortality and poor capacity for relationship raise doubts about whether they have souls or possess the *imago dei* and are therefore human beings. Readers will have to re-read my original article (and the fuller web version at *www.cmf.org.uk/pubs/nucleus/nucjul98/deadly.htm*) to judge the merits of my counter-arguments; but either way, I still maintain that the benefit of any doubt should be given to the embryo. The HFEA submission was a personal one, and not representative of CMF, although interestingly, Sheila Grieve does not mention that 66% of the student sample in the 1996 survey sample believed life had full value from the moment of fertilisation. If, as I have argued, embryos are human beings, then the devil certainly is in the very foundation of the HFEA Act, since it offers them very little protection.

Jodie and Mary

*Barts graduate **Fiona Schneider** is outraged by Siamese twin pics.*

I was outraged by your last editorial page (*Triple Helix* 2000; Autumn:3). John Wyatt offers a sympathetic and balanced Christian view on 'Jodie and Mary': 'as Christians we must firstly be concerned to protect the dignity, privacy and grief of the family'. It is incomprehensible to me that you then have a photograph of the children. I am appalled by your lack of sensitivity and intrusion into the private sphere of this family. I hope you will apologise to the parents. Has sensational journalism eroded the CMF judgement?

*Pharmaceutical Medical Director **Jane Barrett** feels similarly.*

I was concerned to see the photograph of the Manchester conjoined twins with no reference to the fact that their parents had given consent for the photograph to be published. In view of the fact that the wishes of the parents have been so similarly overridden, can you reassure me that permission was sought, and consent given?

*The **Editors** reply.*

No photograph of the Manchester twins has been released, only drawings. The photo in *Triple Helix* was of a similar pair of twins and obtained from the Press Association. We are sorry that this was not made clear and the point is taken. The response from readers has been varied. In contrast to those opinions expressed above, others have said that it was the photo, rather than the editorial, which moved them most to outrage over what was done to those two little girls. John Wyatt's article in *Nucleus* (see *Eutychus* on p14) uses stronger language than his editorial to condemn the action taken by the surgeons. *Triple Helix* readers are welcome to ask for a copy.

FEELING DISAPPOINTED?

The airmail letter came from a successful applicant for a grant, enabling him to attend an ICMDA conference. 'Please pray for those who have not received bursaries,' he wrote. 'They could feel bitter or resentful, which would spoil the fellowship.' It seemed that this group of young believers still needed to learn from the apostle Paul, who said: 'I have learned, in whatsoever state I *am*, therewith to be content.' (Philippians 4:11)

When I was growing up and upset about something, *my* father used to say, 'Learn to spell disappointment with an '*H*' - His appointment.' Learning is a lifelong process and some lessons have to be reinforced before they become basic to our thought life and responses. Yet if we have handed over our lives to the service of our loving Lord, can we not trust him with all that he allows to happen to us? Whether or not our problems result from errors that are clearly human, we still have the definite assurance that, '*All things work together* for good to them that love God, to them who are called according to his purpose.'(Romans 8:28)

God is able to take shattered dreams, failures (including failed applications) and all other occasions when we are tempted to feel that he's let us down, or made a big mistake, and work any of these things together for good. Unlike us, he is not in a hurry, but with the retrospectoscope we may well see what he has made of the mess we had thought we were in. Such lessons strengthen us for the next time as, like Paul, we *'learn'* to rely on his judgment more than our own aspirations.

It may be that we will never see why he permitted some major disappointment to come our way. Perhaps how we took it will draw someone else closer to faith. It could simply be that we learn to know him and his ways better as we experience something of the 'fellowship of his sufferings', whilst also finding resilience from 'the power of his resurrection'.(Philippians 3:10) The outcome must be trusted to him.

When next disappointment comes our way, it could be consoling to read through the whole of the letter to the Philippians - and remind ourselves that it was written by someone chained up in a prison.

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