TRIPLE HELIX

Winter 2002

For today's Christian doctor

CLONING

SEX EDUCATION

THE EXPERT PATIENT

DIANE PRETTY

ALBANIA

CRISIS COUNSELLING

MANAGING TIME AND STRESS

ABORTION

POST-MODERNISM

OVERSEAS OPPORTUNITIES

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Cover Michael West, CEO of 'Advanced Cell Technology'. Photo: PA

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EDITORIALS

The Government's Sexual Health Strategy
More of the same

Backed with £47.5 million, the long awaited government's first National Strategy for Sexual Health and HIV Services[1] was launched on 27 July 2001 by the Deputy Chief Medical Officer, Dr Sheila Adam and GUM consultant, Prof Michael Adler.

The launch was timed to coincide with the release of the latest STI figures by the PHLS.[2] These showed a continuing escalation of STIs in the UK. Particular causes for concern include the highest number of cases of gonorrhoea for over a decade (new cases rose by 27% between 1999 and 2000), sharply increased diagnoses of chlamydia (with, on average, one new case diagnosed every ten minutes in the UK) and increases in STIs among gay and bisexual men well above that seen in the general population (gonorrhea in this group was up 49% from 1999-2000).

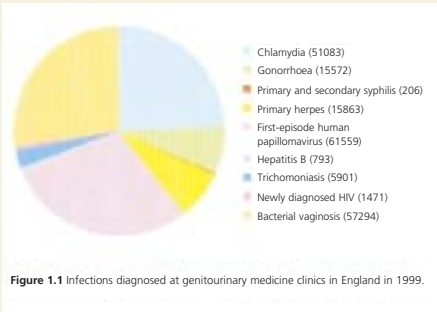

Figure 1.1 Infections diagnosed at genitourinary medicine clinics in England in 1999.

The full details of the strategy[1] contain some very timely specific proposals such as targeted screening for chlamydia and the offer of hepatitis B vaccination to more at-risk groups. However the general trends and the strategy's assumptions give cause for concern.

Though HIV is the fourth largest killer worldwide,[3] in the UK it comprises a small number of cases of STI in comparison with the number of non-HIV STIs. Yet the very title of the strategy document gives undue emphasis to HIV over non-HIV diseases and this is reflected throughout the text. Few people have not heard of AIDS and HIV but, as the document acknowledges, most people do not know what chlamydia is. Yet in spite of this, the strategy does not cover sex education in its remit so there is little chance that education in schools about non-HIV STIs will improve as a result of its implementation.

There is also no evidence of comprehensive and joined-up measures to try and tackle prevention of STIs and unplanned pregnancy together. This is perhaps because the usually proposed solutions for both in isolation (condoms and oral contraception) have their weaknesses exposed when viewed in the light of the dual problem.

Even if condoms were the solution to STIs alone, why do the case numbers continue to rise in spite of increasing condom use in the UK? The recent Center for Disease Control Report on condom effectiveness[4] throws doubt about the wisdom of condom promotion as the primary means of STI reduction. For example, the CDC report found no evidence that condoms provide any protection against HPV, the causative agent of genital warts and the commonest STI in the UK.

In the *Lancet* recently, three other experts from Prof Adler's own department concluded, 'We should ask why condom promotion is apparently not having much effect in most developing countries and whether we have the right balance between messages about condom promotion and partner reduction or selection.'[5]

This latter question is not considered at all by the document, despite many professional submissions to the committee suggesting this was a vital but neglected area to consider. Some wise words from another important document are very relevant: 'Sexual drives are strong, but marriage is strong enough to contain them and provide for a balanced and fulfilling sexual life in a world of sexual disorder.'[6]

Successive government initiatives however seem totally blind to this concept and STIs will continue to rise this year as a consequence.

Trevor Stammers
General Practitioner in West London

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The Expert Patient
A welcome way forward

In 1985 Tuckett proposed that a consultation should be seen as a meeting of two experts.[1] The doctor is an expert in biomedicine; the patient is an expert in his or her own life, goals, priorities, beliefs, and choices. Humane medicine happens when the role of both is given value. This is reflected in Jesus' intriguing question to the blind man whose need was apparently obvious: 'What do you want me to do for you?'[2]

A DoH Task Force has published its recommendations in a report entitled 'The Expert Patient: a new approach to chronic disease management in the 21st century'.[3] The report calls for patients with chronic diseases to be seen not as passive recipients of care, but as experts and partners with us in the treatment process. This has benefits in improving patients' self-efficacy - their confidence in their own ability to solve problems and reduce dependency and disability.

I admit to being sceptical about the usual suspects. The proposals will be piloted between 2001 and 2004, and 'between 2004 and 2007 programmes will be mainstreamed within all NHS areas' (p8), so clearly the fleetingly mentioned evaluation of the pilots is not expected to change the set policy. The report talks of PCTs commissioning projects (p31), but does not acknowledge that the DoH therefore has a reciprocal responsibility to fund them. And can a change of culture be imposed from the top within a framework that is overtly politically and often cynically driven?

Medics and politicians both want to be seen as the champion of the patient. We need to admit that we both fail to live up to our rhetoric. We should not be afraid to share our professional power with our patients. We hold that power as stewards, for their benefit. Jesus calls us to be 'as shrewd as snakes and as innocent as doves'.[4] Yes, we need to scrutinise these proposals with constructive caution, but I believe we should welcome this report's vision of greater patient empowerment with open arms.

David Misselbrook
General Practitioner and Course Organiser, Lewisham VTS

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Michael West, CEO of 'Advanced Cell Technology'. *Photo: PA*

Peter Saunders reviews recent developments in the cloning debate.

The cloning saga

KEY POINTS

The November announcement of the first human clone and Antinori's plans to set up a cloning clinic here caused the government to panic. The resulting *Human Reproductive Cloning Act* is full of loopholes which unscrupulous lawyers and scientists could exploit, and is likely to backfire as badly as the hasty and ill-conceived amendments to the Human Fertilisation & Embryology Act last winter. In the light of new advances in stem cell research, which are making the use of human embryo clones rapidly redundant, a wiser approach would have been an immediate moratorium on *all* human cloning (both reproductive and therapeutic) to allow time for proper primary legislation.

'A milestone in scientific depravity' was one commentator's reaction to the 25 November announcement that American scientists had produced a cloned human embryo. 'Advanced Cell Technology', the Massachusetts-based biotechnology company responsible, were adamant that their intention was 'not to create cloned human beings, but to develop life-saving therapies'. Tony Blair's government brought in emergency legislation to ban reproductive cloning and the public were left to wonder how things had moved so far so fast.

In December 2000 the government legalised research on cloned human embryos by extending the Human Fertilisation and Embryology Act. This legislation was rushed through both houses of parliament within a month on the pretext that it would allow embryonic stem cell research that could potentially lead to cures for serious degenerative diseases such as Parkinson's, Alzheimer's and muscular dystrophy.

However after the legislation was passed a moratorium on all research on cloned embryos was imposed after the Pro-Life Alliance (PLA) launched a case against the government in the High Court. The PLA argued that cloned embryos were not 'embryos' as defined in the HFE Act (ie. produced by fertilisation), and therefore not governed by that Act. Justice Crane upheld their case on 15 November, leaving Britain with no law on cloning. That very day Dr Antinori, the controversial Italian fertility specialist, announced that he was coming to set up a reproductive cloning clinic here. The government's hand was forced and within ten days the *Human Reproductive Cloning Act* - which bans placing in a woman an embryo created by any means other than fertilisation - was passed in both the Commons and the Lords.

Since the birth in 1996 of Dolly the Sheep, cell nuclear replacement (CNR) has been used to clone a variety of mammals including cows, goats and mice. Scientists at 'Advanced Cell Technology' (ACT) claimed to have used the same technique to produce a human clone by transplanting the nucleus of an adult skin cell into an unfertilised human egg – but managed to grow the resultant embryo only to the six cell stage after a week. An embryo of at least 64 cells would be required in order to harvest stem cells for medical use. Many scientists remain sceptical as to whether it is technically possible for human clones to be born. Others see November's announcement simply as a publicity stunt for reasons of prestige and profit.

Christian Medical Fellowship and others called (unsuccessfully) for proper primary legislation and an immediate moratorium on *all* human cloning, whether for reproduction or research.[1] But the government acted in the way it did in order to ensure achieving its twin goals of promoting therapeutic cloning and preventing reproductive cloning.

The new law is full of loopholes which unscrupulous lawyers and scientists could potentially exploit. For example, there is now nothing to stop cloned embryos being produced in the UK and exported for implantation abroad (or in a ship anchored offshore). And cloned babies can still be born here. Because cloned embryos are not covered by the HFE Act, they could now be grown in a lab past 14 days (and if the technology becomes available to the foetal stage or even 'to birth'). Cloned embryos could also conceivably be placed in the womb of a female of another species or in a man (theoretical possibilities but not beyond technological advance).

The new law will also be impossible to police - this is because no-one will announce the existence of illegally cloned humans until after they are born - when it will be very difficult to prove that they were implanted in the UK or even that they are clones. If lawyers were to deny cloning the burden of proof would be then be on the government to produce the two individuals who provided the nuclear (and mitochondrial) DNA. If the donors had since emigrated or eluded detection, or even worse died, the police would presumably be left to hunt down (or dig up) the 'suspects' at the taxpayers' expense.

I have previously argued[2] that the production of cloned embryos, even for stem cell harvest, is unethical because it treats the embryo as a means to an end, dangerous because of the slippery slope to reproductive cloning and unnecessary because there is an ethical alternative in adult stem cell technology.

The Donaldson Report, which recommended the use of embryonic stem cells and which provided the basis for the government's hurried legislation last

THE NEW LAW IS FULL OF LOOPHOLES WHICH UNSCRUPULOUS LAWYERS AND SCIENTISTS COULD POTENTIALLY EXPLOIT

December/January, is now 18 months out of date and based on yesterday's science. The latest research suggests that adult stem cells are much more easily harvestable, more versatile and more easily cultured than was previously thought.[3] Adult stem cells have already been used successfully in humans in the treatment of bowel,[4] skin,[5] and heart[6] disease, and in other mammals for a much broader range of illnesses.[2] Most of this work postdates Donaldson.

It took 277 attempts to produce Dolly and early indications are that human cloning will be much more difficult. Foetuses produced by nuclear transfer are ten times more likely to die *in utero* than foetuses produced by normal sexual means, while cloned offspring are three times more likely to die after birth.[7] Cloning humans would lead to high foetal loss and deformities in the newborn - and will always be wrong for these reasons alone - not to mention the social and psychological sequelae for the clones, their families and society at large.

As Christians we should not be surprised by the legal, social and ethical problems that the whole cloning fiasco is creating. Whilst the responsible use of technology is part of good Christian stewardship, the end never justifies the means (Romans 3:8). We must do God's work God's way. God ordained that his image in human beings (Genesis 1:27) was to be passed on in the context of a loving committed marriage relationship, through sexual union (Genesis 2:24) and that children should be reared, protected, disciplined and educated within the context of a stable family relationship. We disregard his wisdom at our peril.

Peter Saunders is CMF General Secretary and Managing Editor of Triple Helix

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When the Bishop of Oxford advocated therapeutic cloning he found himself under fire from a heavyweight brigade of churchmen and academics. **John Martin** reports.

Cloning advocate

under heavy fire

Human cloning - which route to take? *Photo: PA*

As a long-time contributor to BBC Radio 4's 'Thought for the Day', Richard Harries, the Bishop of Oxford, is widely regarded as one of the country's leading Christian apologists. The late Archbishop Robert Runcie used to say that one of the strengths of Anglicanism was a quality that he improbably labelled 'passionate coolness'.

Listen to Harries on the BBC at 7.50am and you hear a calm, carefully modulated voice that conveys strongly held convictions with an air of measured thoughtfulness. Few Church leaders have got passionate coolness down to such a fine art.

Behind the media persona is a Christian ethicist who the Church systems have found to be a safe pair of hands on a whole range of subjects. Harries, a former Dean of King's College, London, has had a longstanding link with the Council for Arms Control. When the Campaign for Nuclear Disarmament was at its zenith, Harries was an important Christian voice that sought a different route to pacifism and unilateral nuclear disarmament. On another stage he was mandated by the Church of England to testify before the Eloff Commission, an attempt by South Africa's nationalist government to silence Bishop Desmond Tutu, when he was General Secretary of the South African Council of Churches.

Not surprisingly, then, Harries quickly became a highly influential spokesman on ethical issues as an Episcopal Member of the House of Lords. His manner and erudition commended him to a wide cross-section of parties and factions. He now chairs the House of Lords' Select Committee set up to consider the ethical issues involved in stem cell research.

Now the normally unrufflable Harries is at the epicentre of a sharp debate in which he stands at odds not only with Anglican heavyweights such as Rowan Williams the Archbishop of Wales. Lined up against him is a formidable array of Catholic ethicists, academics, and pro-life activists. Among the other leading churchmen is Cardinal Cahal Daly, the Catholic archbishop emeritus of Armagh, and Kallistos Ware, leader of the Eastern Orthodox community in Great Britain. Among 19 academics joining the fray are Oliver O'Donovan, Regius Professor of Moral and Pastoral Theology at Oxford, John Milbank, Professor of Philosophical Theology, University of

HIS OPPONENTS ARE NOT ONLY ANGLICAN HEAVYWEIGHTS … [BUT] A FORMIDABLE ARRAY OF CATHOLIC ETHICISTS

The Bishop of Oxford is regarded by some as one of the country's leading apologists, but, as chair of the House of Lords' Select Committee on therapeutic cloning he is under fire from Anglican and Catholic ethicists and theologians who claim he has misrepresented the church's historical position on the status of the embryo both to politicians and the public. In a letter to *The Tablet*, and in a longer submission to the Select Committee, they argue that the church, from apostolic times until the present day, in spite of disagreements over the origin of the soul and penalties for abortion, has been constant in affirming that life must be defended from the time of conception.

Virginia, and Nigel Cameron, Professor of Theology and Culture, Trinity International University, Illinois.

This remarkable international collection of church leaders and thinkers have joined forces in taking Harries to task for contending during the highly public debate about therapeutic cloning (in an article in *The Tablet*, 16 December 2000) that the Catholic Church did not regard the early embryo as always sacred until the nineteenth century.[1]

He wrote that 'it was only in the nineteenth century that the Catholic position [on the status of the embryo] became absolute. Earlier Christian thought on this subject indicates an awareness of a developing reality, with developing rights as we would put it.' He cites for example Aristotle (or views attributed to him) that there is a 'vegetable soul, then an animal soul and an intellectual soul, and it is only at this last point there is, properly speaking, a human being'. He claimed that 'the Church's tradition acknowledged a similar process. Abortion was always regarded as gravely sinful. But there is a distinction in the gravity of the offence, depending whether it occurred before or after the foetus was "formed".' He brings to bear the Septuagint (the early Greek version of the Old Testament) translation of Exodus 21:22. He cites St Augustine of Hippo and Celtic penitential practice that imposed severe penalties for abortion but spoke of 'the liquid matter of the infant matter in the womb' – which he claims was a phrase used to describe an embryo – and a more mature form where 'the soul has entered it'. This is the historical/philosophical framework of his argument. Earlier in the article Harries offered two other arguments. Firstly, he says, three-quarters of eggs fertilised in the normal way are lost since they do not implant. Moreover, at least half of those that miscarry are abnormal. 'We do not mourn the loss of these eggs as the loss of a person. To put it starkly: if all these early losses were people, the afterlife would be mainly populated by those who had never been born outside the womb,' he says. Secondly he raises the much-used distinction between the acorn and the oak tree where potential (the acorn) is not necessarily accorded the rights of a mature tree where preservation orders may apply.

It is Harries' interpretation of history that draws the fire of the churchmen and academics and they have put their names to a submission to the House of Lords Committee chaired by Harries drafted by Fr David Jones, former director of the London-based Linacre Centre for bioethics.[2] The submission contends that the earliest Christian writings 'considered abortion to be murder, and the spiritual soul to be present from conception. The

earliest church legislation contains no reference to a distinction between formed and unformed…'. Referring to the Celtic disciplines cited by Harries the submission asserts that 'aborting an unformed foetus was sometimes regarded as a lesser sin than aborting a formed foetus. But it continued to be a grave sin'.

The submission contends that later when the thought of Aristotle led to a belief that the spiritual soul was infused 40 days or so after conception, 'there was no suggestion that the unformed foetus was ever expendable, and it continued to be regarded as sacrosanct'.

They conclude: 'In asserting that life must be defended from conception, twentieth-century Christians were in continuity with the belief of the early Church that all human life is sacred from conception. This view has been constant in the Christian tradition, despite disagreement over the origin of the soul and the penalties thought appropriate for early or late abortion.

They offer five principles (here in summary)

- The Christian tradition has never allowed deliberate destruction of the fruit of conception even though penalties for this have varied.
- Every human is a special work of God in which God is involved from the very beginning.
- The Christian doctrine of the soul is not dualistic; it requires the belief that where there is a living human individual there is a spiritual soul.
- Each human is called and consecrated by God from the womb from the first moment of existence.
- Jesus was clearly a human being from conception.

The weight of the argument seems to have left the normally unruffled Harries very much on the defensive. We await the next round of this heavyweight contest.

John Martin is a writer and broadcaster and associate editor of Triple Helix

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Nigel Sykes argues that hard cases make bad laws.

Diane Pretty


Photo: PA

Diane Pretty is a 42 year old woman with motor neurone disease who wishes to commit suicide but is now too disabled to do so. She would therefore like her husband to end her life instead.

In October 2001 the High Court heard Mrs Pretty's appeal against an earlier decision of the Director of Public Prosecutions (DPP) not to rule out action being taken against her husband in the event of his securing her death. The Court rejected her case on the grounds that the DPP had no power to grant a pardon in advance. This ruling was upheld by the House of Lords on 29 November and she is now planning to appeal to the European Court of Human Rights.[1] As with the 1997 case of Annie Lindsell, who also had MND and asked the courts to allow her to have the distress of her illness relieved by medical treatment that might also shorten her life, Mrs Pretty was supported by the Voluntary Euthanasia Society as part of their persistent campaign to legalise euthanasia in this country.

Diane Pretty based her case principally on two types of assertion. The first was that if she continued in the course of her MND she would suffer from severe pain and disability and distressing symptoms, would undergo inhuman and degrading treatment, and would be compelled to endure her condition unrelieved. The second was that the blanket prohibition in English law on assisting someone to commit suicide was against the European Convention on Human Rights.

Article 2 of the Human Rights Convention, which last year formally became a part of English law, protects the individual's right to life. However, such protection is not unconditional and in a Swiss case the European Court has held that the Convention does not require the State to prohibit suicide. Article 3 of the Convention says that no one shall be subjected to inhuman or degrading treatment: Diane Pretty's lawyers argued that her continuation of life amounted to exactly such a mode of treatment and that her absolute right not to be so subjected, together with her right to personal autonomy, outweighed any duty of the State to protect her life.

MND is a most unpleasant condition that results in a progressive loss of many body functions. It is incurable and leads to death in an average of about three years. The mode of death is the loss of respiratory muscle function leading to respiratory failure. Aside from this, the pattern of muscle weakness is highly variable but eventually a greater or lesser spread of paralysis always occurs. In so-called bulbar motor neurone disease, when the muscles of swallowing are impaired, there is difficulty in swallowing not only food and drink but also saliva. Diane Pretty appears to have this form of MND, and her needs for nutrition and the relief of hunger have been met by the insertion of a gastrostomy feeding tube.

The treatments for the control of the symptoms of MND have much in common with those used for symptom management in other neurological diseases and in cancer. If such treatment is to be classified as 'inhuman and degrading' this does not apply uniquely to people with MND but also to the many thousands receiving palliation for other progressive diseases.

As Christians we may feel both that despair is in effect a rejection of God's eternal promise of his loving presence (Mt 28:20), and a sin against the Holy Spirit (Mk 3:29), while suicide itself is contrary to the sixth commandment (Ex 20:13). However, in our society acceptance of euthanasia cannot be prevented by arguments from faith.

Whom is euthanasia meant to benefit? Even among the terminally ill, assisted dying is a minority interest: just 6% of hospice patients even discuss the matter, and only 3.6% of terminally ill patients in other care settings.[2] These figures are very different from the 80% or more of healthy adults who say in opinion polls that they support legalisation of euthanasia. When illness happens, something changes for most people.

Security and skilled maintenance of comfort are important and in Holland where euthanasia is now legal, two-thirds of requests for assisted suicide or euthanasia are rescinded as a result of palliative interventions. Nearly half of candidates for physician-assisted suicide in Oregon, where such acts are permitted, withdrew their request if offered even one palliative care intervention.[3] Not caring is always cheaper than caring, and in a cash-limited system it is unlikely that resources for such palliative care would improve if euthanasia offered a cheaper alternative.

Death by euthanasia is not necessarily easier than a natural death. Difficulties have been reported in nearly 15% of Dutch euthanasia cases, some of which have had distressing effects such as vomiting, muscle spasm, extreme gasping or the re-awakening of the patient.[4] If such events occur when death is being brought about by qualified physicians they would be even more likely to result from the efforts of a lay person as envisaged by Mr and Mrs Pretty.

Then there is the question of why people would want euthanasia. Of those who died after assisted suicide in Oregon in the years 1998, 1999 and 2000 the proportion who felt themselves to be burdensome was 12%, 26% and 63% respectively, ie. the longer the Oregon right-to-die legislation has been in force the greater the proportion of those dying under its provisions who have felt that others would be better off if they were not there.[3] To allow this to go on would not build a caring and cohesive society.

To make provision for Diane Pretty to be killed would not only affect her as an isolated individual. Instead, it would be likely to have repercussions for a multitude of other very ill people through reducing their opportunities to achieve comfort and reducing, rather than enhancing, their autonomy.

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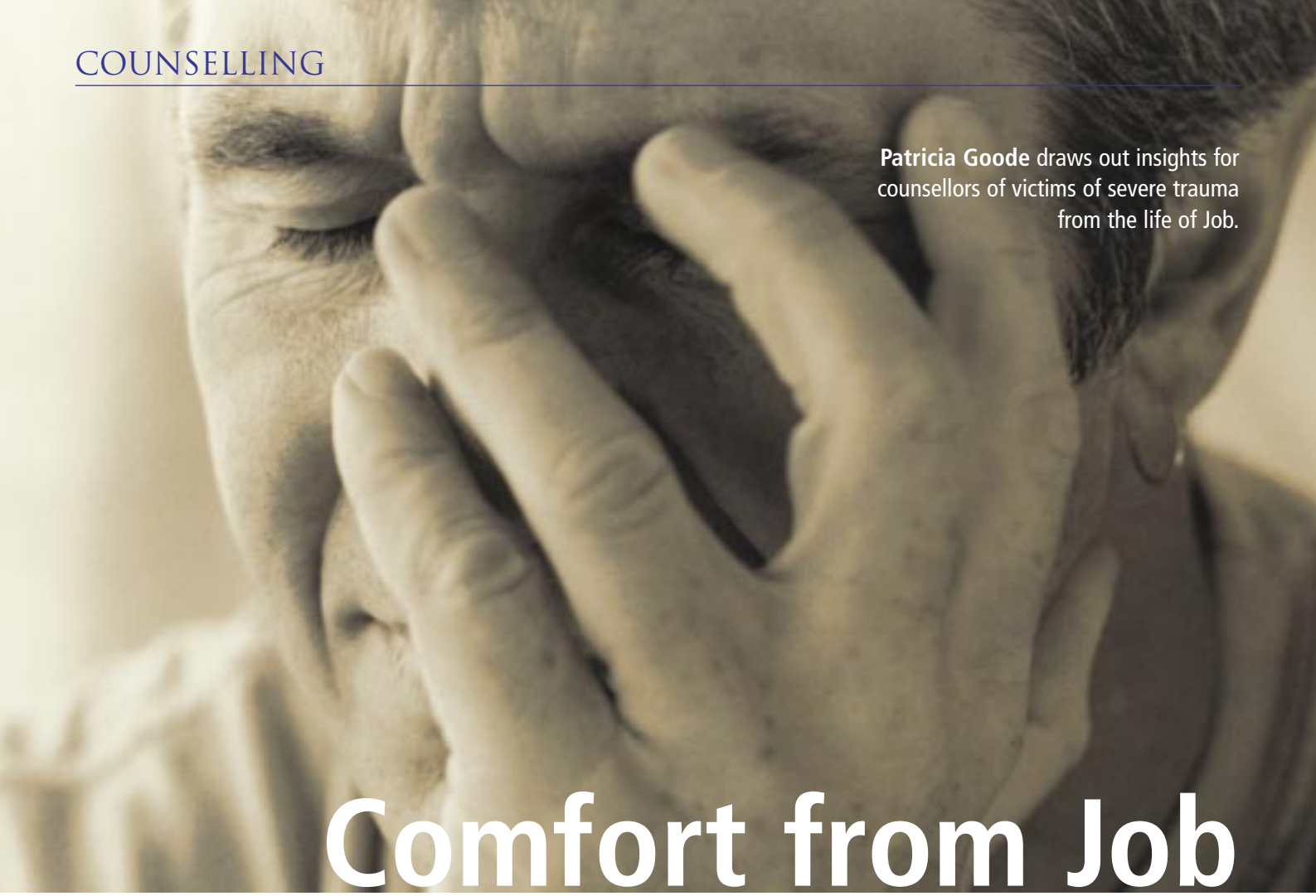

Patricia Goode draws out insights for counsellors of victims of severe trauma from the life of Job.

Comfort from Job

The best thing Job's friends did … was to sit with him quietly for a week

Post-traumatic stress disorder can follow rape, assault or major life-threatening accident or illness. It also occurs after seeing shattering incidents happen to others, especially when the person is called upon to help the victims: examples are serious train or air accidents and events such as the football disaster at Hillsborough.

Victims of such trauma need help with their anxiety and depression and particularly to relieve their feelings of guilt. Even though it is obvious that the victim was in no way responsible for what happened a complex of guilt can build up, making that person feel that in some way they were to blame.

This article explores possibilities for helping such victims using the pastoral theology of the book of Job. The book of Job grapples with the problem of suffering, especially the affliction that may come to a perfectly innocent and good person. Applying the book may lead the sufferer to find a path to submission before, and a new relationship with, an all-powerful and sovereign God.[1]

Moreover, the book of Job demonstrates, through the role given to Job's friends, how easy it is to engage in careless pastoral theology and mistaken pastoral approaches to suffering people. The best thing Job's friends did for him was to sit with him quietly for a week at the beginning. In this they showed real empathy, only to spoil it afterwards by their misguided approach. Job raises many classic questions about human suffering. This article considers three such questions.

Question 1: Is suffering the result of sin?

The doctrine of the Fall and subsequent corruption of every member of the human race would explain Job's suffering in traditional religious terms. His three friends assume that God always rewards good and punishes evil; therefore Job's suffering must have arisen because he has sinned. But to this Job replies that he is innocent as far as it is possible for a man to be: he knows that he has led a good life. The very beginning of the book states that Job was blameless and upright; he feared God and shunned evil. His suffering was certainly not the result of his sin.

Few people get through life without at some stage suffering some sort of trauma, be it ill health or experiencing tragedy. It is usually genuinely no fault of their own but in spite of knowing this they still tend to react with 'What have I done to deserve this?' or 'Why has God allowed this to happen to me?'

Just as the story of Job shows that his suffering was not the result of his sin, so the suffering of people in crisis is seldom the consequence of their sin. This knowledge may well relieve them of the burden of guilt that so often prolongs the suffering after a traumatic experience. Some views relate sin

and suffering in terms of the equation theory (ie. exact retribution). This closes the doors to many developments and the value of Job is that it reopens some of those doors.

Counsellors should avoid trying to explain suffering as punishment for sin: this is where Job's three friends went wrong. In addition counsellors should not explain the failure of prayer for healing in terms of lack of faith or of unconfessed sin. Patients can obtain comfort and encouragement from Job and his experiences. In the end Job was restored, but it was in God's way and in God's time.

Jesus himself was emphatic about the mistaken belief that the wicked always perish while the righteous always flourish. When told about some Galileans whose blood Pilate had mixed with their sacrifices, he replied, 'Do you think that these Galileans were worse sinners than all other Galileans because they suffered this way? I tell you, no!'[2] On another occasion Jesus was confronted by a man who had been blind since birth and was asked by his disciples, 'Who sinned, this man or his parents, that he was born blind?' He replied, 'Neither this man nor his parents sinned'.[3]

Of course, there are times when suffering can be the result of unwise action or sin: for example smoking related-illness and sexually transmitted diseases. The sin or carelessness of others can indeed cause suffering. The drunken driver who kills or maims causes suffering to an entire family, not just the victim.

Recovery from trauma can possibly be hindered by unresolved sin and it may fall to the counsellor to point these things out in a sensitive and gentle way. The well-known passage in James 5 emphasises the need to confess sin when seeking healing.[4] Job was himself aware of this when he asks Bildad, 'How can a mortal be right before God?'

Question 2: Why do bad things happen to good people?

Although Job deals with a good man to whom bad things happened, the answer to the question 'why' is not immediately clear, although there are some pointers. The main questions are, 'Can human beings have a disinterested faith in God, not fearing punishment or seeking reward?' and, 'Are human beings capable, in the midst of suffering, of asserting faith in God and speaking of him without expecting return?'

It seems that Job's suffering was inflicted because of his supreme righteousness, making him a sort of test case. Job needed to be seen to remain faithful to God for God's own sake.

Question 3: Is it wrong to be angry with God?

It is not uncommon for the sufferer of trauma or stress to feel extreme anger with God. Why does God allow this? Why doesn't he do something to stop it? Job experienced some of these emotions: confusion, disillusionment, frustration and even anger.[5]

It will be of comfort to the distressed patient to know that he or she is not alone in experiencing such feelings; even a righteous man like Job did for a time although never completely losing his faith in God.

The idea of venting anger and frustration towards God as Job did may provoke uneasiness and guilt both in counsellor and patient. However, God understood Job's anger and ultimately commended him. C S Lewis, in the journal he kept about his wife's death (*A Grief Observed*) recorded that at the moment of his greatest need God, who had seemed always available to him, suddenly seemed absent. But in spite of suffering a patient can keep in communication with God especially when God's love is perceived through very ordinary people.

Warnings

There is a very real warning to counsellors here. The three friends were concerned with their view of how God acted and their thoughts about the theory of retribution, rather than with actually helping and comforting Job. They only added to Job's misery because they neither pointed him towards a positive answer nor offered him sensitive pastoral support. People who have suffered trauma may be angry with God and say terrible things about him. It does not help to propound personal theories, however deeply felt, or to correct their theology. Care must be taken in the choice of biblical texts. Some may appear inappropriate and unhelpful at the time.

Job is a book for anyone who knows a suffering person. Learn how not to help a sufferer!

The book of Job with its story of an innocent man's suffering encourages looking forward to Christ, that other, but this time perfect, innocent sufferer. All the 'meanings' of suffering converge on Christ.[6]

It is easy to dismiss the book of Job as too difficult to understand and inappropriate for today's living. However, Francis Andersen, formerly Research Fellow at the Australian Institute of Archaeology, describes it as 'the story of one man who held on to his life in God with a faith that survived the torment of utter loss and expanded into new realms of wonder and delight'.[7] It is possible to show that Job can well be used as an extra tool by Christian crisis counsellors.

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The book of Job gives valuable insights into the pastoral management of post-traumatic stress disorder. Whilst suffering can be a result of our own or others' sin, accidents, sudden bereavement and illness also happen inexplicably and indiscriminately to innocent people. In these situations it is both appropriate and healthy for sufferers to vent anger and frustration towards God, and the best approach for counsellors wanting to help people hold onto faith is to sit quietly and offer pastoral support rather than attempted explanations. Overall Job points us forward to Christ, through whose innocent suffering God worked sovereignly to bring great blessing.

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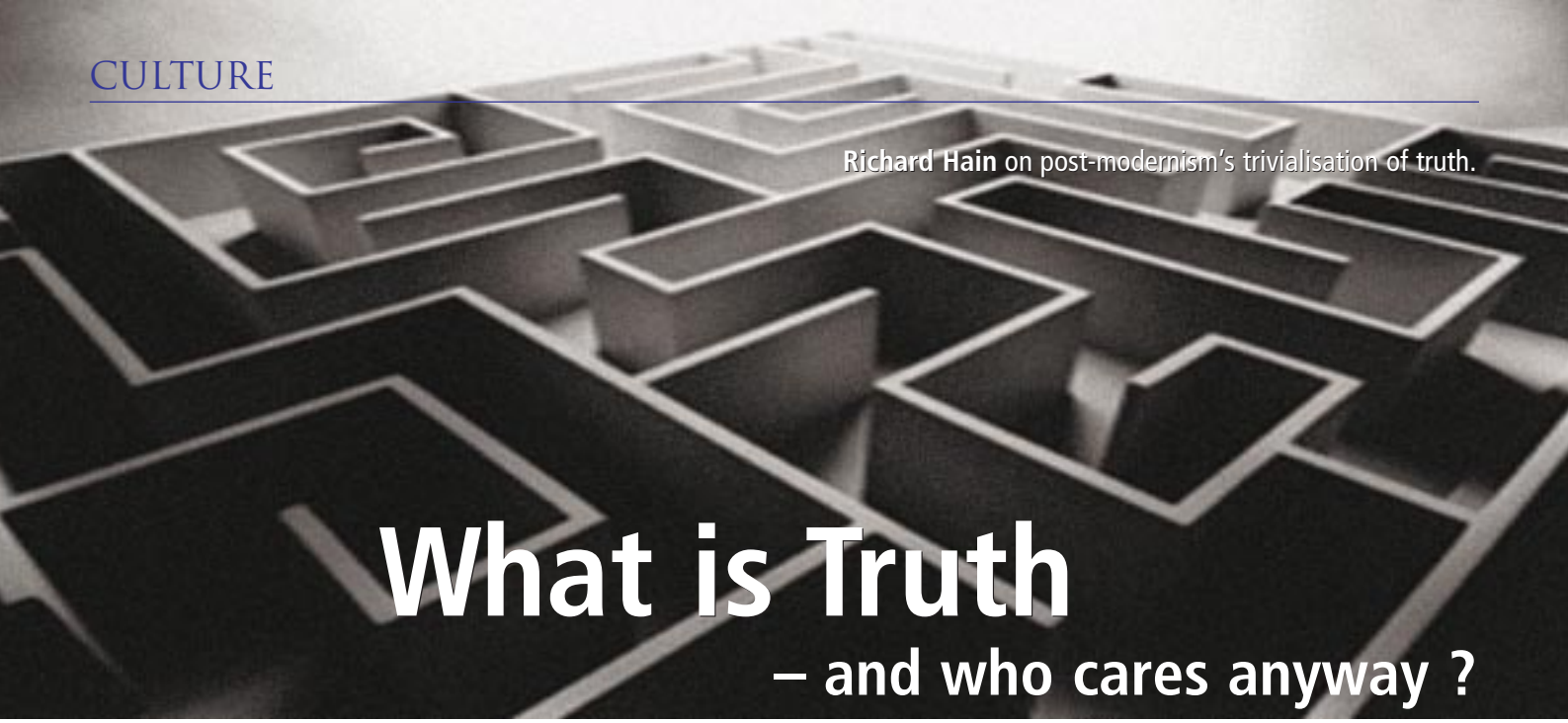

Richard Hain on post-modernism's trivialisation of truth.

What is Truth – and who cares anyway ?

Someone whose faith is not grounded in reason is like a stream of water that can be led anywhere.[1]

What [Christians] cannot believe is that God is bad, that Jesus was not God's son, or that the resurrection did not occur

Christianity claims to be the story of God's broken relationship with his creation and its subsequent healing. If it is true at all, it remains equally true for anyone, in any place, in any culture and in any era. All this depends on an assumption that the concept of truth is universally acknowledged.

In the past, people of different cultures may not have agreed on what was true, but they did at least agree on what 'being true' meant. Yet at the beginning of the twenty-first century, we find ourselves dealing with the trivialisation of truth; not so much a denial that things can be true, but a suggestion that it doesn't really matter either way.

The Post-modern mind

Post-modernism is an extreme reaction to scientific certainty that answers the question 'is it true?' with the retort 'who cares?' Post-modernism does not deny the possibility of objective reality, but regards it as essentially unimportant. Truth is valid only so far as it directly influences day-to-day experience. It is perfectly possible to accept the historical accuracy of the Gospel and to recognise the logical consistency of Christian philosophy, without acknowledging that any personal response is required.

It is as though we are throwing a lifebelt to a drowning friend who agrees that he will drown without the lifebelt, fully concurs that the lifebelt exists and is able to prevent him from drowning, and even admits that he would prefer to avoid drowning but, as he sinks beneath the waves for the third and final time smiles, shrugs his shoulders and says, 'I just don't feel like catching a lifebelt today'.

Post-modernism sees all opinion as equally valid and post-modernists tend to equate this with all opinion being equally true. He or she will regard as pedantic and irrelevant the observation that this is impossible.

For the Christian, the parameters of truth are wide but not infinite. Christians may, for example, see Christ as a political revolutionary or else as someone meek and mild. We may think of God as immanent or transcendent. What we cannot believe is that God is bad, that Jesus was not God's son, or that the resurrection did not occur. Because it puts at its very centre a sequence of historical events and therefore the whole intolerant, black and white business of absolute truth, Christianity stands in many ways as the very antithesis of post-modernism. Drew remarks that 'Post-modern culture is sometimes described as "Post-Christian"…more accurately, post-modern culture can be described as anti-Christian. We can expect increased hostility to Christianity'.[2] So, while it provides little firm structure to belief, a post-modern philosophy can nevertheless restrict philosophical discourse. There can be no perspectives on truth if every perspective is in itself the whole of truth.

Post-modernism pervades current society and profoundly influences even the world of clinical medicine. How does our Christian philosophy differ from a post-modern worldview, and how can we reach across this philosophical divide? Briefly, we differ in what we know (axioms), how we think (rational process) and who we follow.

What we know

The Christian story provides us with some axioms. For example, Christians see the spiritual realm not simply as a metaphor or a vague feeling, but as another dimension of reality. If the Holy Spirit is real, so are bad spirits. This became an issue when our hospital wished to introduce complementary therapies, including *reiki*, that seek to invoke or channel spiritual powers for healing purposes. My view confused people. Most medical colleagues opposed the therapies because they felt

there was little evidence that they worked. The therapists, using a post-modern paradigm, felt it didn't matter how or even whether they worked; if people wanted them they should be provided. For me as a Christian, there was a third possibility; that some genuinely effective complementary therapies are positively dangerous because they invoke a real and unhealthy spiritual power. We risked exposing our patients to adverse effects we barely understand.

How we think

Christian and post-modern thought also differ in the very way in which we construct an argument. With no roots in absolute reality, and no yardstick in absolute truth, post-modern culture is very vulnerable to paradigm shifts. A recent editorial in a leading paediatric journal asserted that as a society we no longer need smacking. The author was voicing a cultural view. She did not assert that children are better behaved, or that smacking has become less effective or more dangerous than in the past. The fact that (in her view) society had 'changed its mind' about smacking was sufficient.

Christian thought does not tell us unequivocally whether smacking is right or wrong. However, it does provide us with principles for us to make up our own minds. Many Christians might agree with the opinion of the editorial (I do not). Like me, however, they would reach their conclusions through the application of biblical teaching, rather than simply because that is the current cultural view.

Who we follow

Christianity pre-dates not only post-modernism, but also the scientific rationalism against which it is a reaction. In fact, the scientific age has no more in common with Christianity than its successor. Ultimately, Christianity is not primarily a set of axioms, nor even a way of thinking; it is a relationship with the resurrected Christ. The gospel is paradoxical in that although it makes sense according to moral and rational arguments, and although absolute truth is in every line, it actually arises from an experiential premise: that God loves his creation enough to die so that his relationship with us could be healed. No post-modern view could be more relational or experiential.

A response

The gospel is accessible to the post-modern culture, as, if it is true at all, it must be so in all times, present, future and past. How then can we present it? St Paul appears to have met post-modernists in Acts 17:16-34. Epicureans believed that happiness is the supreme good – or to put it another way, that morality is experiential rather than absolute. How did Paul respond?

1. Firstly, in verse 22, Paul acknowledges their wisdom. Post-modernists have got a lot of things right that our rationalist Christian predecessors got wrong. Experience, after all, is extremely important and to suggest that we should live a life in which only the rational has value would be quite counter to Christ's teaching.
2. Paul identifies the common ground. He stops before the altar of an 'unknown god' (v23) and uses that as the jumping-off point for a discussion; he doesn't simply contradict them and then expect them to change their philosophy. There is common ground between post-modernism and Christianity; a sense of spirituality, the valuing of individual viewpoints and feelings. All these paraphernalia of the 'holistic approach' are Christian as well as post-modern ideals.
3. Paul then goes on (vv27-31) to say something about what God has done. He states it as historical fact, but emphasises that the reason behind it is to heal the breach between man and God (v27). He says 'this happened, because men needed it'; to use Zafren's words, he emphasises the relational without denying the propositional. [3]
4. Paul is obviously familiar with the culture in Athens and in concluding his talk is even able to quote two Epicurean poets. If we are to influence post-modern culture, it is important that we are familiar and can engage with it.

Nothing new

We are emerging from an era in which our culture pinned all its hopes on rationalism. In those days, Christians needed to emphasise that the gospel was and is a matter of credible premise combined with rational thought. We are coming into an age where our culture has rebelled against the rational so thoroughly that the nature of truth itself has been questioned. For this new age, we need to emphasise a different part of the Truth. Rather than 'did it really happen?' post-modern society asks 'does it meet my needs?' In the twenty-first century as in the first, Christ does exactly this.

Finally, this reminds us that for all its spin, post-modernism is simply a rejuvenated version of an old way of thinking. There really is nothing new under the sun. [4]

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In post-modern culture all opinions are equally valid and truth doesn't matter. This way of thinking, which profoundly influences society and clinical medicine, is at odds with the Christian worldview which emphases rational thinking, the existence of a God who communicates truth, and the historical facts of Christ's life, death and resurrection. Paul's address to the Athenians in Acts 17 provides a useful model in communicating the gospel to post-moderns. We need to begin by agreeing with them about the importance of experience and spirituality, but move on to share the good news of God entering history in the person of Christ to heal man's broken relationship with God.

Albania: The country than banned Christmas. We report on two important initiatives.

Sarah Germain tells how a link between junior doctors and students from Oxford and Tirana is helping change lives.

Students find faith

How can a country, that was declared the world's only atheist state until ten years ago, where the regime even banned Christmas, be turned to Christ?

In the mid 1990s there were only two Christian medical students in Albania and no Christian doctors. Edvin Selmani was one of those students. Today, Edvin is working part-time as a staff-worker for BSKSh (the Albanian IFES movement), whilst training in orthopaedics. He and his colleague, Eralda Turkeshi, now lead a growing number of medical students and doctors who meet regularly for Bible study and prayer, and are actively witnessing to their friends and colleagues.

Edvin attended the CMF student conference in January 2001. During this visit the idea was sparked to hold an evangelistic summer camp in Albania, and to invite a team from the UK to help run it. Over the past few years CMF have been encouraging links between regional groups and a number of countries abroad.

CMF General Secretary Peter Saunders suggested to some of us in the Oxford region that this would be a great opportunity for us to be involved. How could we say no! Over the coming months we saw many answers to prayer as God brought nine individuals together to form the team – doctors, medical students and one teacher. It included Willemina, a Dutch GP, who already spoke fluent Albanian. We were especially grateful that Bernard Palmer was able to come, at relatively short notice, to be our main Bible teacher.

Raising the money needed to finance the trip seemed like an impossible task in the time we had available. Again, God was very gracious and touched many people's hearts to help support us financially and in prayer. Team members played our part too – raising sponsorship to complete the Three Peaks Challenge – Ben Nevis, Scafell Pike, and Snowdon in 23 hours and 53 minutes.

Before we knew it, 17 August had arrived and we were being met at Tirana airport. What a joy. After all those months of preparation and prayer, we were finally in Albania.

There were 21 medical students at the camp held in Durres, a resort on the coast, about 40km from the Albanian capital Tirana. These students quickly became our friends, as we shared in a programme of Bible study, discussion in small groups, ethical seminars, and medical teaching. We covered topics from 'What is the evidence that Jesus existed?' through 'Science and faith' to 'What are the causes of right lower quadrant abdominal pain?' We learnt traditional Albanian dancing, were thrashed at volleyball, and managed with running water for only six hours a day.

What we will remember most, though, is the way God worked in individual lives. At the start of the week we had comments like: 'Christianity is not part of my culture. I don't know anything about it and it doesn't fit into my life' and 'I'm not sure Jesus even existed'. However, after hearing the evidence for the Christian faith presented and the Gospel explained, many were struck by the truth of the message.

WHAT WE WILL REMEMBER MOST, THOUGH, IS THE WAY GOD WORKED IN INDIVIDUAL LIVES

Bernard Palmer described the process of investigating the Christian faith like a series of stepping stones across a river. When you reach the last one, you have to make a decision whether to go forward or back. You can't just stand still. One student told how he was overwhelmed by this: 'I'm in an intolerable position – worse off than when I was on the land behind. I'm scared to make a commitment, but can't deny the evidence'. There was much rejoicing when, on our last evening, this student announced he had made the decision to follow Jesus.

Five students made commitments and were given Albanian Bibles to take away and read. Many others left promising to continue reading and thinking about what they had heard. Some even turned up at the church we attended in Tirana on the following Sunday.

Many of us came away feeling we had learnt as much as we gave. The Albanian Christians had such a desire to combine their medical work and Christian faith. Eralda shared her vision for Albania with us, using Nehemiah 8. She likened the rebuilding of the wall to providing an adequate and fair healthcare system in the country. She fervently believed that her people would hear the Word of God and respond in repentance. I was challenged as to whether we have such a vision for Britain.

We hope this will be only the start of an on-going partnership between Oxford and Albania. If you have the opportunity to be involved in a venture like this then go for it!

Sarah Germain is a research fellow in Obstetrics and Gynaecology in Oxford and chairman of the CMF Junior Doctors' committee

How doctors from the UK are sharing a vision of Christian medical practice and consultation skills with Albanian colleagues. **John Caroe** reports.

One small mustard seed

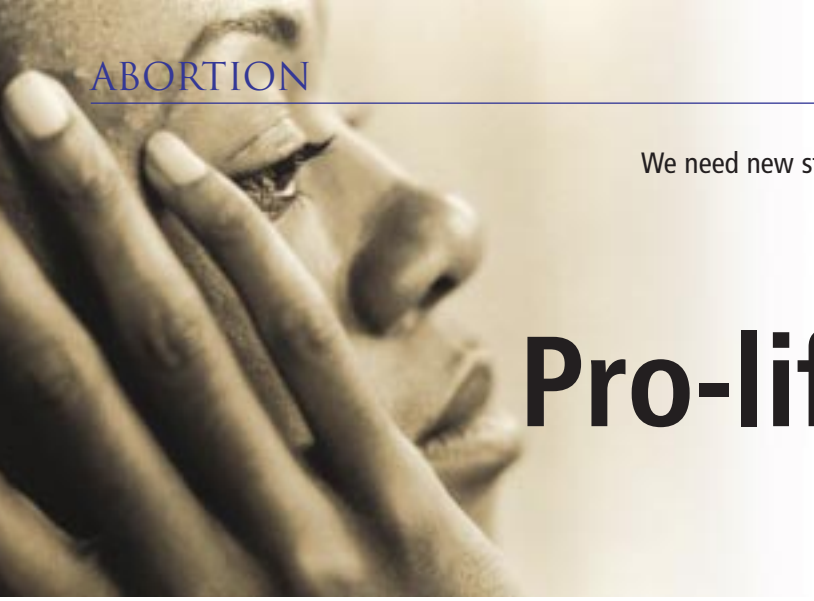
The total isolation of three million people for 30 years is very hard to imagine. Enva Hoxha succeeded in creating an atheistic terror state to rival North Korea. Totally denied all outside contact, many really did believe the propaganda that they were the happiest people on earth, in spite of the repression and persecution.

It was students who led the bid for freedom in 1991, 18 months after other Eastern Bloc countries. The release was a huge culture shock for the Albanians who had never heard Western ideas before and who could not understand what Coca Cola was when they first received TV. Subsequent years have been marred not only by chaos, materialism and the Mafia, but also the collapse of the fraudulent pyramid money scam which lead to bullet-ridden anarchy in 1997. The Albanian Christian Medical Association, led by Eralda Turkeshi, now has a strong core of ten young doctors in Tirana. They meet regularly for both professional and Christian support, and encourage medical students to share their small library set up by faithful American friends. ACMA invited three UK doctors from PRIME (Partners in International Medical Education) to spend six days in Tirana teaching the vision of Christian medical practice and consultation skills. The sadness of their previous experiences of medical learning is perhaps best left to the imagination. However, one might contrast the symbolism of an ancient pot-holed and useless blackboard in an utterly characterless hospital lecture hall, with the sight of such a keen group sitting forward on the edge of their chairs to absorb the excitement of learning basic consultation and examination techniques. Our sense of being at the right place at the right time was enhanced by two important meetings. The tutor who is heading up the embryonic 'GP Training' course in the teaching hospital came to share in the course for some hours and was genuinely enthusiastic about what he saw, committing himself to supporting the group in ongoing learning. We were also very privileged to spend a short time with the impressive Dean of the Medical School who is a neurosurgeon. He was remarkably open about the training situation, and acknowledged the ongoing need to rethink the style and content of the whole of their medical training. This underlines the importance of praying for these contacts at high level to achieve local official accreditation. Without this the fruit of any visit abroad remains solely within the group that we meet. Far greater leverage is possible when one can invest in teaching that will be passed on within an official training program.

Without being specifically Christian, one can still share the vision of Christian care, and the value of the humanity and sensitivity of the one who is sick. While this may seem obvious to us, it is not a concept that is portrayed within the didactic factual teaching of a mechanistic approach to disease, inherited from cold communist days. In such brief encounters between doctors of very different cultures whose resources are at the opposite ends of the spectrum, it is a delicate task to avoid western academic imperialism and to offer genuine humble friendship and support for the mountainous task they face. We see the possibility of very fruitful ongoing quiet Christian influence as doctor training is reformed. Two particular moments of true Christian hope stand out in the memory. The first was the privilege of standing as a group in the middle of a recently discovered Roman amphitheatre where Christians were forced to be gladiators and to fight the lions. We sensed that the pain of those spiritual memories had already been soothed by the worship in later underground churches found in the ruins, where traces of ancient frescoes still remain. Paul and Titus were once in that seaside city of Durres. Then we were all touched by the sense of the Lord's prophetic presence as we prayed together, after a last supper on the roof of a pier cafe, over a smooth sea with an idyllic sunset. We are certain that the Lord's hand is watching over these delightful Christian friends who blessed us so much with their faithfulness, courage, enthusiasm and driving vision. The small mustard seed that we have sought to plant will surely grow into a tree that will shelter and care for so many 'birds of the air', the Albanian people who have suffered and survived these post-war years in a manner that is unimaginable and awe-inspiring.

John Caroe is a General Practitioner in Eastbourne

IT IS A DELICATE TASK TO AVOID WESTERN ACADEMIC IMPERIALISM AND TO OFFER GENUINE HUMBLE FRIENDSHIP AND SUPPORT



We need new strategies for capturing the moral high ground in the abortion debate, insists **Greg Gardner.**

Pro-life movement
at the crossroads

Conflicting compassion for both mother and unborn child has led to an uneasy acceptance of the status quo

It is well recognised that traditional strategies against abortion have had only limited success and there is now a growing realisation that new alliances and strategies are needed.[1]

The solution is far from simple as every reform movement contains members with different opinions over strategy, priorities and the tension between long-term goals and short-term fire-fighting. Within the pro-life movement there is a clash between purity and pragmatism, for example with regard to proposed changes in legislation. On one side are those who recommend a 'no exceptions' absolutist approach. On the other are those who prefer a gradualist, incremental approach, taking back a bit of ground at a time and making compromises where necessary. Is there any possible way forward?

There are several factors that need to be considered here. First, probably the most powerful witnesses for the humanity of the unborn are mothers who grieve over their aborted children. Secondly, the vast majority of people are not pro-abortion but pro-choice. Thirdly, for various reasons the pro-choice position has come to be associated with compassion and non-judgmentalism.

Then, fourthly, from a purely economic point of view, abortion is a matter of supply and demand. Abortion providers in the private sector can only charge what the 'market' can bear. They can only keep their profit margins intact by keeping costs low and turnover high. This has meant a 'conveyor belt' approach to abortion, with inadequate counselling, paltry screening, limited information about risks and therefore a lack of informed consent.

Abortion is Harmful

These factors, taken together, constitute the basis for an alternative strategy for opposing abortion that can be both pure and pragmatic whilst remaining free of compromise. It is based on the fact that abortion is traumatic and poses a significant risk to the health of women. Data from a record linkage study in Finland analysing half a million births and 94,000 abortions over seven years, showed that the mortality rate of women in the first year after abortion was nearly four times that of women who had full term pregnancies.[2] Analysis of subsets of this data showed that the suicide risk in the twelve months post abortion was three times the general suicide rate and six times that of women who gave birth.[3]

Deaths from accidents and natural causes are also increased in the post abortion group. This study only went as far as a year but there are other longer term risks to be factored in such as substance abuse, smoking, depression and cycles of self-harm. There is an increased risk of breast cancer, particularly in women who abort their first pregnancies. There are identifiable factors for women at risk of post abortion trauma.[4]

Targetting the Middle Majority

What Reardon calls the 'middle majority'[5] are people who are ambivalent and uneasy about abortion and wish to adopt a non-judgmental stance. Conflicting compassion for both mother and unborn child has led to an uneasy acceptance of the status quo. This has come by default to be identified with the pro-choice position. Those in the middle majority have two main concerns: not to interfere with the autonomy of women and not to condemn those women who have already had abortions. They are quite receptive to expanding women's rights in ways that would reduce abortion or make it safer.

There are at *least* four areas where pro-lifers could recapture the moral high ground in the minds of the middle majority. These are:

1 Protecting women from being coerced into unwanted abortions.
2 Guaranteeing a woman's right to full disclosure of information.
3 Protecting those women most likely to be injured by abortion by requiring proper screening of patients.
4 Expanding the possibility of fair compensation to women for resultant physical or psychological harm.[6]

Coercion: A woman may 'choose' to have an abortion because she feels this is her only choice. There may be family, financial, social or health pressures that make a woman feel she is forced into having an abortion. If her 'only choice' is contrary to her maternal desires, she should be offered an option which does not conflict with these desires. At the

present time, abortion providers in the private sector steer women towards an abortion decision because it is in their commercial interests to do so.

Disclosure of Information: Valid consent involves the exercise of choice, which is itself dependent on information about the options available and the risks attendant upon each. Inadequate disclosure invalidates consent. The failure to tell a woman of identifiable risk factors for post-abortion injury is concealment of relevant information and a violation of her right to full disclosure. Because abortion is a unique procedure encompassing medical, psychological, social and moral dimensions, the requirements for disclosure are so much greater. This may especially be the case when a woman has not fully explored her own moral views.

Women with pre-existing moral conflicts are more likely to suffer post-abortion sequelae. It is therefore necessary to equip women considering abortion with accurate information in order that they work through their own moral position prior to abortion. Some women may conceal a history of a previous abortion; this should mean that abortion providers should *routinely* disclose all possible risks so that each woman can do her own risk-benefit analysis. Full disclosure is a right. Abortion providers should be expected to provide any information that a reasonable patient might find relevant.

Current British law relies heavily on the doctor-centred Bolam test (what a 'responsible body of medical opinion' might believe) rather than what the patient requires in order to reach an informed choice. This situation is outdated, paternalistic and allows abortion providers to give minimal information. In this respect British law is well behind North America and Australia, which are much more patient-centred.[7]

Screening: The failure adequately to screen for risk factors constitutes negligence.

A competent doctor should:

1. Provide adequate pre-abortion screening to identify those women at risk of negative reactions; for example, those with a history of child abuse, drug dependency, behavioural problems or ambivalence.
2. Provide counselling to high-risk patients explaining why they are at increased risk along with information about possible post-abortion reactions.

The failure to identify known risk factors, the failure to notify the patient of potential risk factors, or the failure to refuse to perform a contraindicated abortion may provide grounds for a claim for malpractice. If screening discloses any high-risk factors, the abortionist should be expected to provide additional counselling above and beyond the normal standard in order to alleviate these predisposing risks and discover a safer course of care. Finally they should document why an abortion is recommended over other options.

Compensation/Legal Issues: A number of changes can be recommended:

1. Abortionists should be required to document the basis for their recommendation of abortion over alternative options for managing the woman's crisis.
2. There should be an end of the prevailing situation that allows private abortion providers to destroy medical records after three years.
3. There should be liability for wrongful death in the case of women being coerced into abortion.
4. The ability of abortion providers to demand up-front payment should be stopped, as such practices involve an element of coercion.
5. There should be mandatory reporting of cases involving potential sexual abuse in under-age girls, as these are more likely to be pressured into unwanted abortions.
6. Family planning agencies such as the FPA and Brook Advisory Centres should have to disclose anonymously all material risks if making an abortion recommendation. Any violation of this should result in withdrawal of charitable status and government funding.

Conclusion

When faced with initiatives such as these, pro-abortion politicians will be forced either to agree to reforms that will harm the abortion industry, or to side with the abortion industry against women's rights, which will harm pro-abortion politicians. These policies can be promoted as something positive for women and would expose the ideology of those committed to abortion regardless of the consequences.

Acknowledgement: most of the ideas for this article came from the authors Reardon and Kreeft cited below.

Greg Gardner is a non-principal GP in Birmingham

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Most people remain ambivalent and uneasy about abortion but could be persuaded to adopt a pro-life stance by strategies which emphasise the considerable adverse physical and psychological consequences of abortion for women. The abortion industry harms women through coercion, failing to offer fully informed consent, neglecting to screen for patients at high risk of adverse sequelae, and through inadequate compensation for those harmed. Christians can play a vital role by telling the truth about abortion's adverse effects and through using political and legal channels both to challenge abortionists and policy-makers and to promote the right of women not to be exploited and abused.

EUTYCHUS

Search and destroy?

Preimplantation diagnosis (PGD) and embryo selection for serious genetic disorders will probably become commonplace in Britain now that a two-year public consultation has found widespread support for the practice. Only 20% of respondents believed that the procedure was inherently eugenic and unethical.The technique has been used in Britain since 1990 in five clinics licensed by the Human Fertilisation and Embryology Authority (HFEA) and includes genetic diagnosis (or sex selection for sex-linked conditions) with affected embryos being discarded. PGD is currently used to screen for Duchenne muscular dystrophy, beta-thalassemia, haemophilia, cystic fibrosis and sickle cell anaemia. (*Daily Telegraph* 2001; 15 November) CMF General Secretary Peter Saunders' personal submission is available on the CMF website at *www.cmf.org.uk/ethics/subs/pgd.htm*.

Profit first

Drugs are developed according to profitability rather than public health need according to a new report from international medical aid agency Medecin sans Frontieres. MSF asked 11 leading pharmaceutical companies about overall resources devoted to malaria, tuberculosis, sleeping sickness, leishmaniasis and Chaga's disease and found that seven spent less than 1% of their research and development budget on any of the five diseases. (*BMJ* 2001; 323:827, 13 October; *www.accessmed-msf.org*)

Healthy faith

Christian faith protects against suicide and alcoholism according to a review in the *British Medical Journal*. A Northern Ireland Suicide Study has confirmed that religious commitment is inversely related to suicide risk; and a North Carolina study has shown that recent alcohol disorders are 42% less common among those who frequently read the Bible or pray privately. (*BMJ* 2001;323:817-8, 13 October)

Gold robbery

Christ's values have been so absorbed by civilised nations that we often take them for granted and many contemporary ethicists steal their best ideas from the Judeo-Christian tradition, without acknowledging the true source. In a recent example Stephen Pattison, the head of the Cardiff University Department of Religious and Theological Studies, attributes the golden rule to ethicist Peter Singer! (*BMJ* 2001;323:840, 13 October) Christ's golden rule, that we should treat others as we would want them to treat us, was unique to him. (Matthew 7:12)

Pacific organ trade

An unsolicited letter from Germany to a clinic in Tokyo challenges the belief that organ sales are just an urban myth. It reads: 'We are selling people of good health for 10,000 US Dollar. Organs including heart, lung, kidney and spleen among others. We bring these people from Europe, Fiji, Papua New Guinea, Macao, Virgin Is, French Polynesia, Kiribati, Nauru, Vanuatu, New Caledonia, Samoa, Tonga, Micronesia and Solomon Is.' (*BMJ* 2001;323:1196, 17 November)

Welcome ruling on drug patents

Developing countries facing serious crises in public health such as HIV/AIDS will benefit from a World Trade Organisation declaration relaxing drug patents. The commitment made at the WTO meeting in Doha, Qatar will enable poorer nations to seek a waiver from the organisation's strict rules - known as trade related aspects of intellectual property rights (TRIPS) - which guarantee patents for 20 years. (*BMJ* 2001;323:1146, 17 November)

Assisted suicide turnaround

In a landmark ruling, US Attorney General John Ashcroft has authorised the Drug Enforcement Administration to take action against doctors prescribing lethal drugs to terminally ill patients. The judgement reversed the previous position of the Clinton administration. Ashcroft said that assisted suicide is not 'a legitimate medical purpose' for prescribing. The decision effectively overturns Oregon's Death with Dignity Act (1997) under which mentally competent patients who are terminally ill have been able to take lethal drugs if doctors agree that they have less than six months to live. (*BMJ* 2001;323:1149, 17 November)

Ireland approves 'morning after' pill

The Irish Medicine Board has approved the 'emergency contraception' pill for the first time. The board had previously refused a licence for levonorgestrel on the grounds that it was an abortifacient. Although the Family Planning Association's promotional literature says that 'emergency pills have not been shown to affect a pregnancy or harm a developing baby' it is well known that one of the main mechanisms of action of the pill is to prevent blastocyst implantation. (*BMJ* 2001;323:1204, 24 November)

Ethicists come out for euthanasia

Two leading British ethicists, the former a member of the British Medical Association's Central Ethics Committee, have argued that euthanasia and physician assisted suicide should be legalised. Len Doyal and Lesley Doyal, from Bart's and Bristol respectively, say in a *British Medical Journal* editorial that 'if death is in the best interest of some patients…then death constitutes a moral good for these patients. And if this is so then why is it wrong to intend to bring about this moral good?' (*BMJ* 2001;323:1079-80). Dr Leo Alexander, a psychiatrist who worked with the Office of the Chief of Counsel for War Crimes at Nuremberg, described a similar strand of thinking in 1949: 'The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the attitude, basic in the euthanasia movement that there is such a thing as a life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged…'. (*NEJM* 1949;241(2):39-47) The War Crimes Tribunal concluded in 1948 that, 'our regretful but inevitable judgement must be that the responsibility for the (holocaust) rests in large measure upon the bulk of the medical profession; because the profession without vigorous protest, permitted itself to be ruled by such men.' (*www.cmf.org.uk/pubs/journal/jul92/thou.htm*)

OPPORTUNITIES ABROAD

Specific Vacancies by Country

Posts often require you to be **UK based** with your own **financial** and **prayer support**. The contact details given are to enable you to start researching possibilities. For many other posts see previous issues of *Triple Helix* and recent issues of ***HealthServe***. (Contact them at Barker House, First Floor, 106-110 Watney Street, London E1W 2BR Tel: 020 7790 1336 Email: info@mmahealthserve.org.uk www.mmahealthserve.org.uk)

AFRICA

Cameroon (North)

Meskine Hospital need a physician or GP willing to include simple on call surgical cover, a surgeon willing to include medical cover, an ophthalmologist and other health professionals. Need flexible attitude, basic French (training available) short tropical medicine course. 'We are actively sharing Jesus through quality care and friendship. Community relations excellent'. Family environment with school on site.

Contact Dr Mark Houghton (Action Partners Ministries), 45 Crimicar Drive, Sheffield S10 4EF Tel: 0114 230 2162
Email: mhoughton@doctors.org.uk

Chad

Action Partners require **GP or experienced nurse** to work in Ndjamena among English-speaking families at the forward edge of mission. In the demanding environment continuing care and screening would reduce the attrition rate. Referral options limited. Air ambulance involved occasionally. French and some tropical medicine required and readiness to develop links with other health providers local and ex-patriate.

Contact: Dr Mark Houghton (see Cameroon above)

Gambia

Dr Gisela Schneider asks for a **locum doctor** to oversee an HIV programme from 20/01/02 – 20/03/02. Mainly outpatient care, some community care and supervision, training etc.

Required qualifications:

- Preferably GP or physician with at least 2 years postgraduate experience
- Preferably with overseas and/or HIV experience
- Able to adjust to international staff team and able to integrate with government services
- Some experience with data management would be an advantage (Access database)

The task would involve

- Regular clinical services in a reproductive health clinic
- Supervision of a voluntary counselling and testing service for HIV
- Supervision of the medical care for people living with HIV/AIDS [PLHA] under limited resources, of their care in the community and as outpatients and of the management of their data.
- Participation in community education activities
- Working in multidisciplinary team offering a holistic care package

Contact Email: gschneider@gamtel.gm or gamfld@gamtel.gm or **contact** WEC, UK office Bulstrode, Oxford Road, Gerrards Cross, Bucks SL9 8SZ Tel: 01753 890828

Sibanor Clinic. One or two **Doctors** from spring 2002 until autumn 2003. Applicants for short-term work would be welcome but the team would also challenge doctors to consider long-term service with them.

Contact for details of work contact Dr James Erskine WEC International, PO Box 86 Banjul, The Gambia Email: erskines@ganet.gm. All applications to WEC International [as above].

Malawi

Livingstonia Hospital requires a replacement **Medical Officer** for Dr Donald Brownlie who is due to retire and would like to hand over to a successor. Livingstonia is a 100 bed general hospital with a strong community health programme and is under the control of the Livingstonia Synod, CCAP.

Contact Donald Brownlie, P O Box 5, Livingstonia, Malawi, Tel: 00 265 368207, or Rev Terry McMullan, Overseas Board, Presbyterian Church in Ireland, Fisherwick Place, Belfast BT1 6DW Tel: 028 9032 2284 or Sheila Ballantyne, Church of Scotland Board of World Mission, Tel: 0131 225 5722.

St Peter's Hospital, Likoma Island requires a **GP with some surgical experience** in January 2002. Small rural hospital in beautiful but isolated island near Mozambique coastal communities. Excellent staff in well-run hospital, good accommodation, salary covers expenses and return airfare.

Further details available from Dr Douglas, Tel: 01729 822531, or apply to Bishop C. Boyle, P O Box 120, Mzuzu, Malawi, Central Africa.

ASIA

TIbet

Doctor for community/public health skills, teaching village doctors and volunteers and other projects. Enquire at this office.

Pakistan

Kunri Hospital requires a **General Surgeon** including **Obstetrics** and a **Physician** including **Paediatrics** (ideal for a married couple) with medical and educational interests. The hospital is situated at the edge of the desert separating India and Pakistan and deals with mainly Hindu patients from the desert and Muslim patients from the town. There is a lively ecumenical community.

Good free accommodation. Hospital supported by Church of Pakistan voluntary donations and patients' fees.
Further information from Dr Douglas, Tel: 01729 822531

PACIFIC

Solomon islands

Helena Goldie Hospital. Medical Superintendent and Senior Medical Officer required for this 55-bed hospital serving a community of 30,000 people. There are 38 sites visited by a touring team at two-month intervals by motorised canoe. The hospital is administered by the United Church Solomon Islands. Applicants should be able to cope with general obstetrics and gynaecology and some general surgery. Furnished accommodation is available.

Contact Hospital Secretary, Connie Cann, Helena Goldie Hospital, PO Box 166, Munda, Solomon Islands Email: helenagh@welkam.com.sb
Tel: 00 677 61121, Fax: 00 677 61258, Tel: School 00 677 61120

REQUESTS

Olympus Upper GI Endoscope needed

By **Michael Cotton** FRCS, CMF member and government surgeon in Zimbabwe at 59 Circular Drive, Burnside, Bulawayo, Zimbabwe Tel: 00 263 9 245240 or 00 263 9 242862 Email: mikeytha@mweb.co.zw

EVENTS

Overseas Update, Residential Refresher Course dates in 2002 are 24 June - 5 July. Brochure available.

By **Brian Hogbin**

A to Z

of stress and time management

I have worked as a general surgeon who is a follower of Jesus. The last ten years were related mostly to patients with breast problems. In retirement it's been possible to look back and review how I had tried to manage my life. What emerged has been a rather mixed selection of principles and helpful hints, presented here from A – Z. My prayer is that this will help you to keep control of your life and not always be squeezed by others. '*Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind*'. (Rom 12:2)

Aims for life – Know where you are going - you are more likely to get there. Important for everyone but especially for followers of Jesus.

Be prepared – Plan ahead. Anticipate the effect of your proposed actions.

Communicate carefully – Convey choices. Allow options for patients. She may have different priorities. With seemingly identical breast cancers one patient would see it as obvious that she needed a mastectomy but the other would insist on lumpectomy.

Death – 'Few people die wishing they had spent more time at the office'. Keep assessing priorities and sail with an eye on the compass not the storm.

Extra staff – Be ahead of colleagues in asking for more staff unless your patients have a *fully* adequate service. Extraordinary excuses will be found for not requesting enlargement of the consultant grade - though colleagues will deny it is related to diluting the private practice.

Fast vs slow – In all of life we need to speed up on the easy bits and remember to slow for the difficult bits.

Gradients – Control them! The general attitude today is 'down' to patients and 'up' to just a few 'above' us! However, before God, every one else is equal to me. What a difference this should make to my interactions with patients. As a consultant relating to the chief executive or the latest government directive my first responsibility is to God. This gives me a freedom some colleagues lack.

Holy: the sabbath – Value rest: 'Six days you shall labour and do all your work' (Ex 20:9) the fourth of ten *equal* commandments. Guard Sunday at all costs from non-urgent medical work, including all sorts of paper work, writing, reading or anything else medical. And work out the implications of being on call!

Innovate – Embrace change which you anticipate will still be here in 5 years. Think of new ways to make life easier. Audio taping my 'bad news' consultation for the patient allowed me to move on with the technical details and options faster and it facilitated sharing the news with the family that evening. Building a Breast Care Centre and appointing Breast Care Nurses meant that the work ran much more smoothly.

Jane - My other half – Not just a platitude but a statement of reality – an essential balance to my own foibles. Protect this relationship above all else.

Kind or Good doctor – What does the patient want? Either/or. Both/and.

Love – Love God: God's key to freedom and good healthy abundant living! Love your neighbour: Yes, but reflect regularly on what it means for you each day.

Management – God loves managers as well! Co-operate and be involved as an aspect of serving the patient by changing the systems for better outcomes. Go the extra mile in the NHS instead of seeing more private patients.

Money – Decide where to be different…and how to achieve it. Private schooling, progressively enlarging house, expensive holidays….? Less private work; controlled work and spending - it can be done.

Nice – Love your enemy - sleep on it. Send the letter tomorrow. Always talk. In hospital life there is a lot of scope for misunderstanding and disagreement with any staff but especially other doctors. When this happens go out of your way to see them and to speak …not about the difficult subject but about something different and non contentious so they have to find themselves agreeing with you. It re-establishes contact.

No – Say no whenever necessary. Accept invitations of all sorts with care.

Origami – Keep your outside interests alive.

Perfection – The pursuit of perfection is the enemy of the possible. A reasonable compromise allows progress… but this does not apply to matters covered by Matthew 5:48!

Quiet Time – Daily prayer and Bible reading essential for getting life into perspective - the key to an orderly day.

Retire at 60! – Or at least reduce the workload. I have not so much *retired* as *re-attired* to a different life.

Systems – No mistake should happen a third time. Make lists of jobs and decide priorities.

Time – Make time to escape from medicine, church and family to be alone with your spouse. We did this on Tuesdays. Get a baby sitter if needed. See it as a prior appointment in your diary so if asked to do something else you are simply not available. Family and 'church' also need planned and protected time!

Urgent items – Beware of telephone requests for help. They always sound urgent and worthy but may squeeze out the important. As a policy never say yes to do anything extra on the phone. 'I will call you back' or 'Please put it in writing' …anything may help till you have a chance to put the request in perspective and check with your spouse, secretary, etc.

Value the team – There may be tension …but not conflict. Especially value your secretary. In the private sector pay well, and for rather more hours than you expect to be worked. Be happy to use this time for some work to be typed that should be done in the NHS such as the report which you need typed.

What if… and Why – Always ask 'why?' Keep asking questions and challenging accepted wisdom. Ask 'Is that really what the article showed?'

X = an unknown quantity – Usually the work behind a seemingly innocent request. Beware!

Yes/No – As Jesus said. 'Let your yes be yes and your no be no'…Be straightforward in your answer and keep your word, even when highly inconvenient. This makes you more careful what you promise next time!

Zeal – Defined as 'fervour in advancing a cause'. What is your 'cause' Back to A and start again.

Brian Hogbin is Emeritus Consultant in General Surgery, Brighton

ReviewWWWs with Cyberdoc

Cyberdoc reviews the Diane Pretty case and the Bishop of Oxford - the words in bold correspond to links on the CMF website at www.cmf.org/cyberdoc/pretty

Diane Pretty

The Diane Pretty case (see p7) holds personal interest for Cyberdoc as a member of our church, who died only recently, had also been suffering from Motor Neurone Disease. Using a computer and email to communicate she spoke of her faith in God to the end and valued her life as a precious gift. Of course we can see why those without Christian hope see things rather differently.

The judgement of the law lords on Mrs Pretty's case makes the point that her appeal was solely on the grounds of the recent Human Rights Act. Many Christian ethicists have argued that the concept of laws based on rights rather than principles such as the absolute value of life are potentially dangerous to a Judeo-Christian legal system. The **BBC News** site has an excellent piece on euthanasia with extensive reference to the case. The pro-life article is unusually robust and talks of a 'torrent of death in Holland where the elderly are terrified of entering hospital for fear of involuntary euthanasia'. It points out that the 'right to choose' could be logically extended in the future from the life of the unborn child to the life of adult dependents. 'The barbarians are inside the walls.' If euthanasia is legalised the generation that killed its children may in turn be killed by its surviving children.

Richard Harries

As Bishop of Oxford, Richard Harries (see pp5-6) has been outspoken on a range of topical issues and is seen by many outside the church as speaking on behalf of mainstream Christianity. But within the church he is a controversial figure who many believe has compromised the gospel message and biblical ethics in an attempt to make them intelligible and attractive to post-moderns. How does the Internet portray him?

On homosexuality: He is quoted on **churchnet** as strongly supporting a publication on homosexuality which called for a recognition that it was appropriate for some Christians to believe it right for them to enter into a committed same-sex relationship. **Another site** quotes him as supporting lowering the age of consent for homosexual activity to 16. While neither of these sites provide citations for their sources, they do ring true to speeches found on his **official webpages**, where he says of homosexuality that it appears 'inevitable that the church will eventually rethink and repent, as it has in the past in its attitudes to slavery and women'. He also makes clear his opposition to section 28, believing that part of a compassionate attitude to homosexual people includes teaching children about same-sex relationships.

On ethics: His website also includes speeches he has made in the House of Lords. On embryos he has stated:'"Human life must be respected and protected absolutely from the moment of conception. For the first moment of existence, the human being must be recognised as having the rights of a person – among which is the inviolable right of every innocent being to life". That is a quotation from the Catechism of the Catholic Church and it is a view I respect deeply but it is not one I share.' Bishop Harries is, quite clear in one of his House of Lords' speeches that voluntary euthanasia or assisted suicide is not the route he feels we should be going down believing the Netherlands experiment will prove to be a cul-de-sac.

On the gospel: The Star Wars film **The Phantom Menace** will 'reinforce the truth and strength of religion….if people get reassurance that good will overcome evil through a film, far from being a threat to religion, it is an echo of what …the Christian religion, is proclaiming'. **One of his thoughts of the day** for radio 4 defines the Christian message in the following way 'Because something, somewhere has gone terribly wrong Jesus came to recreate or reconstitute that society round himself, under the loving wisdom of his heavenly father as he invites people to follow him in the way of love'. His website also explains his involvement with interfaith dialogue and the BBC quotes him as suggesting that people who believe in God but don't accept Christianity should become Jews.

Cyberdoc is Adrian Warnock, locum consultant psychiatrist in London. This article and links to previous Cyberdoc reviews can be found at http://www.cmf.org.uk/cyberdoc/

BOOKS

The Medical History of the Reformers: Luther, Calvin and Knox

John Wilkinson
Handsel Press Limited
2001
£9.95 Pb 117 pp
ISBN 1 871828 60 0

This book will interest all CMF members. Our CMF statement of faith declares many of the biblical truths which the subjects of this book laboured diligently and fearlessly to proclaim and for which they suffered poverty, persecution, abuse and exile. Many of the freedoms we enjoy today are the fruit of their work.

It is a lively book giving vivid cameos of Martin Luther, John Calvin and John Knox, their family background and contemporaries, with fascinating accounts of the diagnostic and therapeutic methods of sixteenth century medicine. John Wilkinson' s painstaking research, sifting of evidence, clear documentation, refutation of fallacious popular opinions and well- reasoned conclusions, his spiritual insight and sympathy with his subjects make it a pleasure to read.

Martin Luther, 'a prodigious man in a prodigious age, a hero in a time of heroes', suffered gout, renal calculi, urinary retention with acute renal failure, hypertension, ischaemic heart disease, chronic suppurative otitis media, chronic venous ulceration and many febrile episodes.

John Calvin, though slandered as a cold detached individual, is shown through his letters 'as a deep fountain of tenderness and affection'. He suffered gout, renal calculi, anaemia, malaria and pulmonary tuberculosis from which he died.

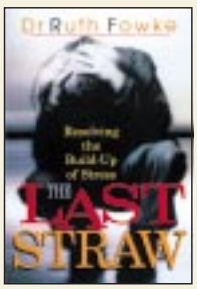
John Knox while a galley slave for 19 months, 'a form of life which for unutterable horror is perhaps without parallel in the history of humanity', suffered 'galley fever'(possible louse-borne typhus or bubonic plague), dehydration, malnutrition and renal colic. He later suffered a mild cerebral thrombosis with left hemiparesis and finally died with acute bronchopneumonia.

Despite their physical and mental suffering they achieved a monumental volume of work including Bible commentaries, theological treatises, and copious correspondence in the midst of daily preaching, teaching and pastoral work and responsibilities as Reformation leaders. Their motivation was their deep strong faith and experience of the saving grace of God in Christ. John Knox, for example was 'a great Christian leader and statesman who exhausted himself in his battle for the political social and above all the religious freedom of his people...He left a national and religious heritage...(whose) influence can still be seen in the character, literature and institutions of Scotland today'.

This book is an inspiration and challenge from the lives of great Christian leaders.

Stephen Browne is a General Practitioner in Birmingham

The Last Straw



Ruth Fowke
Eagle 2000
£6.99 Pb 158pp
ISBN 086347 363 6

Hands up those who've got stress sorted! If you haven't got your hand up, there is probably something in this excellent little book for you. Aided by some delightfully humorous personal illustrations, Ruth Fowke provides an opportunity for all of us to take a little time out to examine how we allow stress to build up in our lives and to see whether something can be done about it.

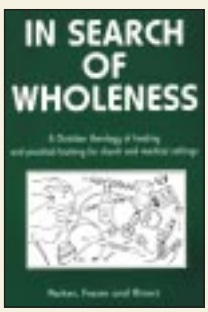
Most of us recognise that in addition to individual burn out, stress is also damaging to relationships. The author helps us to see how factors such as different personality type, poor communication, delay in decision making and 'baggage from the past' can be recognised and better handled.

The book is easily readable and parts of it can be appreciated at a level of straightforward common sense or basic psychological insight. However, all the writing is under-girded with biblical truth and recognises the fundamental importance of our ongoing relationship with Christ. Coping with change is often a struggle, but 'if the shifting sands of change reveal that our foundation is also insubstantial', we may recognise an opportunity to do some fundamental repair work to our spiritual life.

Whether we consider ourselves to be orthodox Christians or not, the book unpacks how a false half-image of God can lodge unrecognised within us and do untold damage. Many doctors find themselves driven by work and lose any sense of identity outside the workplace. However, in the Bible, work and leisure are two sides of the same coin so one without the other is meaningless. Ruth Fowke encourages us to beware of reducing life to the merely utilitarian but instead to rediscover the astonishing truth of 1 Timothy 6:17: 'God richly provides us with everything for our enjoyment.'

Kevin Vaughan is a General Practitioner in Birmingham

In search of wholeness: a Christian theology of healing and practical training for church and medical settings



R Parker, D Fraser & D Rivers
St John's Extension Studies, Nottingham.
2000
£9.95 108pp
ISBN 1 900920 09 3

The co-authors of this study manual are the Director of the Acorn Christian Foundation and two hospital chaplains. Their intention is 'to help Christians who want to be involved in God's gracious healing processes in the world today'. Discussion includes the theology of healing; the skills needed and attitudes involved when engaging with

sick people; becoming a renewed and healing church; coping with failure, death, and spiritual warfare. There is also a checklist, indicating to intending participants whether they are better suited for health care or church work, if not both. Taffy's cartoons break up the (easily read) text.

The authors hope to encourage better listening between Christians of two major persuasions. Some believe that all sickness can be healed if both prayers and prayed for have enough faith, regardless of God's gifts of modern medicine and skill. Others, including some doctors, expect healing only through medical means or spontaneous remissions. Recovery after prayer is attributed to underlying psychosomatic disorder, as though this diminishes its impact.

As James 4:14-16 indicates, the early church used both physical and spiritual means to restore health. There is still room for this combination. 'Going to the doctor and receiving the laying on of hands are not mutually exclusive'. (p24)

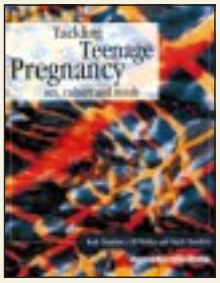
Those persisting in exclusivity can behave as though God must abide by their rules. Yet medicine without prayer and prayer without medicine fail equally to acknowledge that healing is in his hands. Although we may be instrumental in furthering his purposes, he is responsible for the final outcome. The last section, *Hard Questions*, considers the complexity of some of his ways, as when healing never comes.

All of us need to exercise a sensitivity not always reported in health professionals. The section, *Visiting the sick*, offers hints for any who hope to contribute to their wellbeing.

The frequent confusion of singular and plural (as in '*The client*/person and *their*...') should be corrected in the next edition, but should not deflect from the usefulness of this one. In particular, we are reminded that a renewed church and its health workers, besides exchanging different perspectives and experiences, need prayerfully to exercise together their unique and God-given gifts of healing.

Janet Goodall is Emeritus Consultant Paediatrician, Staffordshire

Tackling teenage pregnancy: sex, culture and needs



Ruth Chambers, Gill Wakley & Steph Chambers
Radcliffe 2001
£17.95 Pb 219pp
ISBN 1 85775 497 2

This is a well-written, easy-to-read and up-to-date book on a crucial topic. It stems from the authors' extensive involvement with a teenage pregnancy prevention initiative in Staffordshire. Steph Chambers was 14 at the time she wrote her contributions and one of the major distinguishing marks of the book is its determination to reflect what young people are really thinking. The introductory chapter '*A Teenager's Viewpoint*' by Anna Brown, aged 16, sets the tone and provides much for *Triple Helix* readers to reflect upon.

The approach is primary care-focused, practical and very comprehensive with chapters covering clinical governance, reaching young people, confidentiality, contraception, unplanned pregnancy, STIs, disability, sexual abuse and influence of peers, media and the press.

Culture, religion and beliefs also merit a chapter, which concludes with the warning to 'Make sure that you understand your own belief systems so that you do not unwittingly try to impose them on others inappropriately'. This sounds reasonable but of course implies there is little or no place for such belief systems (except presumably pragmatic humanism) having any influence wittingly or appropriately.

The text reflects the universal belief-system of books on teenage pregnancy in the UK that since teenagers will have sex whatever you tell them, provision of accurate sex information and easing access to contraceptives are the keys to preventing both unplanned pregnancy and STIs. Yet these authors do at least show awareness that these are not the only factors involved in sexual health. For example they conclude the section on Regretted sexual intercourse with the admission that 'Spreading the word that many teenagers regret exerting pressure and not planning their first intercourse might help other young people to postpone instant gratification in favour of later satisfaction'.

A paragraph from the section on *Gender and sexuality* movingly describes where most young people are at: 'Young women often know about safe sex, and intend to use condoms, but find themselves unable to be assertive enough to do this within the context of a sexual relationship. They feel they should be passive and undemanding and that the man should take the lead. Young men are confused too. How can they take the lead with these apparently more confident and knowledgeable young women?

Whatever they do will be wrong….They are encouraged to despise the "easy" sexual conquest (as "cheap" and having no value), but equally they brand women who resist their sexual advances as "frigid". How can they ever get it right?'

This wistful questioning surely tacitly acknowledges that there is more to teenage sexual health than correct use of contraceptives. Religious values and especially Christian ones have a more important place in sexual relationships than these authors are consciously aware of. Spirituality and sexuality are inextricably linked and we separate them at our peril.

Trevor Stammers is a General Practitioner in West London who writes and broadcasts on sexuality

LETTERS


The Spectre of Bristol

The Spectre of Bristol

Gordon Stirrat, *Professor of Obstetrics and Gynaecology in Bristol, responds to Michael Keighley.*

Having been Dean of the Faculty of Medicine in the University of Bristol from 1990 to 1993 and a member of both the South-Western Regional and then Avon Area Health Authority over the crucial period, I have direct knowledge of the issues surrounding paediatric cardiac surgery in Bristol Royal Infirmary shared by very few not directly involved. There is much in Professor Keighley's article (*Triple Helix* 2001; Autumn:2-13) with which I find myself in total agreement. For example, I would highlight his sense that it could all happen (is happening?) again elsewhere and the failure to acknowledge fully the consequences of a chronically under-resourced NHS. I also fully endorse his suggested Christian response. But, in what was otherwise a reasonable and balanced article from someone obtaining his information second-hand from the Kennedy Report and the medical and other media, I felt that the table entitled 'Bristol's catalogue of failure' with its final and unanswerable 'Many, many more', was inappropriate. While accepting from my first hand knowledge that there is truth in some of the bullet points as they relate to Bristol, I also know that many of them also apply equally elsewhere. Can Professor Keighley assure me that the hospitals in the city in which he works are free from the criticisms attributed to Bristol? I doubt it.

More importantly his article contains several factual errors. He states, 'Excess mortality in paediatric cardiac surgery (PCS) at Bristol seems undeniable'. The authors of the analysis have subsequently described their *modus operandi* and findings in more detail.[1] They accept that 'excess mortality' is an unsuitable term but could think of no other. The comparator against which the mortality is deemed to be excess is itself unreliable, leaving a question mark at the size and significance of the finding. What was the cause for the 'excess mortality?' The surgeon's defence was that it lay in the unusually high level of risk factors in the small groups of patients which were the focus of the controversy, and which constituted just 3% of their paediatric workload. This judgement can neither be confirmed nor refuted because as Spiegelhalter states, 'there is no recognised procedure for adjusting for clinical risk factors in paediatric cardiac surgery'. They concluded that the excess mortality was 'in open-heart operations in children under one year of age' and not for PCS in general. Neither the GMC nor the Inquiry found that any of these excess deaths were due to surgical errors.

He also writes, 'for me the most frightening statement was that the surgeons just kept going, hoping that things would improve (that a paediatric surgeon, an ITU and a children's hospital and a children's hospital would materialise) rather than stopping so that the politicians and the health economists would do something. Nobody did anything.' Nothing could be further from the truth! To believe that, by stopping, the powers that be would 'do something' is naïve. In addition the record shows that the two surgeons constantly worked for the enlargement of, and the commitment of increased resources to, the PCS Unit. Indeed, together with the whole team, they worked for the transfer of PCS to the Bristol Children's Hospital from as early as 1990. During my time as Dean, James Wisheart obtained funding for a Chair in PCS and a potential candidate was identified only to be lost when the Trust felt that they could not fund the necessary capital works. The decisions to appoint a new paediatric cardiac surgeon and transfer the work to the Children's Hospital were ultimately taken in the summer of 1994. In light of what has happened subsequently it is important to note that this was *before* Steven Bolsin leaked the findings of his 'secret audit' in January 1995. The surgeons and cardiologists saw Bolsin's data for the first time only after he was required to provide it to the Trust in May 1995. This enabled its serious errors to be identified and subsequently acknowledged by him in September 1995.

Finally, Professor Keighley's insight into what James Wisheart and his colleagues were trying to do by 'keeping on going to try to make it work' is absolutely right. As a result of this, two surgeons of the highest personal integrity have been made scapegoats for an NHS that failed them and, even more importantly, the children and families so tragically affected.

1. Spiegelhalter DJ, Aylin P, Best NG et al. Commissioned analysis of surgical performance by using routine data: lessons from the Bristol Inquiry. *Journal of the Royal Statistical Society* 2002;165:1-31.

Africa's Church Hospitals

Angus Grant*, working at Chogoria Hospital in Kenya, makes a good suggestion we intend to take up in subsequent issues. Any offers from potential authors?*

I enjoyed reading Gordon MacFarlane's article on Africa's Church Hospitals and the comments from others (*Triple Helix* 2001; Summer:12-14 and Autumn:20-21).

While every country, indeed every church and institution's situation is different, the issues raised are major challenges that we wrestle with: Health care funding, resource allocation, equity of access to care, the place of church-run health care, relationships with other providers, changing health needs, corruption, upholding standards of care, putting health on the political agenda (and keeping it there) etc.

These issues are not limited to the developing world. For example politicians of all nations tacitly recognise that health care funding cannot be limitless, but publicly try to avoid the issue. These are issues where Christians and in particular Christian health professionals must have a voice - we are at one of those turning points in history where everything is up for grabs and where concerted efforts could result in huge improvements in the health of millions. Even if we are working in a system which is relatively equitable, such as the NHS (UK), there is much that can be done to reduce global inequalities. I would welcome more articles looking at these issues - perhaps a series taking each one in turn.

Passage to India

I paid for my trip to India in stress and sweat. Not out there, but in the mad rush to clear my desk before departure, and in the bulging in-tray and looming deadlines on return. However the blessing I received in ten autumn days, through being involved in the EMFI (Evangelical Medical Fellowship of India) national conference and in visiting hospitals and health projects in the northwest, was well worth it. There is much to tell, but let me share the three things that struck me most.

The first was a sense of thanks for the blessings Christianity has brought in Britain. We easily forget that we have clean drinking water, low infant mortality, few street children, minimal corruption, good health and education, a functioning legal system and a good standard of living largely as the legacy of Christian revival in the18th and 19th centuries. What Wesley and Whitefield sparked in the 1700s led ultimately to profound social reform through notables like Wilberforce, Barnardo and the Clapham sect. Our medical system too is indebted to the foundation laid by Christian doctors like Lister, Jenner and Sydenham and most of our present difficulties are because we have forgotten as a society what once made us great. By contrast, India's principle problem is a suffocating ideology which stratifies people into castes, values cows more than children and promotes spirituality without morality. Hinduism has two main failings: it isn't true and it doesn't work.

The second thing that struck me was a sense of wonder at what God is doing today in India. There are now over 40 million Christians, and 44,000 Indian missionaries serve cross-culturally within its borders. Past missionary efforts have led to the Syriac church in Kerala, the Catholic Church around Goa and the Protestant churches in the northeast and south-east tip, in the 1st, 16th and 19th centuries respectively. In some states Christians now make up over 80% of the population. But all these past incursions of God's spirit are being dwarfed by the current wave of new converts, from all backgrounds, but especially amongst the poor. I met new Christians who were formerly Jain, Animist, Sikh and high-caste Hindu and visited areas where Buddhists and Muslims are coming to Christ. There is a real sense of expectancy amongst the churches and doors are wide open.

But third, I was most challenged by the way many of our Christian doctor colleagues integrated their faith and lifestyle, particularly in their concern for the poor. The Evangelical Medical Fellowship of India (EMFI), our sister organisation, is growing rapidly, and has been built on a firm foundation of sacrificial and compassionate service to those in most need. There are still over 1,200 church hospitals in India largely staffed by Indian Christian doctors, many of whom trained at one of two Christian hospitals, Vellore and Ludhiana. Most are in areas where Christians are fewest in number, and through associated urban and rural community health, literacy and development projects, are empowering marginalised people and transforming communities. One team of 70 healthcare professionals, in ten years on the ASHA project, had helped transform the lives of 200,000 of Delhi's slum dwellers to the extent where child mortality had fallen 80% and there was 95% immunisation, almost full employment and minimal malnutrition or TB. Pregnant women received antenatal care of almost UK standards (including ultrasound) and, in one site I visited, most of the houses had metered electricity, many with electric fans and televisions. What the Christians do provides the opening for what they say. In the same way, in the aftermath of the Orissa floods and the Gujerati earthquake, Christian compassion through healthcare has opened up to the gospel those regions most antagonistic to Christianity.

I wonder if, as Christian doctors in the UK, we are as radically different from non-Christians in our attitudes and actions as our Indian brothers and sisters. And if not, what effect it has on how the gospel is received by our patients and colleagues.

Peter Saunders
CMF General Secretary

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